



PATIENT

Bartolo Rogers

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

8 ½ years

WEIGHT

10 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons), DACVECC

IMAGING PERFORMED BY

Meghan Myers VMD

HOSPITAL NAME

Hershire AH

REFERRING VET

Dr. Glass

INVOICE

43108

DATE

3/6/23

PRESENTING CLINICAL SIGNS

History: O presented patient on 2/28/23 for concerns of vomiting a lot more than “normal.” He also has a history of urinary blockage. O reports no current urinary issues. Per O he has always been a “chronic vomiter” and he vomits every few days or once per week. O have been trying to feed small frequently meals and report that he seems to tolerate wet food better than the dry. PE reveals weight loss of 1.1# since last seen Nov 2022. He is painful upon cranial abdominal palpation and his stomach & small intestines palpate thickened. fPLI = normal. Abdominal radiographs revealed: LEFT kidney 2-3X the size of the right kidney w/ 4-5 nephroliths present, no apparent stones in bladder. Abnormal PE/Chem/CBC/UA Results: creat: 2.9, bun: 35, globulin 5.2 (normal up to 5.1), cbc pending bc machine broken :(u/a with UPC and urine culture pending.

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. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

Left kidney is normal in size with a smooth capsule and mild hazing of corticomedullary definition. Hyperechoic shadowing in left renal pelvis is consistent with nephrolithiasis with mild pelvic dilation (0.29cm). No ureteral dilation visualized. The left kidney measured 4.4 cm.

Right kidney is severely atrophied with a smooth capsule and hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Hyperechoic shadowing in right renal pelvis consistent with nephrolithiasis. No evidence of pelvic dilation was present. The right kidney measured 2.42 cm.

Adrenal Glands

Left adrenal gland was visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland was not definitively visualized but the vasculature in the area was within normal limits. The left adrenal gland measured 0.81 cm in length and 0.26 cm at the cranial pole and 0.32 cm at the caudal pole.

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.



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No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally

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Gastrointestinal

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The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric 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 visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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.

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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.

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Lymph Nodes

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No clinically significant lymphadenopathy or abnormalities noted.

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Free Abdomen

No masses or free fluid were noted.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Degenerative left renal changes with nephrolithiasis and mild pelvic dilation
2. Atrophied right kidney, nephrolithiasis
3. Normal GI tract

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Left pyelectasia with concurrent azotemia is concerning for pyelonephritis and urinalysis and culture are recommended, along with initiation of broad spectrum antibiotics while awaiting urine culture results along with IV fluid therapy. Given the presence of nephroliths, it may also represent obstructive ureterolithiasis, either present or resolved. Pain associated with ureterolithiasis can cause vomiting. There is no visible ureteral dilation to suggest current ureterolithiasis and renal pelvis is only mildly dilated. Nephroliths may act as a nidus of infection and predispose to urinary tract infections. They have the potential to move into the ureters or bladder causing obstructive nephropathy.. Leptospirosis, toxin

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exposure, increased urine production from fluid diuresis, or other causes of polyuria/polydipsia remain differentials.

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Right renal atrophy is likely secondary to previous or chronic insult (nephrolithiasis vs other) and subsequent decreased function and atrophy.

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There is no other ultrasonographically evident cause of reported GI signs in this abdominal study. Pancreas and GI tract are within normal limits. Renal changes are a reasonable explanation for the reported vomiting. Treatment as above for possible pyelonephritis, along with analgesia and GI support (anti-nausea, appetite stimulant) as needed should be considered.

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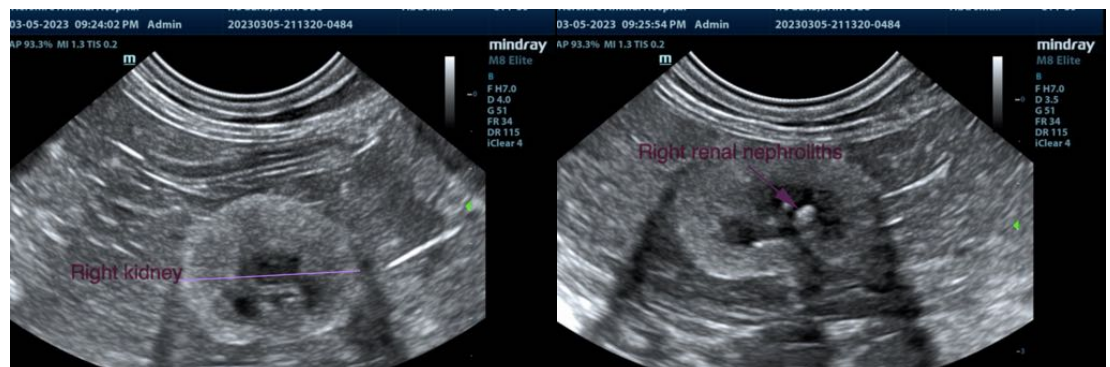


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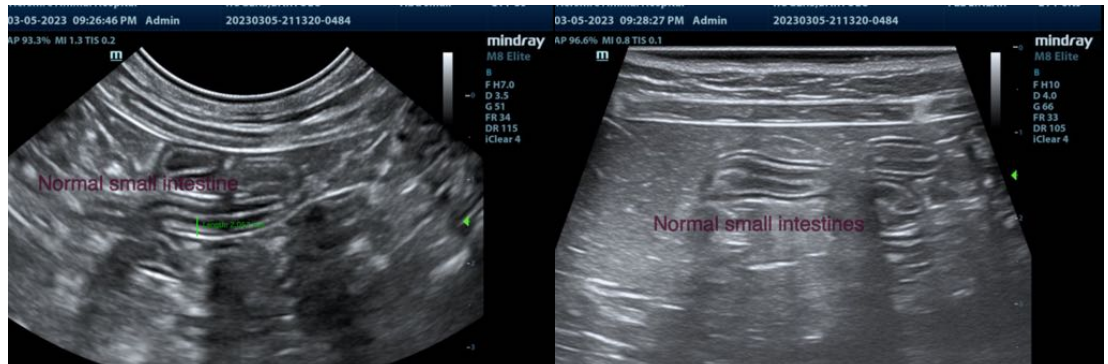
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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