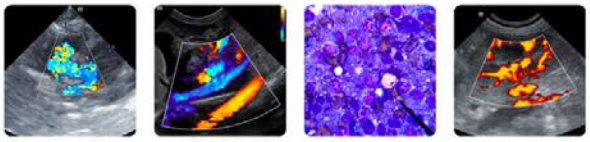

PATIENT

Charlotte Chan

SPECIES

Feline

BREED

DSH

SEX

Not Provided

AGE

6 Years

WEIGHT

5.12 kg

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Mariusz Chmielinski, DVM

HOSPITAL NAME

Apex Veterinary Services, Ltd.

REFERRING VET

Alpine 24/7 ER

INVOICE

72512

DATE

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PRESENTING CLINICAL SIGNS

Onset of vomiting (~9:00 PM); initial vomitus contained undigested food, followed by yellow bile. Development of liquid diarrhea. Became lethargic, anorexic, and stopped drinking. Minimal urination reported overnight.

Abnormal PE/Chem/CBC/UA Results: • Mentation: QAR, lethargic, T: 39.7 °C (febrile), Hydration: ~5–6% dehydrated, MM icteric • Abdomen: Moderate discomfort on palpation • Bladder: Empty on palpation CBC: Mild leukocytosis with suspected left shift; basophilia; thrombocytopenia (likely clumping) Chemistry: o Creatinine 470 µmol/L, BUN 23.8 mmol/L o Hyperbilirubinemia (TBil 130) o Mild ALT elevation (196) o Hyperproteinemia, hypophosphatemia Abdominal Radiographs: o Mild gastric fluid distension o Small intestinal gas (cranial/mid abdomen) o Mineral opacities near left kidney; left renomegaly → concern for nephrolithiasis vs pyelectasia • Urinalysis and Culture - pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately to mildly distended with anechoic urine. The Bladder wall appears normal with a smooth mucosal surface. There is a small amount of focal shadowing material in the dependent portion of the urinary bladder, most consistent with sandy debris or a small, flat stone. There is some mineralization visualized in the region of the right ureteral papilla, with a dilated distal right ureter, and a stone visualized 1-2 cm proximal to the urinary bladder measuring 0.34 cm.

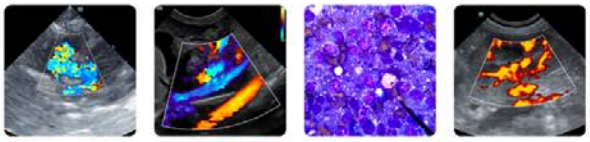
The left kidney is large, measuring 5.3 cm, with perinephric inflammation and very scant effusion surrounding the kidney. There are some pinpoint non-obstructive nephroliths visualized. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size but irregular in shape with scalloped margins, possibly consistent with previous infarcts. There is significant pyelectasia measuring at 0.72 cm, and hydroureter. There are some poorly defined mineralizations visualized in the renal pelvic measuring 0.72 cm. The proximal ureter is dilated, measuring at 0.27 cm, with a small stone measuring 0.18 cm approximately 2.0 cm from the kidney. Just distal to that there are some larger stones with more significant ureteral dilation measuring 0.44 cm. The stones in this region measure 0.77 cm (approximately 2.5 cm from the kidney). In the distal ureter approximately 1-2 cm from the urinary bladder there is a small mineralization measuring 0.34 cm. The ureter is thickened and dilated, measuring 0.18 cm at this level. There is a small amount of mineralization at the ureteral papilla. There is significant perirenal inflammation and a small amount of effusion. Findings are most consistent with severe ureteritis and obstructive urolithiasis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.47 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.45 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.



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Spleen

The spleen is large and mildly scalloped, measuring 1.58 cm. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a mild amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.28 cm. Jejunum wall measures 0.17 cm.d Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is a small amount of free abdominal fluid. No significant lymphadenopathy noted. A prominent lymph node is visualized near the ileocecal junction measuring 0.21 cm. A jejunal lymph node is visualized measuring 0.63 cm. The omentum is severely hyperechoic around the right kidney and somewhat around the left kidney.

PRIMARY FINDINGS

- Large left kidney with pinpoint non-obstructive nephroliths and scant perirenal inflammation and effusion with an irregular right kidney with severe pyelectasia and evidence of hydroureter and severe ureteritis with at least 4 partially obstructive ureteroliths visualized.
- Large, scalloped spleen – Findings could be consistent with anatomic variation (large cat), congestion, sedation, lymphoid hyperplasia, splenitis, or infiltrative neoplasia.
- Dependent mineralization in the urinary bladder – Findings are most consistent with sandy debris or a small stone.

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SECONDARY FINDINGS

- Pancreatic changes consistent with chronic pancreatic remodeling.
- Mild gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting. Incidental gall bladder debris is less common in cats.

