



PATIENT

Arnold Beverly

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

10 Years

WEIGHT

10 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Irene Lavigne

HOSPITAL NAME

Kings VH

REFERRING VET

Dr. Irene Lavigne

INVOICE

21230

DATE

2/21/23

PRESENTING CLINICAL SIGNS

History: Arnold presents today for hospitalization for CKD. He has been having inappropriate defecation and urination and has been PUPD. Little vomiting. Sat he had blood sent out that showed severe azotemia, hypokalemia, anemia. He was brought back for care.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. No mineral is observed. Mild bilateral pyelectasia is noted. The left kidney measures 2.9 cm. The right kidney measures 2.9 cm.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas



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The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

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- Chronic kidney disease with mild to moderate bilateral pyelectasia – This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc. Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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Additionally, a blood pressure is recommended if not recently evaluated.

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In the meantime, as is reportedly already in place, medical management for an acute on chronic kidney insult is recommended, in the form of diuresis, electrolyte normalization, gastrointestinal support, nutritional support, etc.

Depending on the level of anemia, blood transfusion may be necessary, followed up potentially with an erythropoietin/darbepoetin supplementation pending levels.

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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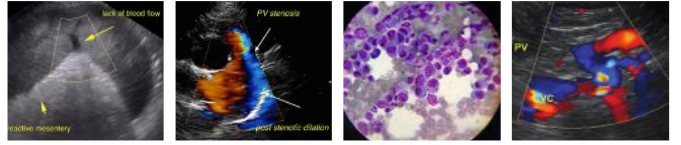
Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

DATE

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Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com



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