SonoPath
Clinical Sonography & Telecytology
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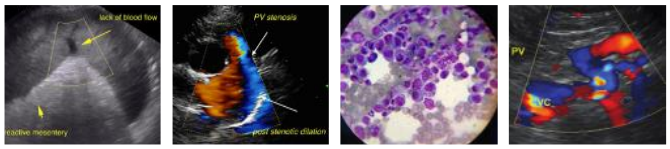


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Jake Rubert

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years

WEIGHT

5 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Callihan

HOSPITAL NAME

Animal Emergency Care

REFERRING VET

Dr. Williams

INVOICE

21033

DATE

2/7/23

PRESENTING CLINICAL SIGNS

History: Lethargy and inappetence for couple days, has history of FUO approximately yearly for many years, extensive testing with FeLV/FIV, FUO panels always negative. History of heart murmur. Used to be indoor/outdoor but past year or so strictly indoor

Abnormal PE/Chem/CBC/UA Results: Temp 105.8, some tenderness cranial abd palpation; left parasternal murmur 3/6; BCS 6/9, otherwise pretty unremarkable CBC today mild neutrophilia, low potassium, t.Bili 1.5, glob just slightly over ref range at 5.2, urine showed cocci and rods and USG 1.030, culture pending Cytology of spleen and lymph nodes tonight was nonspecific/ reactive

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents, as well as a large amount of echogenic and some swirling debris. No masses or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally uniformly enlarged/swollen with an overall hyperechoic echogenicity and slight loss of corticomedullary definition. Normal smooth peripheral margination and shape are maintained. The renal pelvis are dilated with anechoic fluid and hyperechoic thickened pelvic fat. No overt evidence of neoplasia or mineral is observed. The perinephric area is enhanced by hyperechoic fat and mesentery. The pyelectasia in the left kidney measures 0.32 cm in the transverse view. The pyelectasia in the right kidney measures 0.32 cm in the transverse view. The left kidney measures 5.08 cm. The right kidney measures 4.84 cm.

Adrenal Glands

Left adrenal gland is normal in size (1.13 cm long x 0.6 cm thick), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.94 cm long x 0.53 cm thick), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

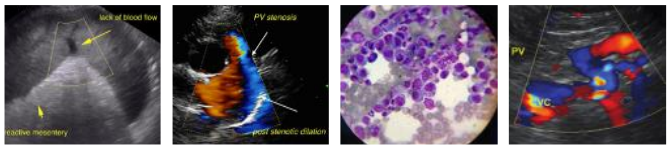
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

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



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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly fluid distended with no evidence of obstruction, foreign material or infiltrative disease. 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 colon is diffusely thick, measuring between 0.3 cm and 0.4 cm thick with layering primarily intact but an overall hazy heterogenous appearance to the wall.

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Pancreatic duct dilation is noted.

Free Abdomen

There is no evidence of peritoneal effusion. The mesenteric lymph nodes, as well as the lymph nodes medial to the spleen around the left kidney, are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Pyelonephritis – These changes are most consistent with chronic pyelonephritis. Chronic scarring and fibrosis and/or chronic nephrolith passage can also result in these pelvic dilation changes. Early infiltrative disease, especially given the concurrent lymphadenopathy, cannot be ruled out but is considered less likely.
- Diffusely thick colon with a heterogenous wall and lymphadenopathy is concerning for infiltrative disease and both benign infectious, parasitic, infectious, other disease, as well as infiltrative neoplasia are differentials.
- Aggressive mesenteric and splenic lymph nodes – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- Chronic active pancreatitis

Secondary Findings

- A large amount of echogenic urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urine culture, as is reportedly already pending, is recommended to help direct medical management of the suspected pyelonephritis. Additionally, if possible, and if patients coagulation status is appropriate, fine needle aspirate of the enlarged mesenteric and splenic lymph nodes could be considered if patients coagulation status is appropriate, and/or pending results, fine needle aspirates of the kidneys could be considered.

