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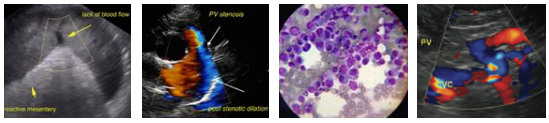

imagine SOUND LLC.
IMAGING PERFORMED BY
dbimaginesound@gmail.com 917-647-4318

PATIENT

Moo Cohen

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

2011

WEIGHT

10.72 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Denise Bruno, LVT, RDMS

HOSPITAL NAME

Brooklyn Heights

REFERRING VET

Dr. Venezia

INVOICE

31168

DATE

6/21/22

RESENTING CLINICAL SIGNS

History: Before blood work: weight loss, inappetent, straining to defecate. Blood work - Kidney failure. Hematuria has developed. Evaluate pathology of kidneys/intestines/prognosis. Labs + Radiographs attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed multiple urethral calculi with over distension of the bladder. Bladder sand was also present.

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. The right kidney measured 4.42 cm. The left kidney revealed pyelectasia that measured 0.17 cm. The left kidney measured 4.26 cm.

Adrenal Glands

The right **adrenal gland** was hypoechoic, rounded and enlarged measuring 1.2 x 1.07 cm. The left adrenal gland was also enlarged and rounded measuring 1.16 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 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

The **gastrointestinal tract** revealed minor variable thickening and echogenic submucosal changes most consistent with low grade end result of chronic GI disease such as IBD and may be related to malassimilation of nutrients if any weight loss is present. Intestinal wall thickness measured up to 0.19 cm. No obvious neoplastic patterns were noted and luminal content as unremarkable.

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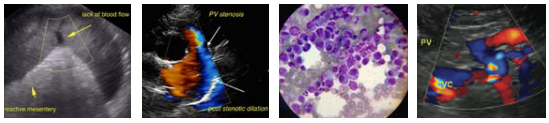

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Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. The pancreatic duct was dilated at 0.4 cm.

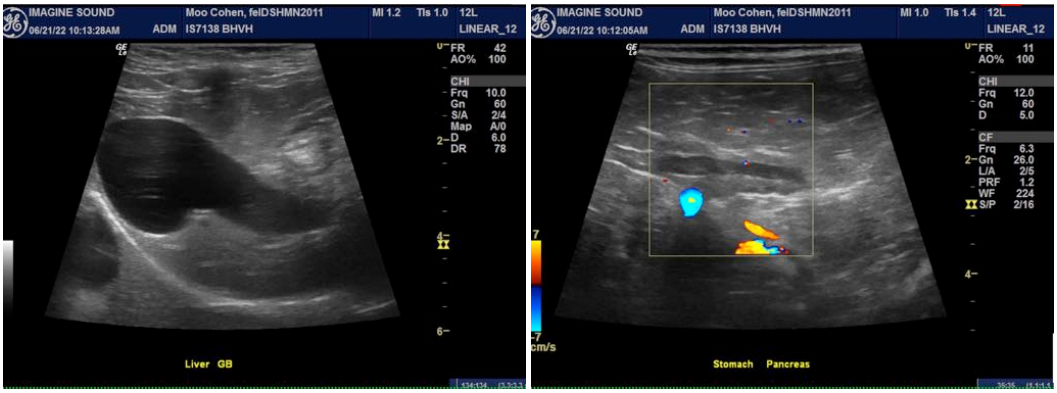
ULTRASONOGRAPHIC FINDINGS

Urethral and bladder sand. Urethral sand is obstructive.

Bilateral adrenal hypertrophy. Possible related to stress; however, fairly excessive.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If the patient appears Cushingoid then pituitary dependent Cushing's is a possibility even though rare in cats it can occur and would be fitting with bilateral adrenal enlargement. Cystotomy with normal and retrograde flush is recommended along with sand analysis and culture. Blood pressure measurements are warranted. I recommend IV fluid support and reassessment of the blood work in this patient. Blood pressure measurements are indicated. If the patient appears Cushingoid then eventual work up for pituitary dependent hyperadrenocorticism is recommended. However, the bladder and urethral sand is the most immediate issue. This patient was likely obstructed in the ureters and now lower urinary tract urolithiasis is the primary issue. Concurrent UTI may also be present, yet the kidneys do not appear to have significant degenerative changes indicative of an acute insult.



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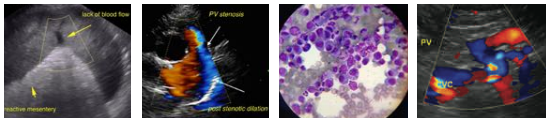

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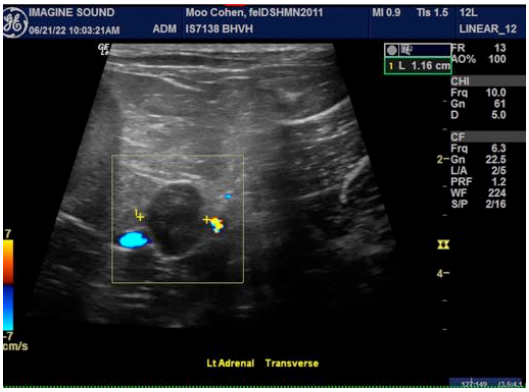

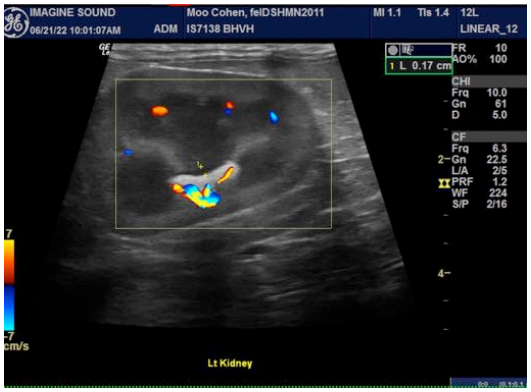

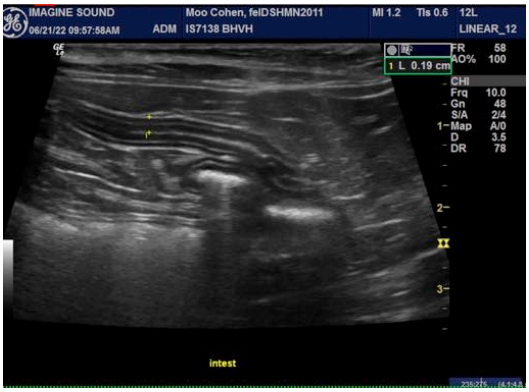

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Eric.Lindquist@SonoPath.com