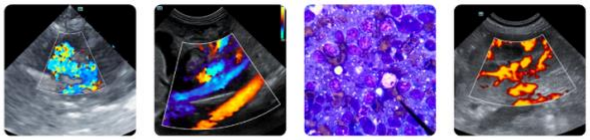


PATIENT

Koobear Berni

SPECIES

Feline

BREED

DSH

SEX

Intact Male

AGE

11 Years

WEIGHT

9.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Wasserman, DVM

HOSPITAL NAME

Highlands AH

REFERRING VET

Dr. Frankenberger

INVOICE

37034

DATE

5/9/26

PRESENTING CLINICAL SIGNS

History: 2 week history of ADR, anorexia, and depression. Patient presented profoundly dehydrated with moderate sneezing, nasal discharge, and labored breathing. No stool production reported secondary to anorexia and decreased water intake. No sedation was administered for sonographic examination today. Patient remained on IV fluid therapy and was temporarily disconnected from fluids for approximately 10 minutes during the ultrasound examination. Current treatments include Penicillin G potassium SQ, enrofloxacin SQ, and Cerenia IV. Patient was hospitalized overnight last night. Patient was tachycardic throughout the sonogram, with heart rates reaching approximately 240 bpm with minimal restraint/stimulation. Subjective left atrial enlargement was appreciated; however, no obvious mitral valvular lesions were identified on limited cardiac assessment (Dr. Wasserman). Interpretation is subjective and made w/ caution given concurrent tachycardia and fluid therapy status at the time of sonogram. At the time of case submission, the referring veterinary hospital was contacted and updated laboratory work reportedly demonstrated worsening values/no clinical improvement. Supplemental laboratory data (most recent 5/9 PM) attached for review if helpful: abnormals below.

Abnormal PE/Chem/CBC/UA Results: CBC-nongenerative anemia, leukocytosis with neutrophilia and monocytosis. Platelets reduced. Blood smear normal platelets, clumping and >10/hpf. Panel- reduced creatinine (anorexia, weight loss). T bili 2.2 (0-0.9) Low Na 142(150-165) and low Cl 105 (112-129) low Ca 6.3 (7.8-11.3). Abdomen rads- ascites, loss of detail. Thorax rads: right heart enlargement possible but pet rotated. Lungs normal. Fluid sampled from the abdomen neutrophils seen throughout the fluid today. Fluid yellow and slightly turbid. Urine sampled via cystocentesis from the bladder which was slightly orange/dark, and turbid. 5/9/26 Bloodwork abnormals: WBC 19.9, Neut: 17.7, Bands suspected, Eos 0.01, Platelets 9.0, Glucose 67, creatinine 0.5, Calcium 5.8 total, Sodium 147, chloride 107, albumin 2.1,TBILI 3.5.

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 were noted. Ureteral papillae were normal. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction.

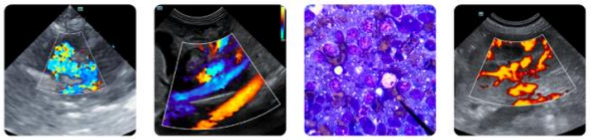
The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex, and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 4.9 cm. The right kidney measured 5.03 cm.

Adrenal Glands

The **adrenal glands** were uniform, yet bilaterally swollen and hypoechoic. This is most consistent with stress-induced hyperplasia. The right adrenal gland measured 0.83 cm at the cranial pole and 0.56 cm at the caudal pole. The left adrenal gland measured 0.65 cm.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the



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spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** parenchyma was uniform, other than the passive congestion pattern. The gallbladder and common bile duct were unremarkable. The vena cava was dilated and overdistended. The hepatic veins were dilated.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The **pancreas** was edematous. Enhanced mesentery was noted around the pancreas. Generalized pancreatic enlargement was noted, partially consistent with edema, however, concurrent pancreatitis, necrosis or even neoplasia are all possible. The right pancreatic base measured 2.65 cm.

Free Abdomen

A mild amount of **ascites** was noted, consistent with passive congestion.

The mesenteric **lymph nodes** were sightly enlarged (1.5 cm x 0.75 cm).

ULTRASONOGRAPHIC FINDINGS

- Pancreatic edema
- Passive congestion liver pattern
- Ascites
- Slightly enlarged mesenteric lymph nodes
- Bilateral adrenal enlargement

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominocentesis and cytospin of the free fluid in the abdomen is warranted. I do not believe the primary issue is in the abdomen, though the pancreas is in question The bilateral adrenal enlargement may be owing to stress or possible acromegaly. Full thoracic work up with echocardiogram and chest radiographs are all indicated, as a significant thoracic diseased causing passive congestion is suspected. There is a mild potential for pancreatic neoplasia, however, I'm more inclined to think this is hyperplasia with pancreatic edema secondary to passive congestion.

