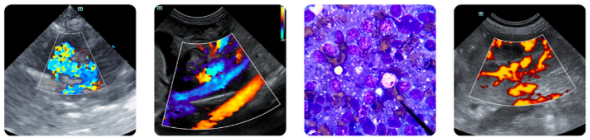

PATIENT

Sephie Lankford

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

5.4 kg

INTERPRETED BY

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores VEC

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Dr. Lisa Miller

INVOICE

35464

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PRESENTING CLINICAL SIGNS

History: *Originally presented 11/1 for hematuria, weight loss, hyporexia, vomiting. Signs started approximately two weeks ago. Taken to primary veterinarian who performed full blood work (reportedly normal) and urinalysis (showed UTI). Received Convenia injection and returned Wednesday for UTI recheck - fewer red blood cells present but some still noted, white blood cells cleared. Still not eating well, ate nothing yesterday but ate some this morning then vomited (vomited only dry food after eating wet and dry). Weight loss from 6.6 kg in May to current 5.46 kg. Previously seen in May for GI upset. Started on Miralax every other day for suspected constipation, but no longer considered constipated. Behavioral changes noted: normally fights getting into carrier but hasn't recently, and after Wednesday vet visit was very vocal and scratching at back door trying to get outside (indoor-only cat, unusual behavior that lasted one evening). Diet consists of wet and dry food. No coughing, sneezing, or environmental changes. No previous health concerns aside from GI upset. outpatient treatment done; sq fluids, cerenia, given an enema. *represented 11/9 for continued hyporexia, nausea, lethargy. rx of elura had been given. admitted for supportive care. Is now having diarrhea. *concern for CKD; dehydration, mild constipation; weight loss, gastroenteritis, other.

Abnormal PE/Chem/CBC/UA Results: *PE: 11/1 hypertension; comfortable, soft and non-reactive on abd palpation *PE 11/9: mild pain; Reactive to abd palpation, some stool in colon; tender in mid abd *11/1: TT4 Normal, FPL Normal, EPOC Elevated creatinine, Stress hyperglycemia, Elevated iCa 1.61; fpL 3.1 normal *11/1 rads: Suspected constipation. No radiographic evidence of a mechanical obstruction. Suspected decreased renal size. Mild increased amount of intraluminal gas in the SI. This is suspected to be secondary to aerophagia, although an underlying enteritis cannot be r/o. No evidence of a GI mechanical obstruction. Normal abd rads otherwise. *11/9: ica ++ 1.92, lacate 3.57, creat 2.02, glucose 145.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

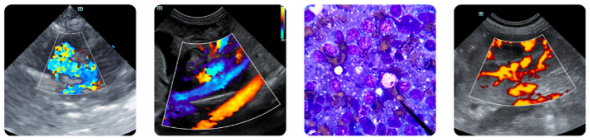
Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction. The iliac trifurcation was unremarkable.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some mild age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex. The left kidney measured 3.9 cm. The right kidney measured 4.31 cm. Slight pyelectasia was noted in the right kidney.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were



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unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.3 cm. The right adrenal gland measured 0.3 cm.

Spleen

The **spleen** in this patient was uniform, yet volume contracted. Hydration status should be assessed.

Liver

The **liver** was diffusely hyperechoic to falciform fat. The gallbladder and common bile duct were unremarkable.

Gastrointestinal

The **gastrointestinal tract** was non-peristaltic. A minor amount of fluid filled lumen was noted, consistent with ileus. The colon was fluid filled.

Pancreas

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

Free Abdomen

The **mesenteric lymph nodes** were slightly enlarged, rounded, and hypoechoic. This is most consistent with lymphadenitis.

ULTRASONOGRAPHIC FINDINGS

- Hepatic lipidosis pattern.
- Mild age-related renal changes with slight pyelectasia of the right kidney.
- Nonperistaltic GI tract with minor fluid filled lumen consistent with ileus.
- Volume contracted spleen.
- Slightly enlarged, rounded, and hypoechoic mesenteric lymph nodes. I cannot rule out emerging round cell neoplasia yet not suspected.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of significant visceral disease was noted in this patient. This is a nonspecific presentation with evidence of volume contraction. IV fluid support and symptomatic therapy should prove effective. Enterotoxins or similar are suspected in this patient.

Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

Note, the kidneys do not appear end stage; complicating factors, such as prerenal disease, UTI, toxin exposure should all be considered.

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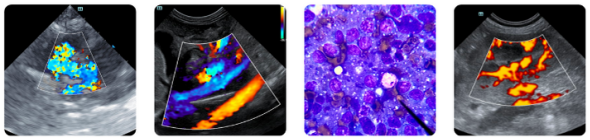

Clinical Sonography & Telecytology
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SonoPath.com info@sonopath.com 1.800.838.4268

