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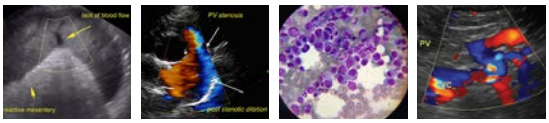


imagine SOUND LLC.
IMAGING PERFORMED BY
dbimaginesound@gmail.com 917-647-4318

PATIENT

Reggie Elbert

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years 3 Months

WEIGHT

17.12 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Denise Bruno, LVT, RDMS

HOSPITAL NAME

Brooklyn Heights VH

REFERRING VET

Dr. Thomson

INVOICE

45810

DATE

3/9/23

PRESENTING CLINICAL SIGNS

Hx Anorexia, lethargy, fever was on Pred for skin dz - but stopped meds. Now (+) Snap fPL, dehydration. current meds- Cerenia, famotidine, Convenia, I/D diet Evaluate for Triaditis, pancreatitis, lymphoma

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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 large in size with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia or infarcts observed. Small bilateral non-obstructive nephroliths are noted. Bilateral incidental cortical cysts noted. The right kidney measures 4.77 cm. The left kidney measures 4.15 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.40 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.07 cm) with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

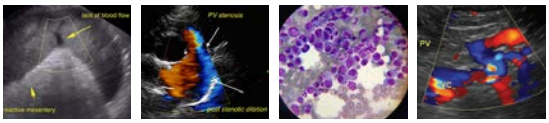
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal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

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. One tiny non-shadowing mineral density/cholecystolith is noted. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty 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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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.



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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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 free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS

- **Feline renomegaly with small bilateral non-obstructive nephroliths and incidental bilateral cortical cysts –** These renal changes can be seen with glomerular or interstitial nephritis, FIP, amyloidosis, acute tubular necrosis or infiltrative neoplasia such as lymphoma. Normal variant due to fat deposition cannot be ruled out but is less common in an enlarged kidney.
- **Scalloped spleen –** can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- Chronic active pancreatitis

SECONDARY FINDINGS

- One tiny non-shadowing cholecystolith

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is reportedly a large cat, and therefore the mild renomegaly and splenomegaly could be normal patient variant. However, infiltrative disease cannot be ruled out, and given the concurrent scalloped appearance of the spleen, a fine needle aspirate of the spleen is recommended if patient's coagulation status is appropriate.

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

Finally, given this patient's history of recent Prednisone administration and a new fever, evaluation for possible secondary infectious disease, especially if the Prednisone was at an immunosuppressive dose, is recommended, beginning with testing for toxoplasma.

In the meantime, a mild acute on chronic flare up of pancreatitis can't be ruled out based on ultrasound. Therefore, supportive/symptomatic medical management in the form of antiemetics, gastroprotectants, appetite stimulants, or nutritional support including a feeding tube if necessary, broad-spectrum antibiotics, and fluid therapy are recommended.

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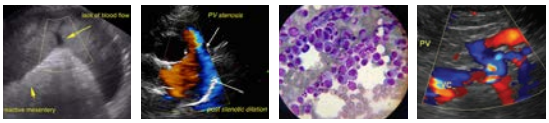

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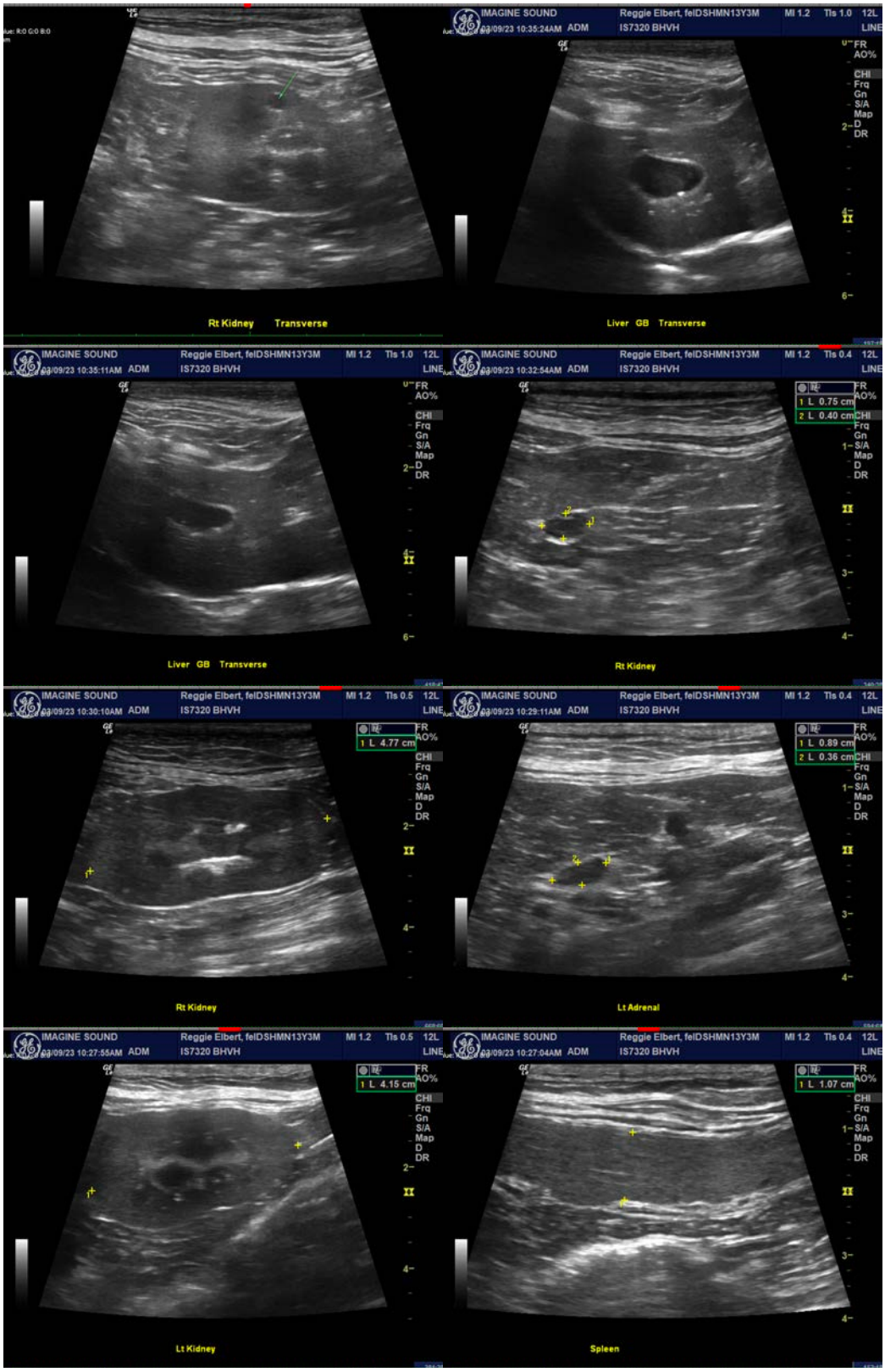