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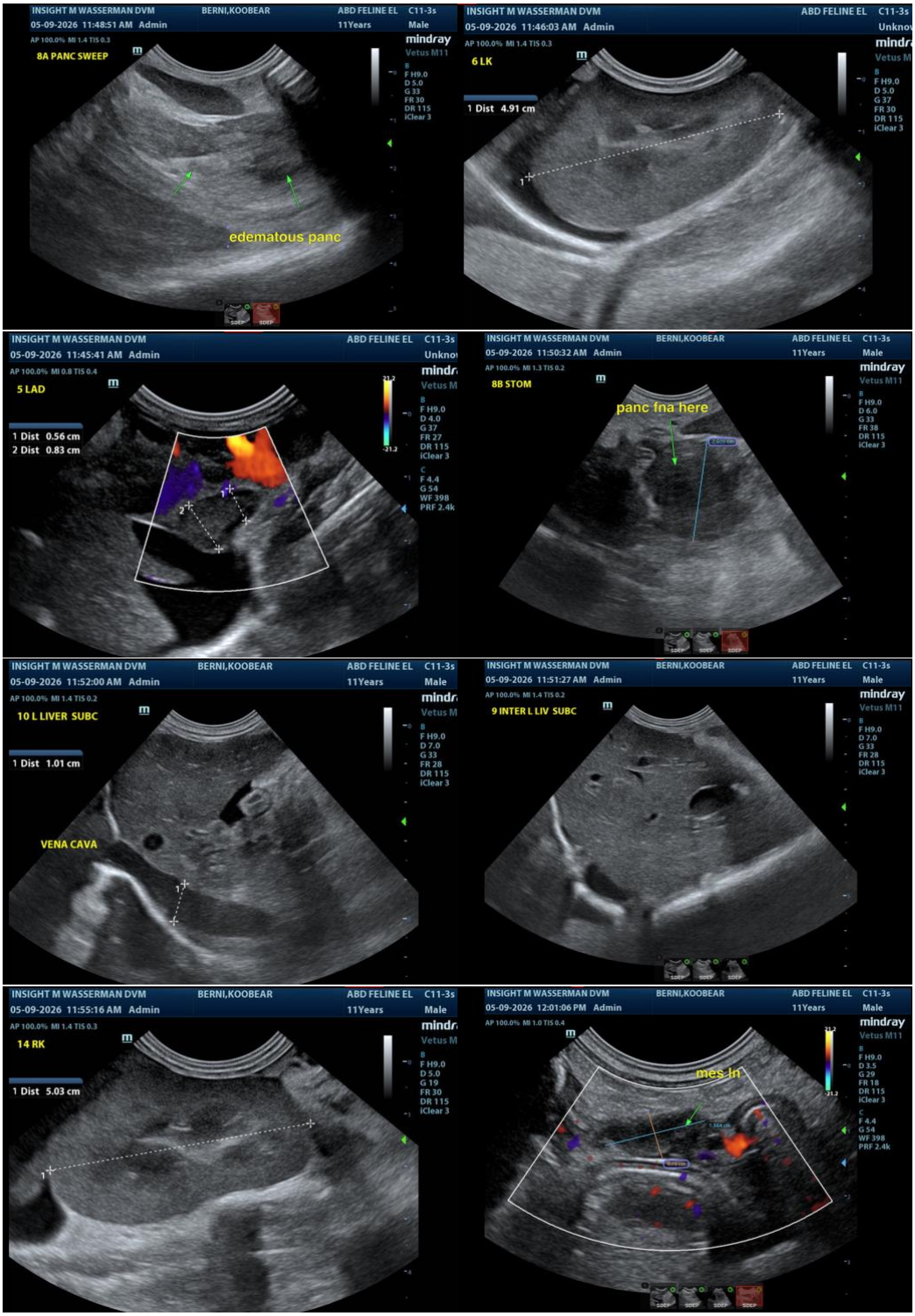

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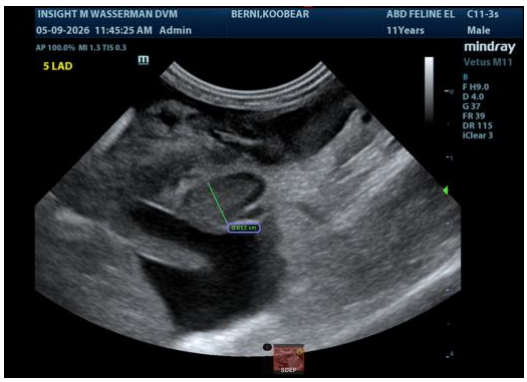

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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