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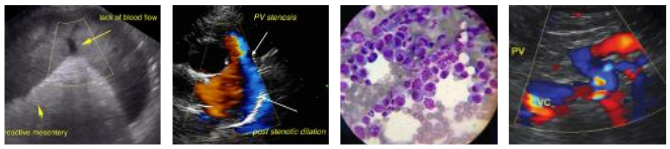

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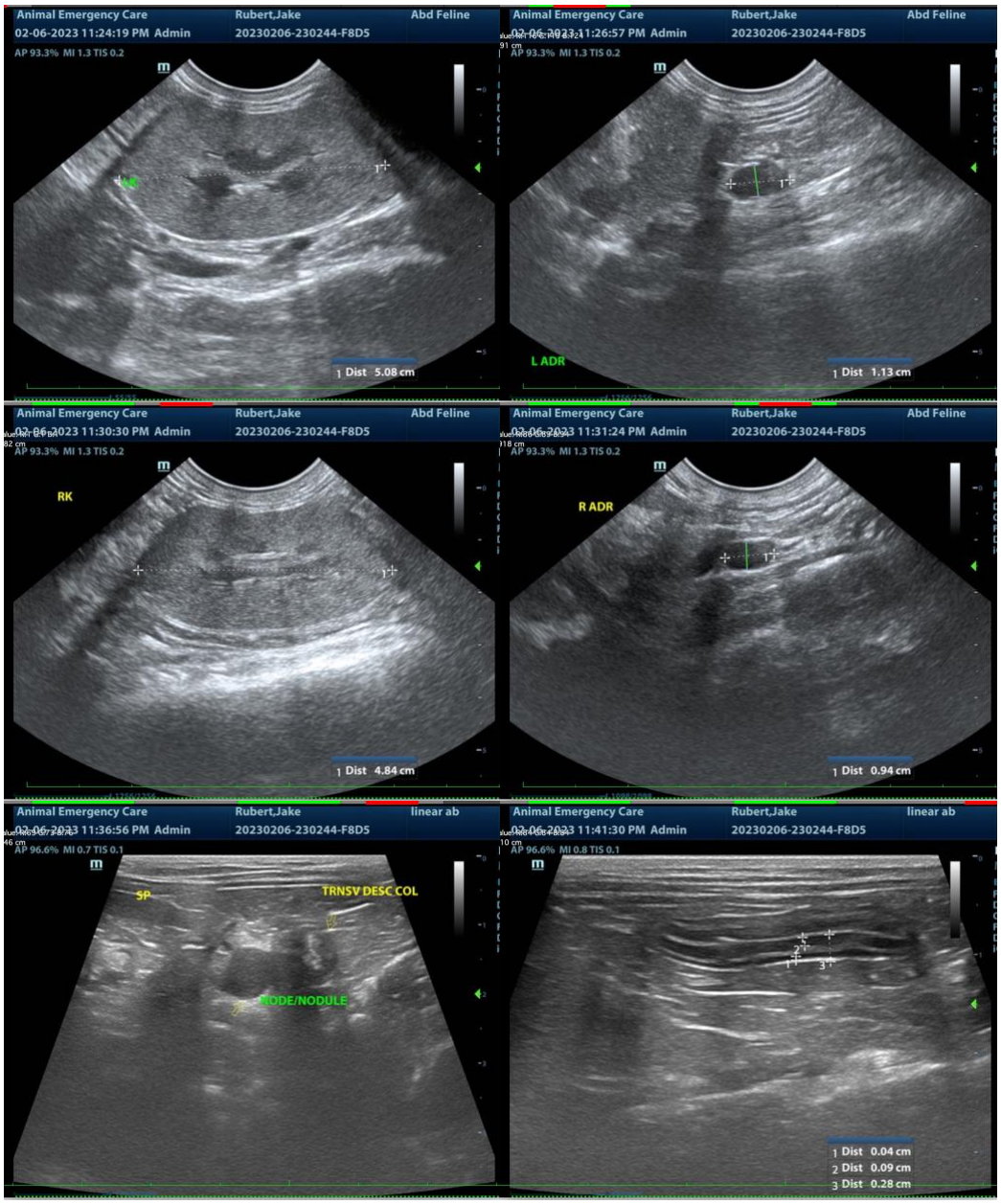
Especially if this patient has a history of gastrointestinal signs, a fecal exam, as well as a fecal enteropathogen PCR panel to Texas A&M GI Laboratory, for further evaluation of possible infectious disease +/- a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, could all be considered for further evaluation the colonic changes.

Ultimately, given the chronic waxing and waning clinical signs, colonoscopy may be necessary for a definitive diagnosis. In the meantime, medical management of the suspected pyelonephritis is recommended with broad spectrum antibiotics, fluid therapy (if needed), etc., as well as supportive care of the gastrointestinal signs.