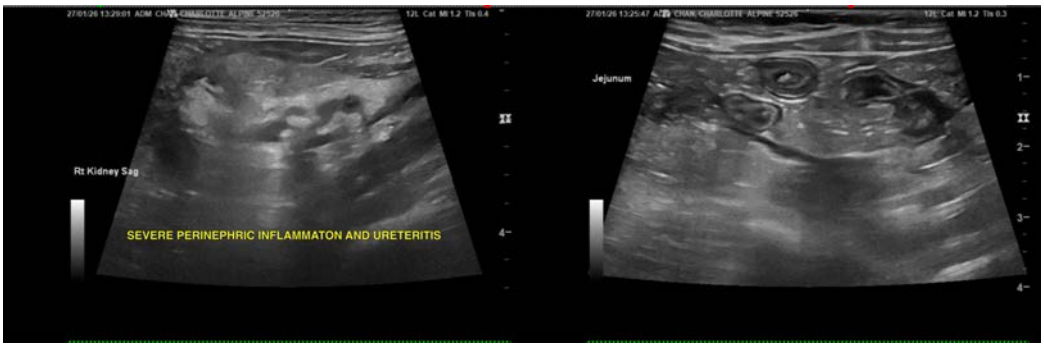
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The right kidney is irregular with severe pyelectasia and hydroureter with a thickened, dilated ureter with moderate dilation extending to the level of the urinary bladder. There are numerous focal ureteroliths visualized. The largest and most obstructive appearing are approximately 2.5 cm from the kidney. The right kidney appears enlarged with some surrounding inflammation. No evidence of an obstructive pattern. Possibly consistent with compensatory enlargement?

The spleen is large. The significance of this is uncertain. A fine needle aspirate could be considered to rule out underlying round cell neoplasia.

Based on the elevation in bilirubin reported and the severe inflammation surrounding both kidneys, there is concern for possible sepsis and concurrent pyelonephritis. This patient should be aggressively stabilized. Medical management for an obstructive process could be considered, but there are numerous stones that are very proximal, reducing the likelihood of a successful long-term resolution with medical therapy. Consider aggressive stabilization and transfer to a facility with the capability of ureteral bypass. If medical therapy is successful, the bypass can be postponed, but if medical therapy is not successful this needs to be done relatively quickly. Recommend aggressive pain management as well as a urine culture, antibiotic therapy, blood pressure management (looking for hypotension secondary to sepsis), potentially diuresis, and possible smooth muscle relaxants. A fine needle aspirate could be considered prior to more aggressive medical intervention depending on the sedation history.

There is a small amount of mineralization in the dependent portion of the urinary bladder consistent with sandy debris or a small stone. Correlate with abdominal radiographs.



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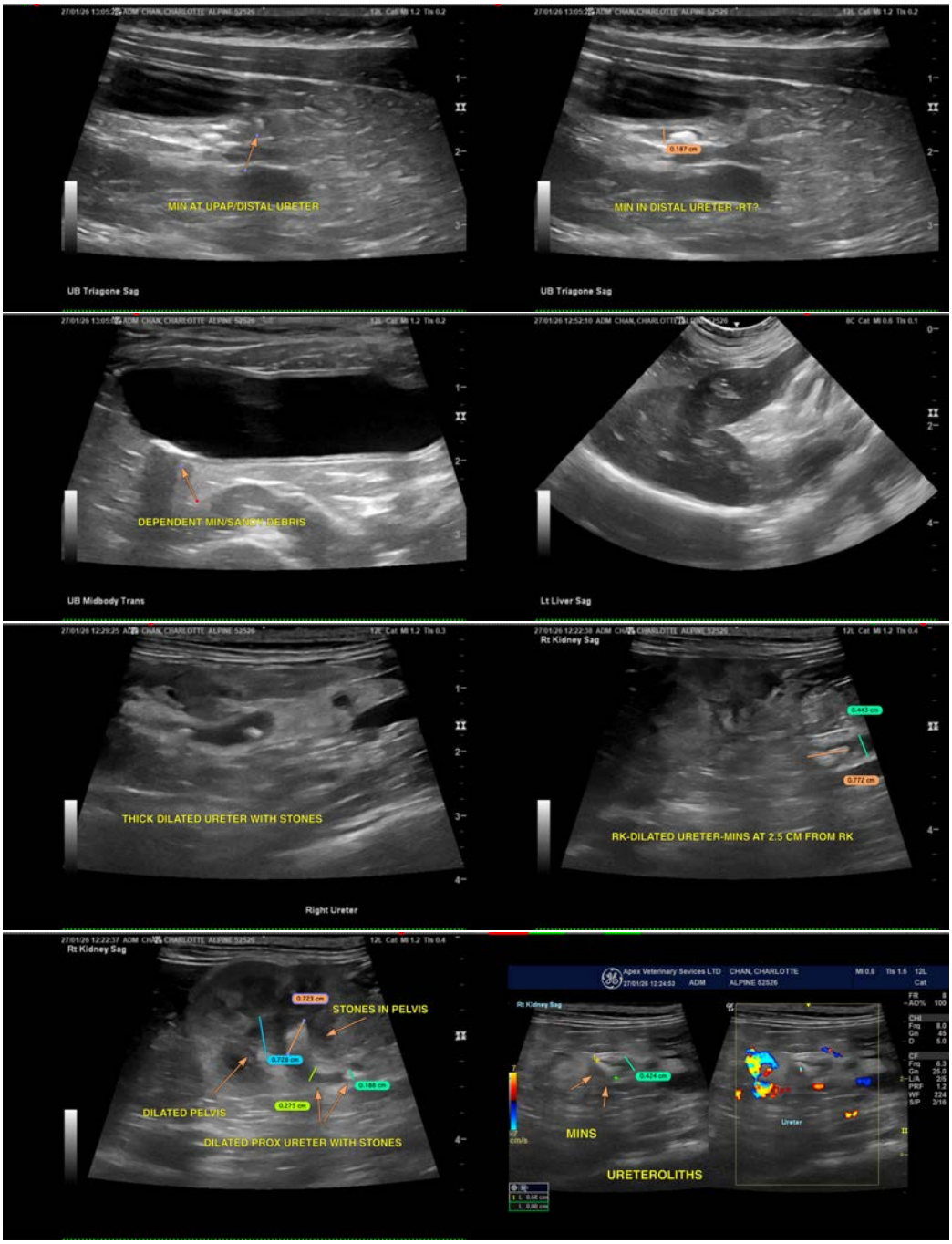

