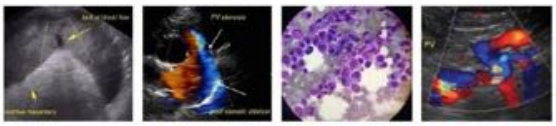


PATIENT

Isabel Gildner

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

14 years

WEIGHT

5.89 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

East Credit VH

REFERRING VET

Gardiner

INVOICE

14037

DATE

8.10.23

PRESENTING CLINICAL SIGNS

History: Hadn't been to vet in a few years. Lives with 3 other cats. Was seen at emerg 7/22/23 for blood noted at hind end. See diagnostics below, was sent with Gabapentin, Clavaseptin for UTI and pain from nephroliths. Seen at RDVM for follow up - Recommend Abdominal ultrasound as has continued to have hematuria and had some soft stools which have resolved.

Abnormal PE/Chem/CBC/UA Results: Urine strip from tabletop - 4+ blood, trace protein, no glucose done at emerg. CBC mild neutrophilia, eosinopenia (stress leukogram) Chem - mild hyperglycemia (high stress in clinic) and elevated Amylase rest WNL. Rads at emerg suggested mildly displaced small intestinal tract(ventrally), bladder intact and small, kidneys normal position but radio-opaque mineralization noted in area of left kidney with large adjacent soft tissue rounded structure.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.43 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The left kidney is overall normal in size (3.62 cm), and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. A 2.20 x 3.30 cm anechoic structure associated with the caudal pole of the left kidney may represent a cortical cyst, but is most consistent in appearance with a perinephric pseudocyst, as there is some visible subcapsular fluid adjacent to the more-distinct cystic lesion. Nonobstructive nephroliths are noted. There is no evidence of pyelectasia or infarcts observed.

The right kidney is overall normal in size (3.30 cm), and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The area of the left adrenal gland is examined without evident adrenal gland pathology.

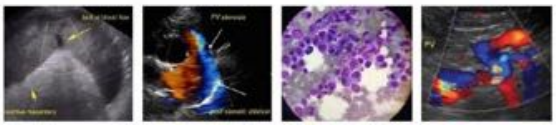
Right adrenal gland is normal in size (0.3.5 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Some nodules are large and result in capsular distortion. 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.



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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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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

Pancreas

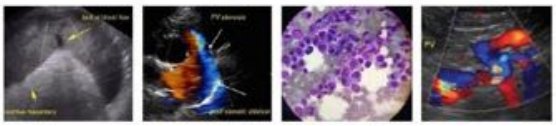
The observed pancreas (primarily the right pancreas) is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

There is no evidence of peritoneal effusion. Enhanced mesenteric fat is noted in the cranial abdomen. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- Nonobstructive nephrolith in the left kidney and a suspect perinephric pseudocyst, although a large cortical cyst cannot be definitively ruled out.
- Mild/subtle inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Mild emerging concurrent pancreatitis should be suspected in the face of supporting clinical signs.
- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given this patient's reported hematuria:

  1. 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.

  2. In the face of negative urine culture(s) and no cystoliths, masses, etc., these urinary signs are most consistent with sterile cystitis or feline lower urinary tract disease (FLUTD)

     Recommendations include maximizing water consumption (water fountains, canned food, etc) as well as reducing stress (recommendations can be found at Indoor Cat Initiative out of The Ohio State University CVM). Transition to a urinary health diet such as Royal Canin Urinary SO (or similar) could also be considered.

  3. Pending results of above and clinical status, etc., a fine-needle aspirate of the left kidney perinephric cyst can be considered (if coagulation status of the patient is appropriate). Often, even after drainage, perinephric pseudocysts return, and ultimately, surgery can become necessary pending patient response, underlying kidney disease, progression, etc.

  4. While the appearance of the splenic nodules trend in appearance toward benign, given the large nature and capsule distortion, fine-needle aspirate of the spleen can also be considered (if coagulation status of the patient is appropriate).

- Finally, while the reported soft stool has reportedly improved, if gastrointestinal signs persist, further evaluation of digestion and absorption, etc., can be considered beginning with 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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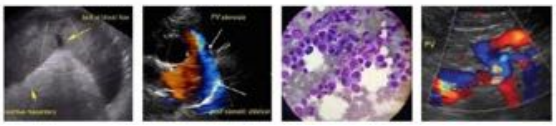

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

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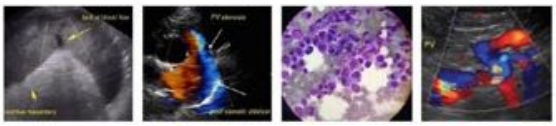

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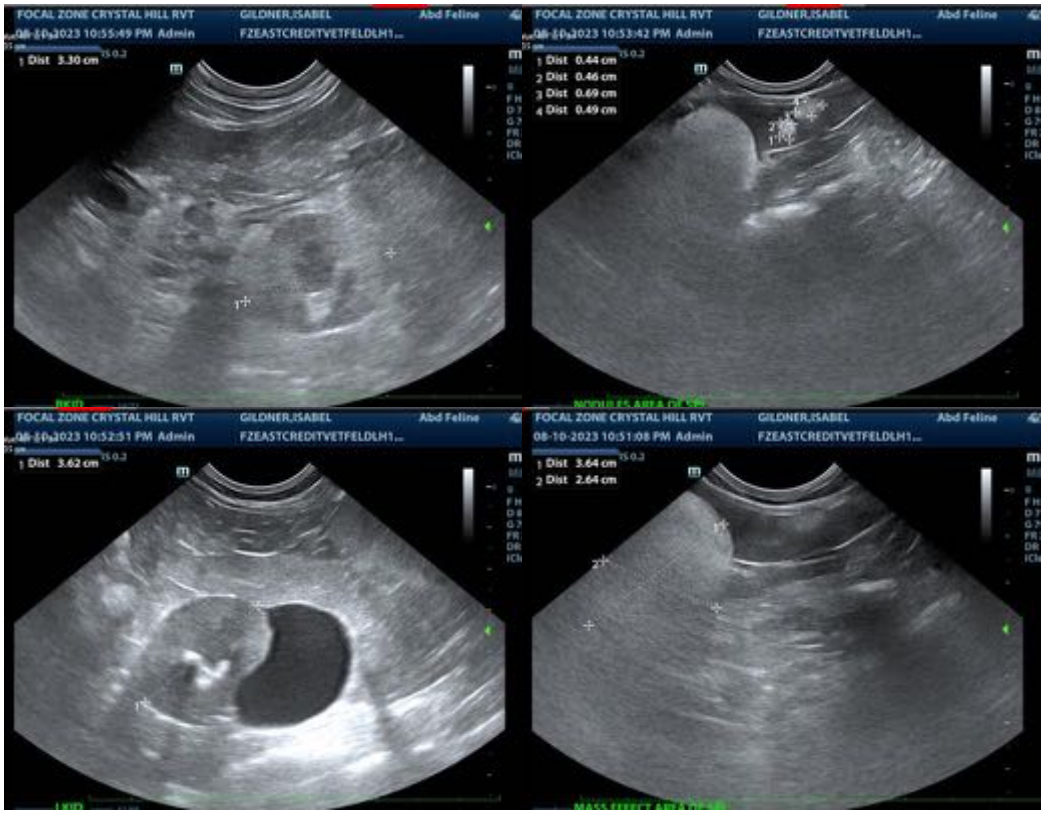

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@SonoPath.com