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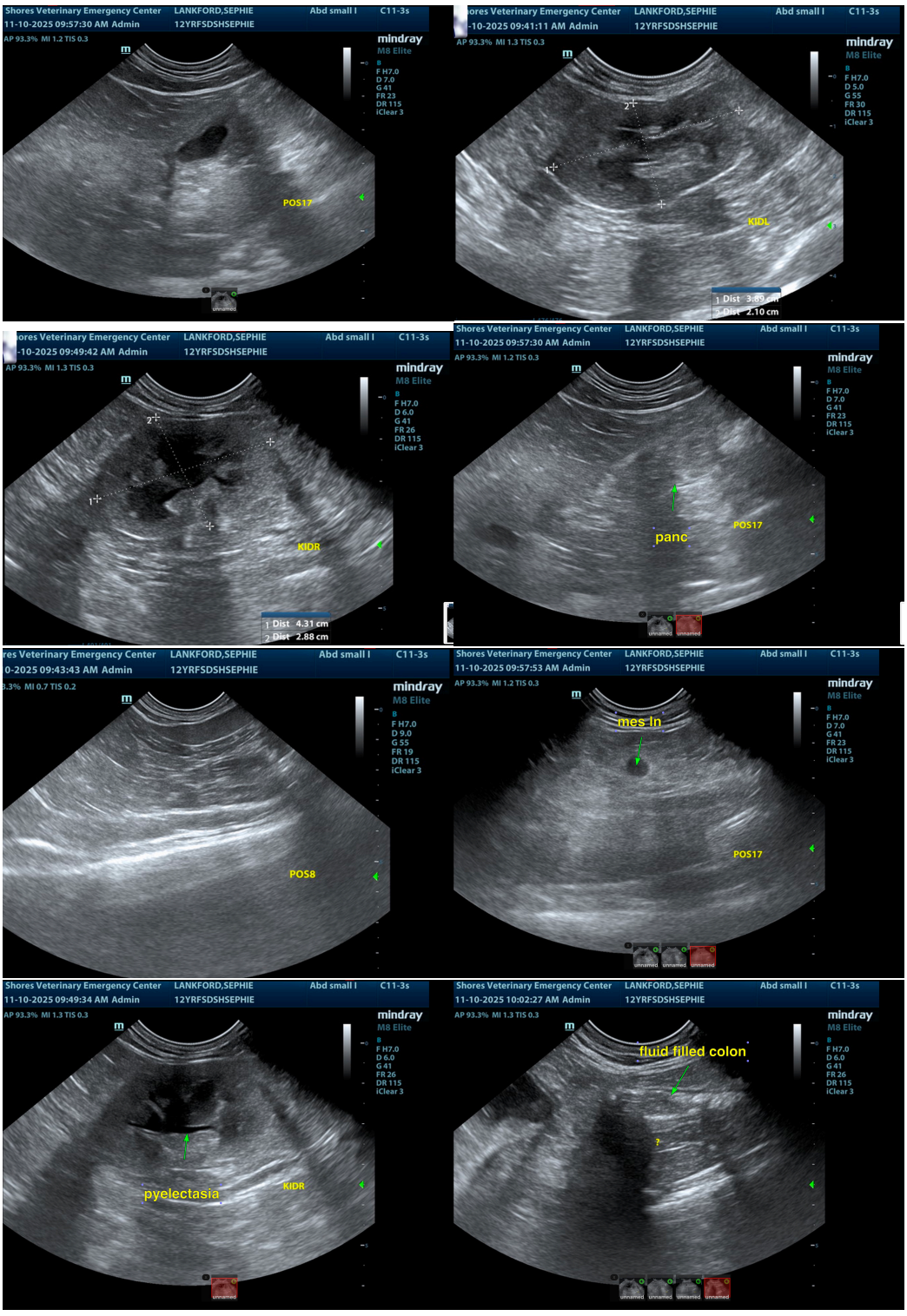

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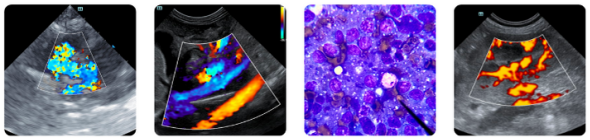

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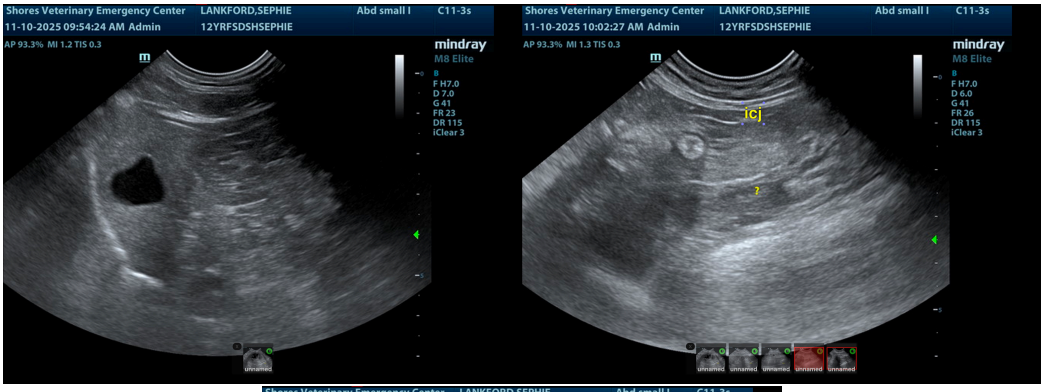

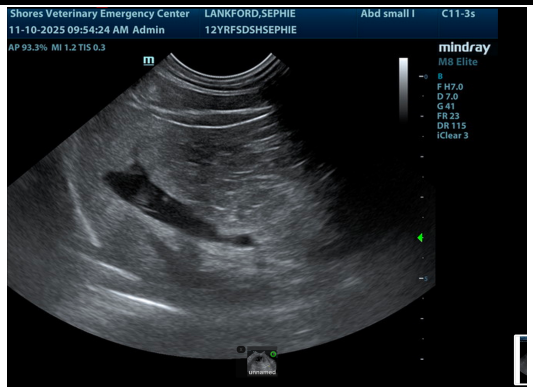

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,
CEO, Owner, Founder -- SonoPath.com
info@SonoPath.com