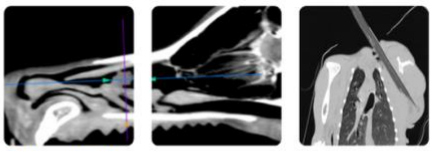


PATIENT

Cosmo Rodrigues

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

14 Years

WEIGHT

4.96 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hamilton Region EC

REFERRING VET

Dr. Diane Ho

INVOICE

36787

DATE

12/8/25

PRESENTING CLINICAL SIGNS

History: Presented for not wanting to get up, not drinking, lethargy, not eating. PE normal except for discomfort and pain on palpation, did eat overnight in hospital at midnight. Has not defecated in hospital but has passed urine. Has been on Maropitant, Ondansetron, Ampicillin, Buprenorphine, Mirtazapine.

Abnormal PE/Chem/CBC/UA Results: BUN 4.4, T protein 94, Globulin 62, urine protein 30mg/dL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Mobile debris present in the urinary bladder. No evidence of inflammatory or neoplastic changes was noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The right kidney measured 3.78 cm in length. The left kidney measured 4.08 cm in length. Hyperechoic shadowing foci was present in right renal parenchyma and calyces consistent with nephrocalcinosis.

Adrenal Glands

Adrenal glands were visualized on still images only. They appear to have normal shape, size, position and echogenicity for this breed and age though this could not be confirmed on cine loops. The left adrenal gland measured 0.37 cm in length. The right adrenal gland measured 0.49 cm in thickness.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

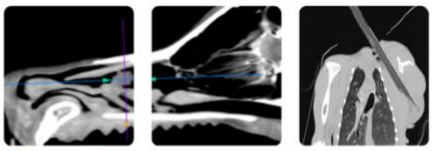
Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. There is hyperechoic shadowing material visible in biliary tracts, consistent with biliary mineralization.

The gall bladder is moderately distended with anechoic fluid, with hyperechoic debris present. There is no surrounding free fluid or signs of active inflammation.

Gastrointestinal

The stomach contains gas and ingesta, obstructing full visualization of contents. It measures at a normal thickness with some variability due to the presence of rugal folds. The distinction of the gastric



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wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

ULTRASONOGRAPHIC FINDINGS

- Biliary mineralization and mineralized debris within gallbladder- likely incidental
- Mild nephrocalcinosis- incidental
- Otherwise, normal abdomen

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Intrahepatic biliary mineralization and mineralized debris within the gallbladder is often an incidental finding. Their presence can cause inflammation and may cause subclinical or clinical cholangitis which can cause elevations in liver values. GI signs of inappetence or vomiting may be seen as their presence can cause intermittent abdominal pain and nausea. Their presence may act as a nidus of infection and predispose to cholangiohepatitis. They have the potential to move into the common bile duct causing obstructive cholangitis. Abdominal radiographs may be of use to further visualize choleliths.

There is no ultrasonographically evident cause of lethargy and inappetence in this abdominal study. Pancreas and GI tract are within normal limits. Consideration for dietary indiscretion, food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Non GI causes of clinical signs remain a possibility. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. If signs are persistent or recurrent, additional diagnostics to be considered include GI panel (TLI/PLI/cobalamin/folate), fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.

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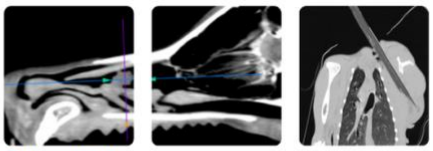

Teleradiology
Educational Teleconsultation Services™

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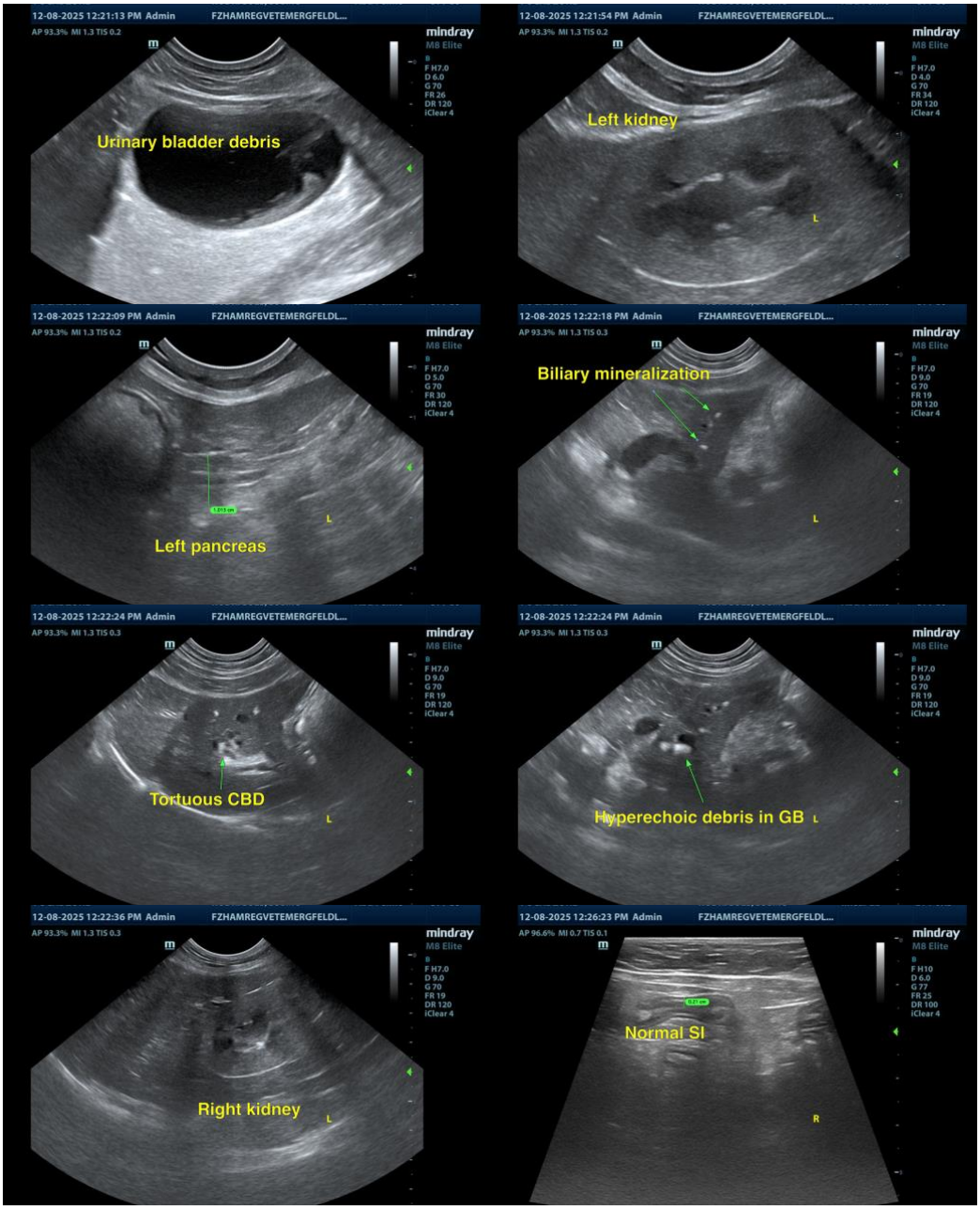
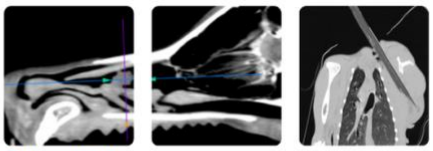


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC



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