



PATIENT PRESENTING CLINICAL SIGNS

Spike Cote History: Weight loss of 2 lbs in July, Dx with CKD. Presented to E. clinic with stranguria and dripping bloody urine, +/- dyschezia. Treated with SQ fluids, Clavamox, Prazosin and Buprenorphine. Improved initially. Owner reports he seems painful when sitting or laying down. Sedated with Gabapentin PO; Butorphanol, Midazolam and microdose DexDomitor IV.

Feline Abnormal PE/Chem/CBC/UA Results: PE: BCS 4-5/9, Grade 2/6 heart murmur. RADS (attached): no visible uroliths, moderate gas in colon. SI loops slt. thickened. CBC/Chem/T-4: BUN 43, Creat 2.2, SDMA 16. UA (cysto): SG 1.017, Blood 2+. Sed: WBC 50-75/HPF, RBC 30-50/HPF, marked Rod bacteria>40/HPF. Urine C&S: E. Coli, sensitive to everything but Amoxicillin - intermediate.

BREED

Domestic Shorthair

SEX

Neutered male

AGE

12 years

WEIGHT

14.7 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Ebersole

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Chadbourne

INVOICE

32533

DATE

8/24/22

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 mild degenerative changes. Blood flow on Power Doppler assessment appeared to be subnormal. The left kidney revealed a blunted caudal pole with infarct and cortical collapse that deviated the left renal pelvis. The right kidney revealed pyelectasia with loss of corticomedullary definition. The right kidney measured 3.55 cm.

Adrenal Glands

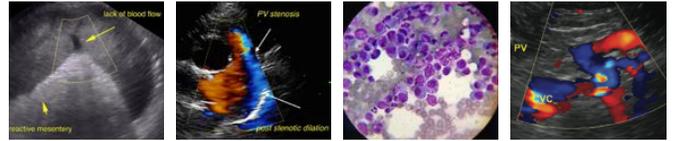
Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.34 cm. The right adrenal gland measured 0.63 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. The spleen measured 0.89 cm.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Occasional parenchymal cyst was noted in the liver. 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.



PATIENT

Gastrointestinal

Spike Cote

Examination of the **gastrointestinal tract** revealed a minor fluid filled gastric lumen. The intestines were 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. The colonic wall was slightly thickened and measured 0.2 cm. The colic lymph node was reactive and measured 0.82 x 0.41 cm. The mesenteric lymph nodes are reactive.

SPECIES

Feline

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Pancreas

Domestic Shorthair

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. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

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ULTRASONOGRAPHIC FINDINGS

Renal dystrophy with infarcts and pyelectasia.

WEIGHT

14.7 lbs

Minor colonic thickening with colic lymphadenopathy.

Reactive mesenteric lymph nodes.

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The kidneys do not appear subjectively end stage. Active inflammation appeared to be present around the left renal pelvis. Chronic, low-grade, pyelonephritis is likely playing a role. An embedded infection in the left kidney would make sense as well as resistant bacteria. Urine culture and sensitivity as well as 6 week antibiotic therapy is indicated. Blood pressure measurements are warranted along with 72 hour IV fluid protocol with injectable antibiotics may allow for further penetration within the renal parenchyma. Recheck sonogram is recommended in 4-6 weeks. There is a possibility of primary renal dysplasia is playing a role, yet these are more likely secondary changes. Fecal test is recommended given the colonic thickening and mesenteric lymphadenopathy to ensure parasites are not an issue. Broad spectrum antibiotic protocol and potential diet change to geriatric hydrolyzed diet may assist with the GI signs.

IMAGING PERFORMED BY

Dr. Ebersole

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.