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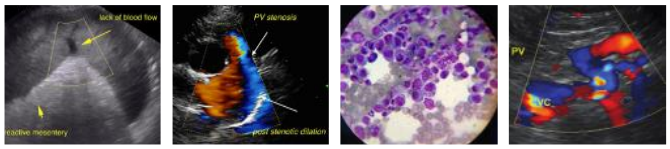

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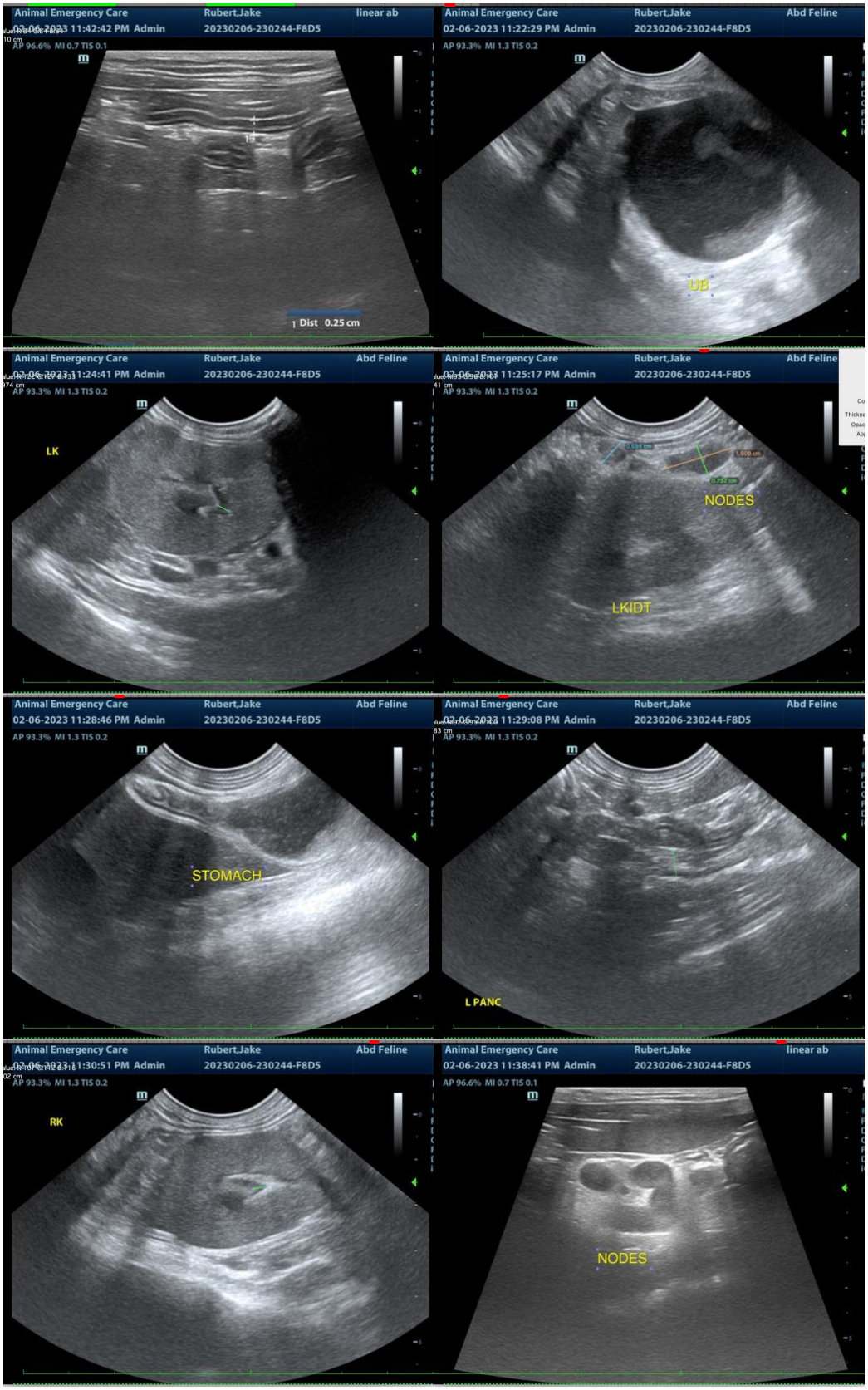

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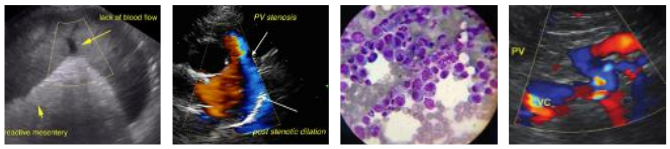

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com