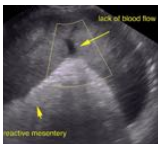

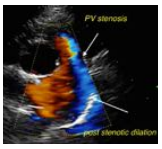

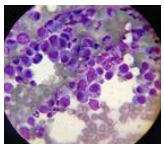
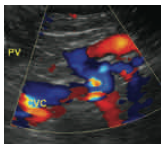

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1-800-838-4268 info@sonopath.com

PATIENT

Denko Gould

SPECIES

Feline

BREED

Siberian

SEX

Neutered male

AGE

11 years

WEIGHT

11.8 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Nelson

HOSPITAL NAME

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PRESENTING CLINICAL SIGNS

History of triaditis (managed on nutritionist formulated kangaroo home prepared diet, probiotics, omeprazole, prednisolone, metronidazole, with cerenia and buprenorphine as needed), hyperthyroidism (treated 2022 with radioactive iodine), history of ammonium urate urolithiasis, stage 2 CKD Presented for routine post radioactive iodine BW when hyperkalemia was first noted 4/20/22. Was on potassium citrate supplement for urate stones, d/c at that time. Potassium was normal for 2 months then presented for another recheck 6/20 and potassium was elevated at over 10 mmol/L - has been on Ca gluconate and NaCl overnight with only mild improvement in hyperkalemia. Recent history (last few weeks): diarrhea, hyporexia, lethargy, occasional vomiting
Abnormal PE/Chem/CBC/UA Results: 6/21: HCT 16% Bicarb 13.9 mmol/L (LOW) Calcium 0.71 mmol/L (LOW) Chloride 138 mmol/L (HIGH) Creatinine 2.69 mg/dL (HIGH) Glucose 168 mg/dL (HIGH) Potassium 9.6 mmol/L (HIGH) Sodium 135 mmol/L (LOW) PCO2 22.4 mmHg (LOW) PO2 143.1 mmHg (LOW) TCO2 13.9 mmol/L (LOW) BUN 74 mg/dL (HIGH) LAST 4 CLIPS ARE RIGHT ADRENAL

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.

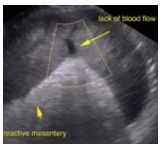
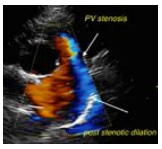
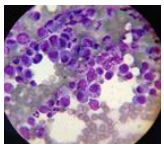
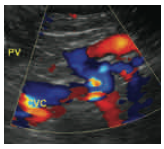
The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex. Slight cortical infarcts were noted in the left kidney. Pelvic calculi were noted with a grouping of which measuring 0.5 cm. The left kidney measured 3.0 cm. The right kidney revealed multiple infarcts along with corticomedullary and pelvic calculi. The caudal pole of the right kidney revealed an expansive nodule. This may be a regenerative nodule secondary to infarct or potential emerging neoplastic event measuring 1.5 cm. There was no inflammation or free fluid noted. The right kidney measured 3.5 cm with slight pyelectasia.

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 unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.4 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 spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of

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congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

A minor amount of non-shadowing, non-obstructive ingesta was noted in the **stomach**. There is a potential for hairball accumulation in the stomach if the patient was n.p.o. at the time of the sonogram. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. 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 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.

ULTRASONOGRAPHIC FINDINGS

Non-obstructive renal calculi with infarcts.

Full stomach, possible hairball accumulation.

Otherwise, unremarkable abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of anemia is unclear. The azotemia can be justified by chronic renal disease. The anemia may be owing to chronic renal disease or possible bone marrow disease. CBC path review is warranted. The prognosis is very guarded to poor. Blood transfusion, 72 hour IV fluid protocol with reassessment of the CBC and bone marrow would be ideal in this patient. Blood pressure measurements are warranted. Full urinary work-up is recommended if not already performed. A recheck sonogram is recommended in 7-10 days primarily the nodule at the caudal pole of the left kidney.

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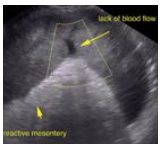

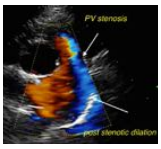

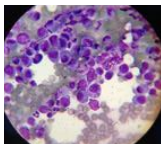
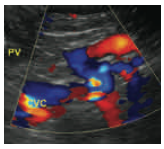

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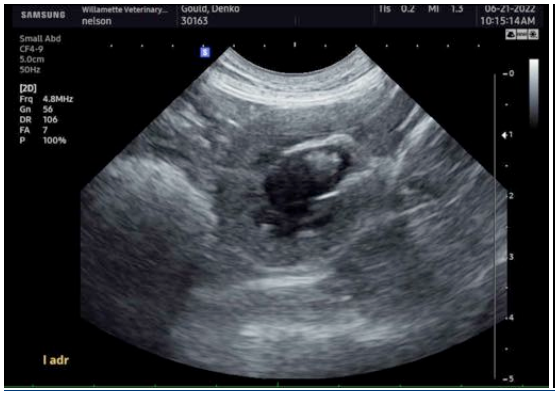