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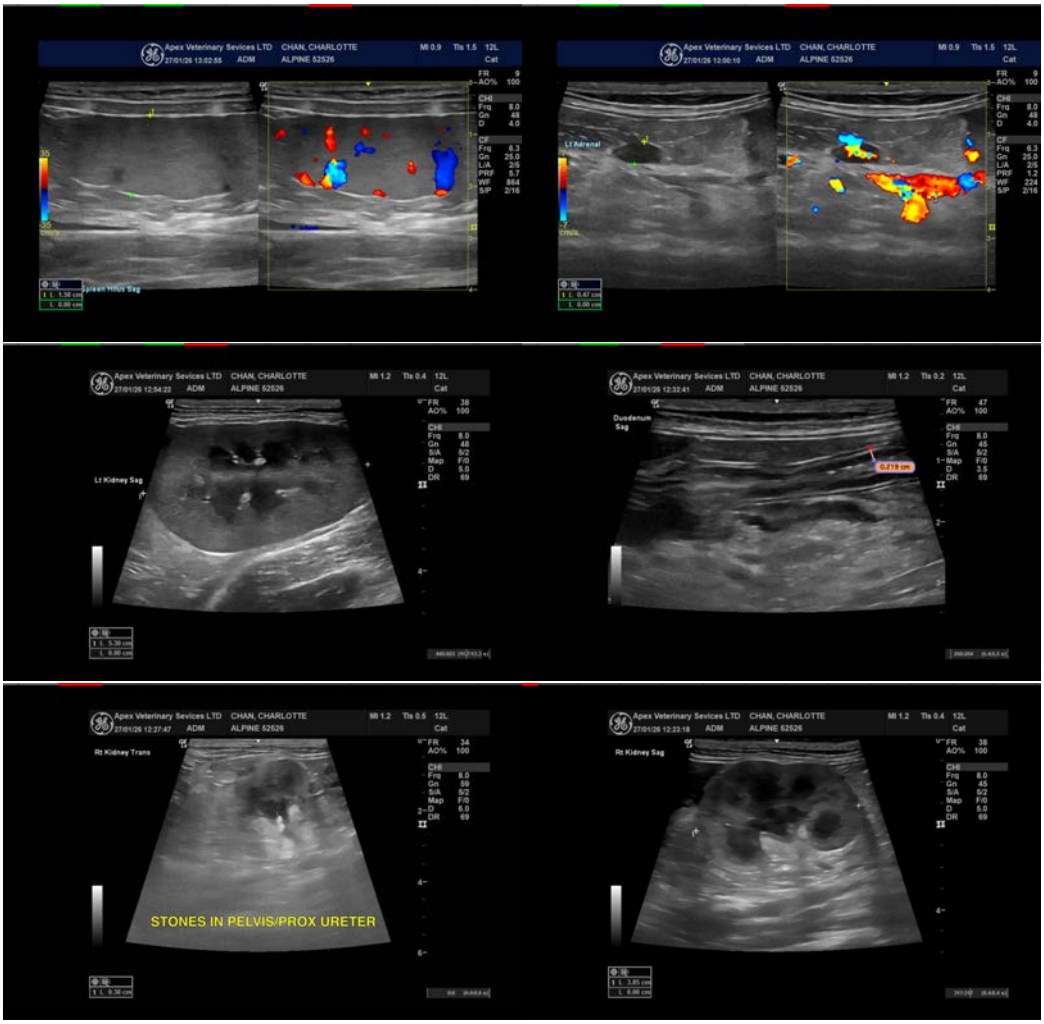

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com