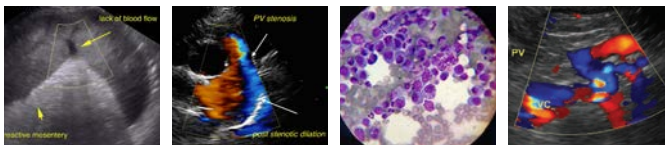
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Girly Yohe

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
13 Years

WEIGHT
5.9 kg

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Erin Wicks

HOSPITAL NAME
Shores VEC

REFERRING VET
Dr. Slenbaker

INVOICE
40476

DATE
8/16/22

PRESENTING CLINICAL SIGNS

Presented at our hospital for 3/21/22 – thought P was diabetic so did full bloodwork a blood glucose with the glucometer- 170, and a urinalysis complete, gave Convenia and treated for a UTI, 4/6/22 was rechecked and did a urinalysis- bacteria still present and still RBC/WBC- did not do anything this time for treatment but did diagnosis with kidney disease and put on Purina kidney care food, 5/13/22 was back for a recheck for kidney disease since we had started the food, did an EPOC and urinalysis complete- bacteria present and RBC/WBC and got prescribed famotidine, 6/4/22 came in because P was vomiting and peeing blood- did an EPOC pre-surgery panel and urinalysis complete- bacteria present and RBC/WBC, got prescribed clavamox, cerenia injection, sucralfate, 8/14/22 was peeing blood again and painful- doctor ordered an ultrasound. Previous Health Concerns: kidney disease, UTI's

Current Medications: famotidine: yesterday 3pm, cerenia-5 am, buprenorphine- 2am

Abnormal PE/Chem/CBC/UA Results: Results of Diagnostics: 3/21/22 full bloodwork- CBC- mono 0.06 low, mono% 0.7 low, mcv 36.5 low, urinalysis- complete: rods present- RBC/WBC, blood glucose with glucometer- 170. 4/6/22 urinalysis- complete: bacteria present WBC/RBC 5/1/22 EPOC: Bicarbonate: 28 H, TCO2: 28.6 H, BE, ECF: 3.1 H, Lactate: 3.31 H, Glucose: 146 H, urinalysis- complete: bacteria present RBC/WBC. 6/4/22 EPOC: Glucose: 163 H, Pre-surgery panel- glucose: 163 H, urinalysis complete: bacteria RBC/WBC. 8/14/22 EPOC: Ca++: 1.06 L, Lactate: 3.33 H, Glucose: 180 H

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size 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. The left kidney measures 4.04 cm. The right kidney measures 4.69 cm.

Adrenal Glands

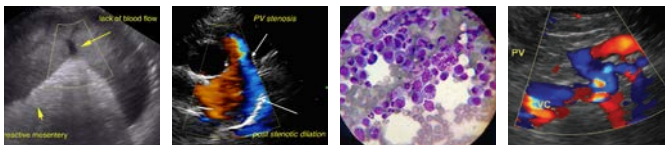
The adrenal glands are unable to be well visualized in these images. The areas were examined without evident pathology.

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.



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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.

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.

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

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Age related kidney changes
- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the historically reported azotemia prior to transitioning to a kidney diet, a blood pressure is recommended if not recently evaluated. Given the history of urinary tract infections, recommendations include managing the current infection based on culture and sensitivity results as a complicated urinary tract infection. This means 4-6 weeks of antibiotics with a 2nd culture 7-10 days after starting antibiotics to ensure full clearance and rule out any secondary bugs, followed by a final/third culture a week to 10 days after finishing antibiotics to ensure full resolution of the infection. If the infection comes back after treating as a complicated urinary tract infection, then at that time, further investigation into potential underlying causes for recurrent versus persistent urinary tract infections would be warranted.

The mild hyperglycemia without concurrent glucosuria is more consistent with stress hypoglycemia. However, if there is concern for diabetes mellitus based on clinical signs, and/or in the future if urinary tract infections become recurrent, a Fructosamine level could be considered.

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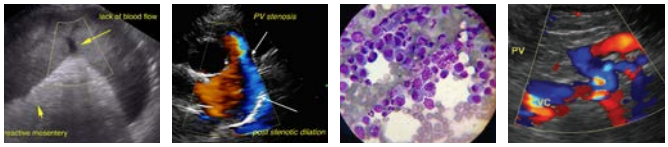

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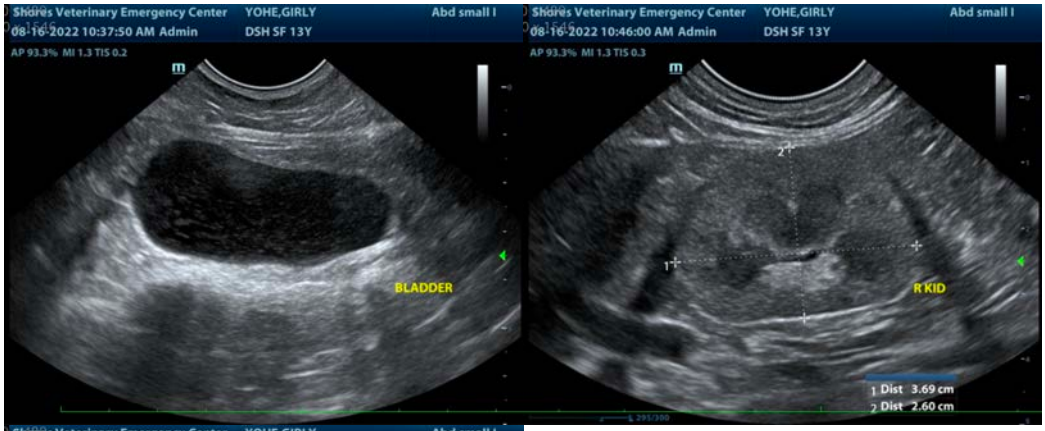

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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