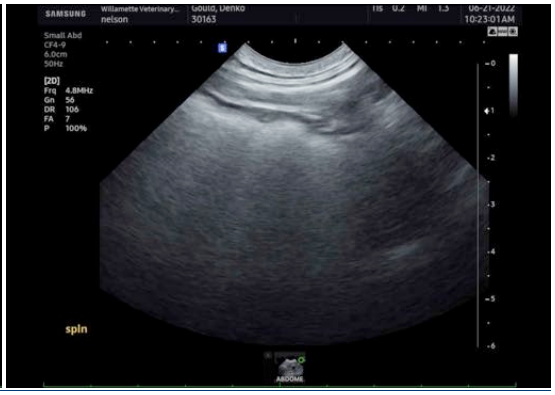

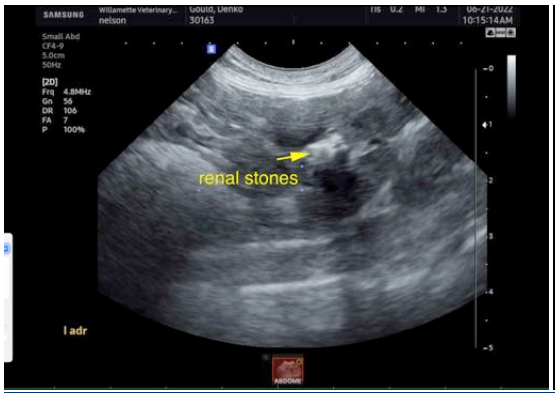

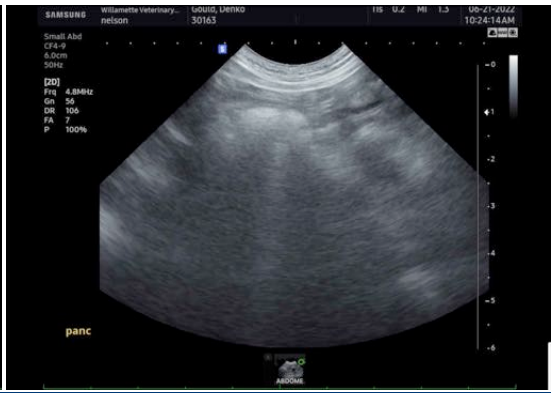

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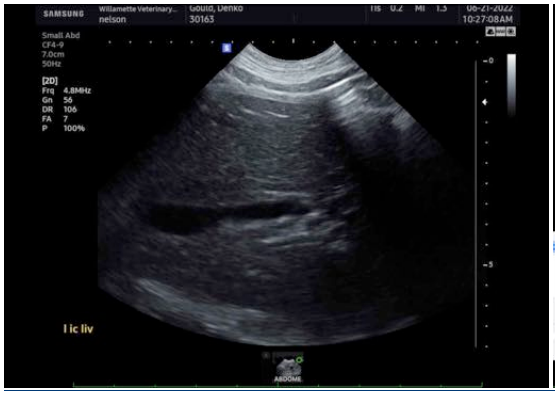

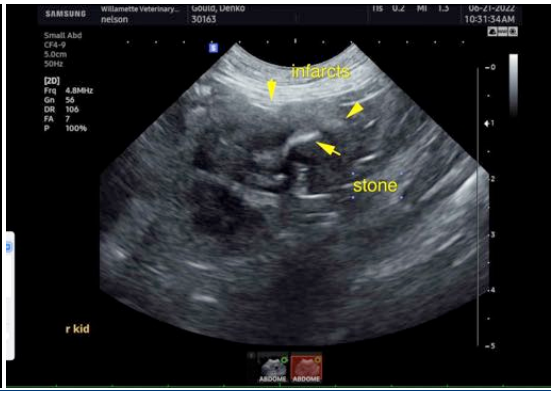

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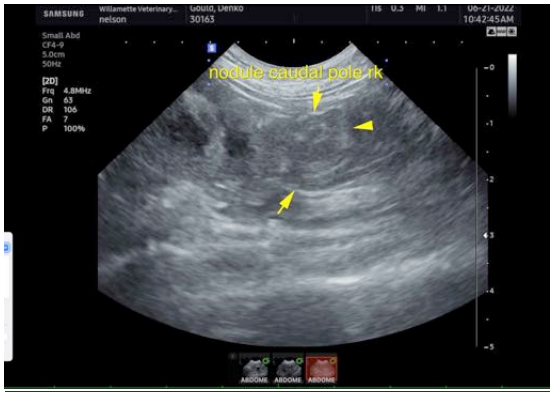

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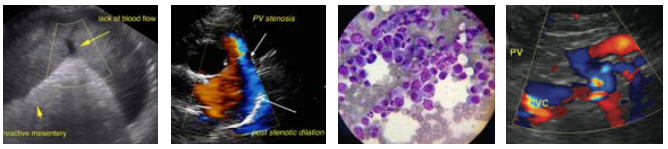

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com