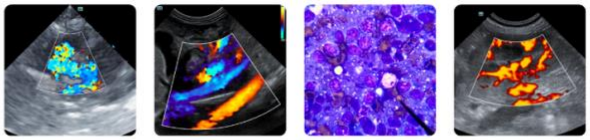


PATIENT

Leonard Bott

SPECIES

Feline

BREED

Maine Coon

SEX

Neutered Male

AGE

5 Years

WEIGHT

9.3 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey AEC

REFERRING VET

Dr. Shally Gastelu

INVOICE

36889

DATE

4/30/26

PRESENTING CLINICAL SIGNS

History: Lethargy, decreased appetite, hiding noticed on 4/28, reportedly normal previously.
PE on presentation: Eyes: Bilateral third eyelid protrusion, bilateral chemosis; OS: fibrin precipitate in left anterior chamber appears to be pushed against endothelial surface of the cornea, mild mucoid discharge. Cardiovascular: Bradycardia

Abnormal PE/Chem/CBC/UA Results: CBC: Unremarkable Chem15: BUN >130 (H), Creat 9.7 (H), Phos 8.5 (H), Ca 6.8 (L) EPOC: Glu 136 (H), BUN >120 (H), Creat 14.92, iCa 0.99 (L), Na 147 (L), BE -9.9 (L), TCO2 15.7 (L), cSO2 99.2 (H), pO2 152.6 (H) proBNP: Abnormal Schirmer tear test: OS: 6 mm; OD: 9 mm Intraocular pressure: OS: 12, 16, 16, 16; OD: 8, 11, 11, 12 Fluorescein stain: OU: No stain uptake 3 view abdominal radiographs: Cardiac silhouette appears unremarkable, no pleural effusion or pulmonary edema. Abdomen shows moderate gas distention in colon, stomach, bladder appears unremarkable, kidneys, spleen unremarkable. No evidence of free abdominal fluid noted.

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.

The kidneys are bilaterally large in size with overall increased cortical echogenicity. Both measure 5.2 cm. Mildly decreased corticomedullary distinction is appreciated. No pyelectasia or mineral is observed but adjacent to the left kidney, is free fluid and enhanced hyperechoic tissue.

Adrenal Glands

The areas of the adrenal glands are examined without evident adrenal gland pathology.

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.

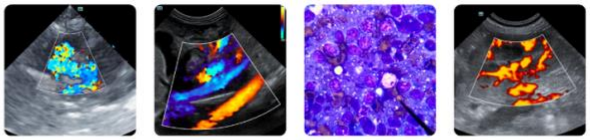
Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The gallbladder wall is thick and edematous characterized by an intramural hypo to anechoic rim or “double rim effect or halo sign”. 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 primarily fluid as well as some echogenic non-shadowing luminal contents and gas



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

Pancreas

**See Free Abdomen section.

Free Abdomen

As described above, free fluid is noted adjacent to the left kidney. No lymphadenopathy is noted. Subjectively caudal to the stomach, the area is enhanced/hyperechoic, concerning for some possible inflammation, potentially secondary to hepatobiliary disease, chronic low grade smoldering pancreatitis versus other.

ULTRASONOGRAPHIC FINDINGS

- The appearance of the kidneys is concerning for an acute kidney insult, such as a toxic insult and/or infectious disease, i.e., pyelonephritis, FIP, other. Other infiltrative disease, including infiltrative neoplasia, such as lymphoma, can't be ruled out without tissue sampling.
- The liver changes are nonspecific, but could represent a concurrent microscopic hepatopathy, including benign bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other infectious or reactive hepatopathy, although infiltrative neoplasia, such as round cell neoplasia, can't be ruled out without tissue sampling.
- Gallbladder “halo sign” – GB wall edema is a non-specific change and can be seen with any underlying etiology (i.e., vasculitis, hypoalbuminemia, CHF, other) that results in edema, as well as immune-mediated disease, anaphylactic shock, other. Cholecystitis cannot be ruled out.
- Chronic low grade smoldering pancreatitis can't be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

A blood pressure is recommended if not recently evaluated.

Ultimately, tissue sampling could be considered, in which case, fine needle aspirates of the kidneys +/- liver could be considered if patient's coagulation status is appropriate.

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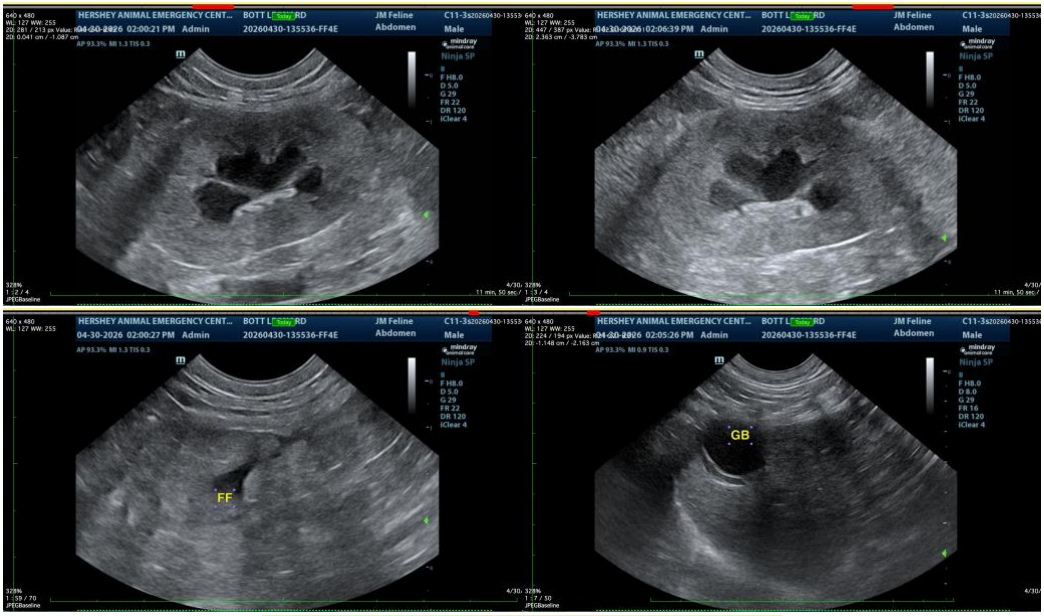
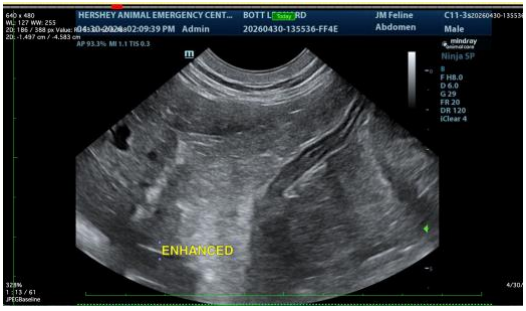
Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.





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

info@sonopath.com