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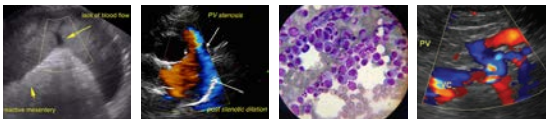

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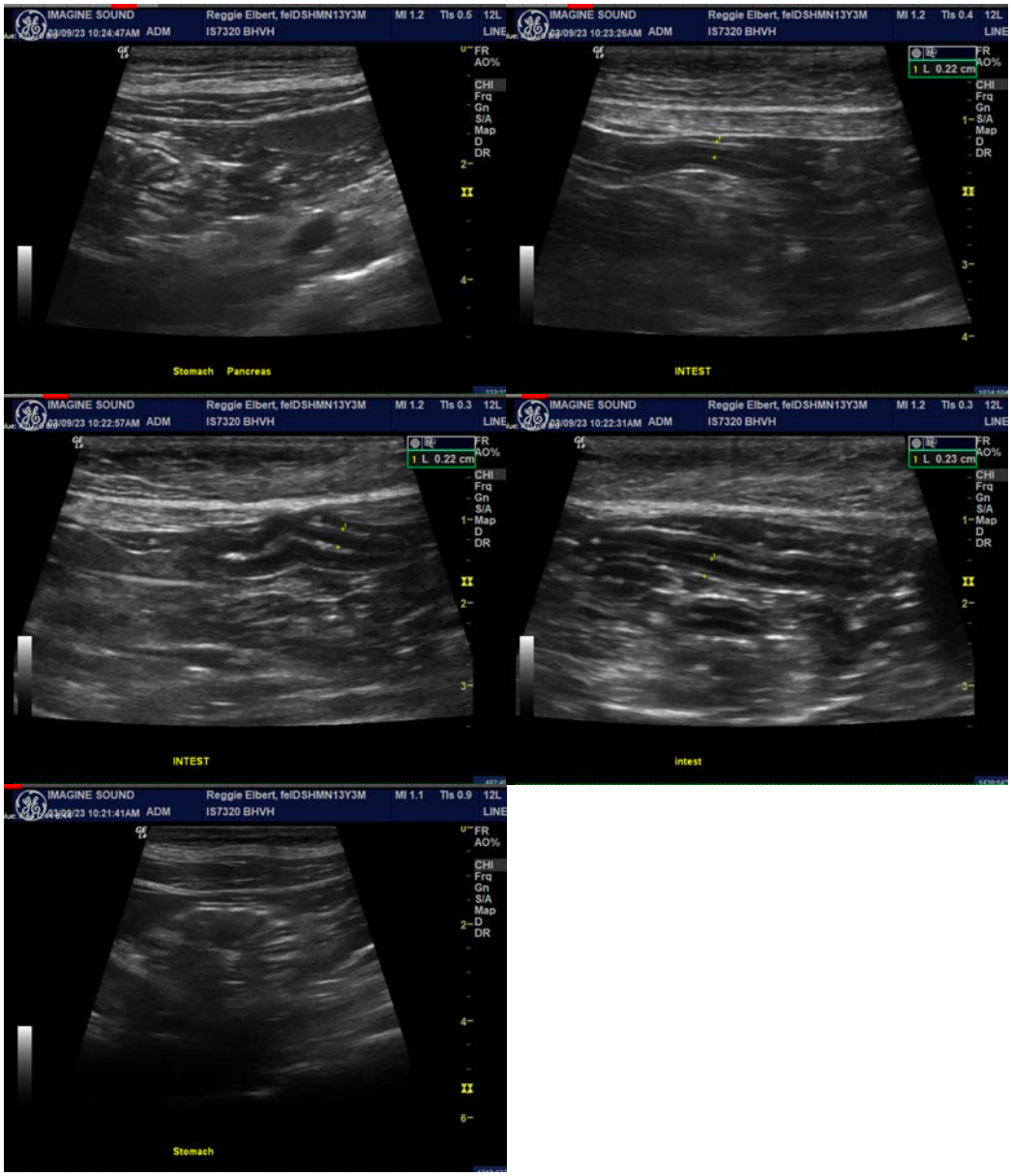

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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