



**PATIENT**

Mr. Spock Sullivan

**SPECIES**

Feline

**BREED**

Sphynx

**SEX**

Neutered Male

**AGE**

13 Years

**WEIGHT**

8.02

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Jessica Green

**HOSPITAL NAME**

Stanglein Vet Clinic

**REFERRING VET**

Dr. Dan Hoffman

**INVOICE**

39234

**DATE**

7/6/22

**PRESENTING CLINICAL SIGNS**

o reports PUPD of several weeks duration; historically p has been a picky eater, but his appetite has also been decreased the past few weeks and there has also been occasional vomiting (bile), p originally seen 6/27/22 which is when BW was performed, his appetite worsened, p was seen again 7/1/22 which is when rads were performed and constipation was diagnosed.

Abnormal PE/Chem/CBC/UA Results: 6/27/22 minimal azotemia, but no significant change from BW performed 4/22 (BUN=40- now 41mg/dL, Creat =2.0- now 2.2 mg/dL, SDMA=17 - now 19ug/dL) but rest of BW was unremarkable, hyposthenuria (USG=1.013) but UA otherwise unremarkable... Rads: 7/1/22 large amount of firm formed fecal matter noted in colon, no significant distension of colon is appreciated, but there appears to be rectal impaction (which was later manually deobstipated). no other significant abnormalities were appreciated on rads. Current Meds: aventi kidney complete, lactulose, transdermal mirtazipine.

**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.

The kidneys are normal in size, but bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney measures 3.85 cm. The right kidney measured 3.85 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (0.33 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.37 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**Spleen**

The 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**

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. 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.



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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**

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The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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 free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

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**ULTRASONOGRAPHIC FINDINGS**

- Pancreatic age-related remodeling – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

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- Chronic Kidney Disease - This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given this patient's history of chronic kidney disease and recent onset of PU/PD, differentials for the reported constipation/obstipation include dehydration secondary to the chronic kidney disease. Therefore, recommendations include:

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- The addition of at home subcutaneous fluid therapy if tolerated, as well as potentially the addition of fiber to the diet to help prevent recurrent constipation/obstipation.

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- T4 and free T4 could be considered if not recently evaluated, just to thoroughly evaluate another potential cause of the recent onset of PU/PD.

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- Finally, given the pancreatic changes, as well as the fact that occult gastrointestinal disease can be present with minimal to no ultrasound changes, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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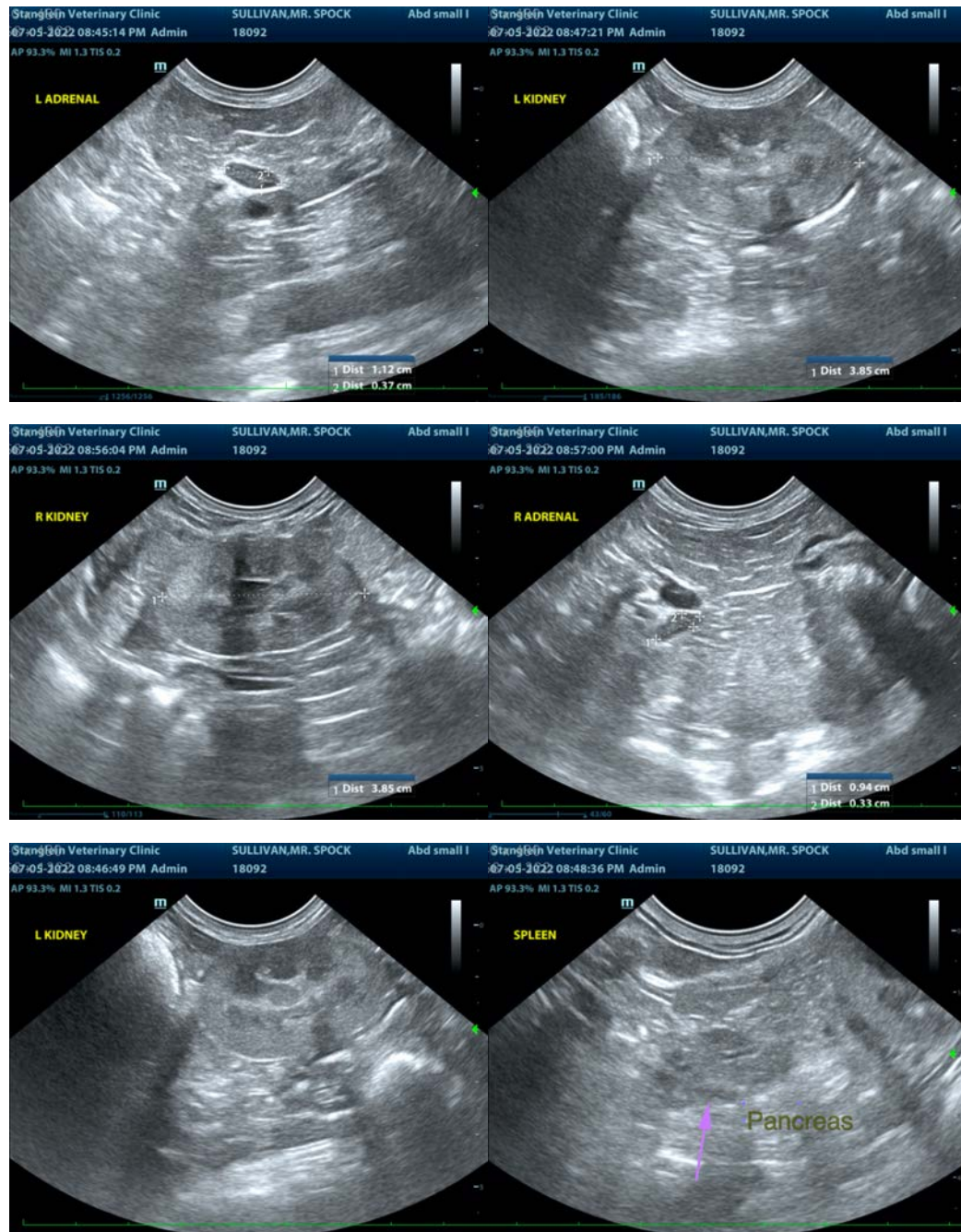
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**  
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