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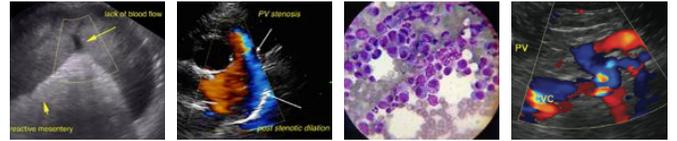
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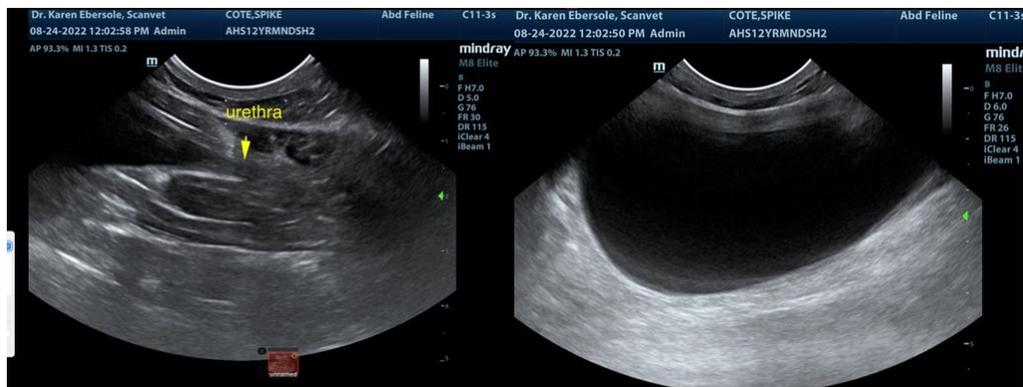
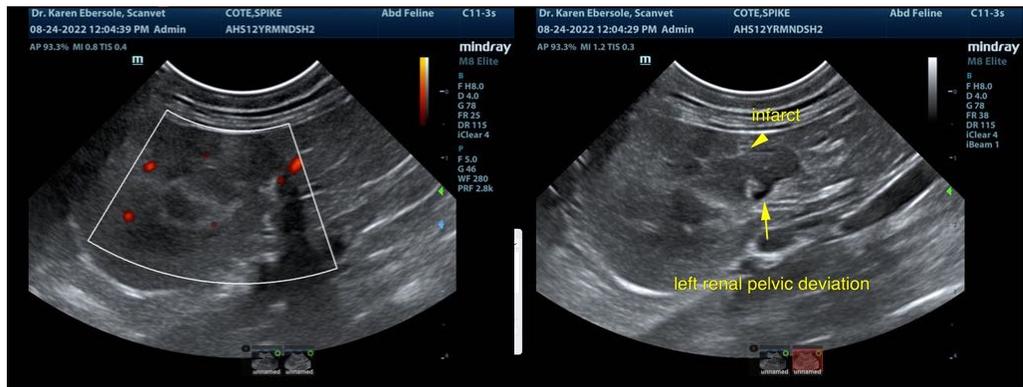
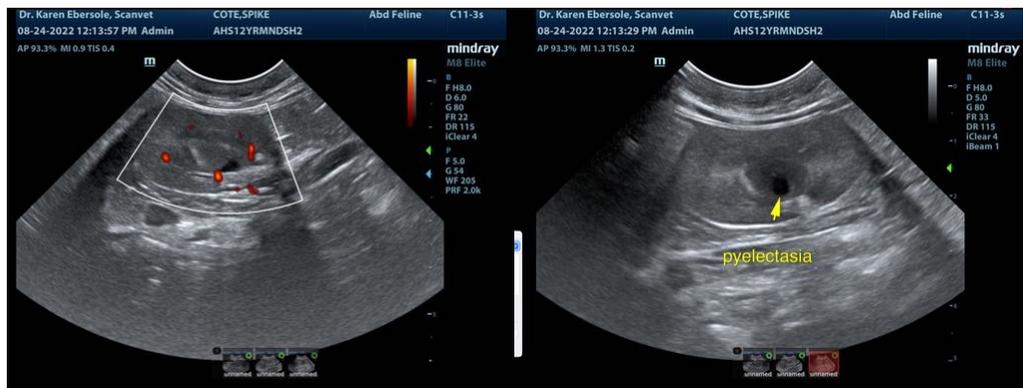
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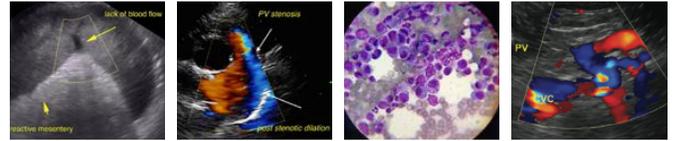
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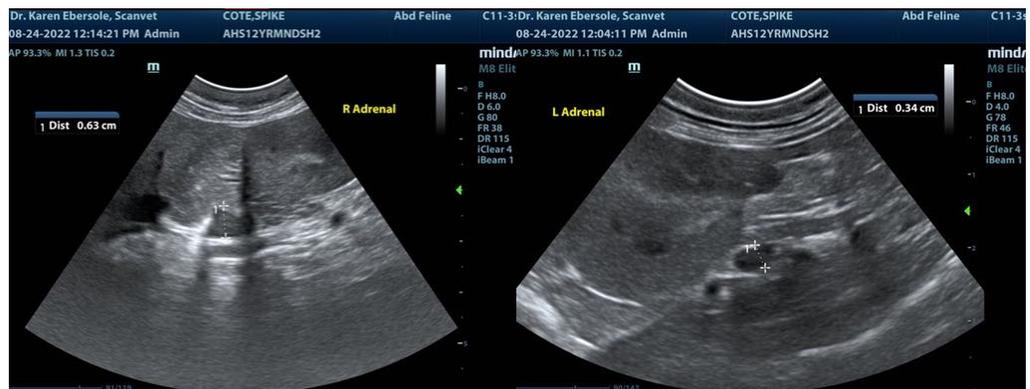
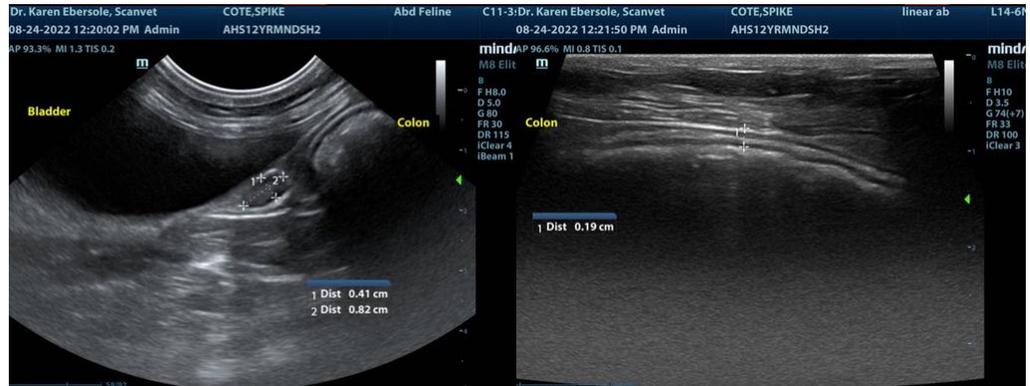
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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