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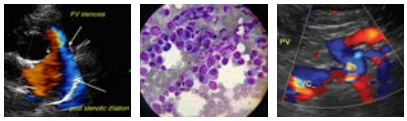

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DATE

1/5/23

PATIENT

Sheldon Foertschbeck

SPECIES

Feline

BREED

Maine Coon X

SEX

Neutered Male

AGE

12/1/08

WEIGHT

10.2 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Kalwa

INVOICE

43996

PRESENTING CLINICAL SIGNS

Lethargic, was eating less two weeks ago, originally thought it had a hairball that he wanted to get out, but in the last couple days he shows no interest in food and is laying down to drink water. Not sure how often he is going to the bathroom, he has been peeing though no vomiting Seems constipated weight loss. Diet: Blue Buffalo Dry And Fancy Feast Can + temptations ATO- - Before Christmas started eating less- allowed other cat to eat his food - O at first thought his changes were due to changes in household- less people in household; thought P was depressed - P showed intermittent interest in eating, last 2 days not eating at all - P drinking a lot, hanging by the water bowl; started drinking out of the toilet - Tried to vomit ~1 week ago, early last week- thought it was a hairball – yellow bile - Indoor only - Parents adopted P in 09 - Saw major decline in last few days, weight loss - Found P urinating in abnormal places- closet, where P lays- unsure if sticky clear urine vs diarrhea.

Current Medications: Potassium Chloride, Cerenia, Protonix, Buprenorphine, Ampicillin, Vitamin B12.
Lab Results: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily dependent echogenic debris present. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (4.17 cm) with pyelectasia at 0.67 cm and intrapelvic debris present. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.43 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.38 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is large (1.2 cm in width at the level of the hilus) and hypoechoic. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. 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. The duodenum measured as normal (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) 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 large and hypoechoic to surrounding mesentery. There is a 0.90 cm x 0.96 cm rounded, hypoechoic structure visualized in the region of the pancreas, most consistent with a pancreatic cyst, although a hypoechoic nodule cannot be definitively excluded. There is evidence of regional mesenteric inflammation. Consistent with moderate pancreatitis.

Free Abdomen
Small volume free abdominal fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Dependent debris visualized in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Left-sided renal pelvic dilation with intrapelvic debris – Findings would be concerning for possible pyelonephritis. Recommend urinalysis and culture.
- Large, hypoechoic spleen – Findings could be consistent with congestion, infiltration, other. Recommend a fine needle aspirate.
- Hypoechoic, irregular pancreas with hypoechoic cystic structure – Findings are consistent with mild to moderate pancreatitis and likely a pancreatic cyst.
- Large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Small volume free abdominal fluid – Consider fluid analysis and cytology.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

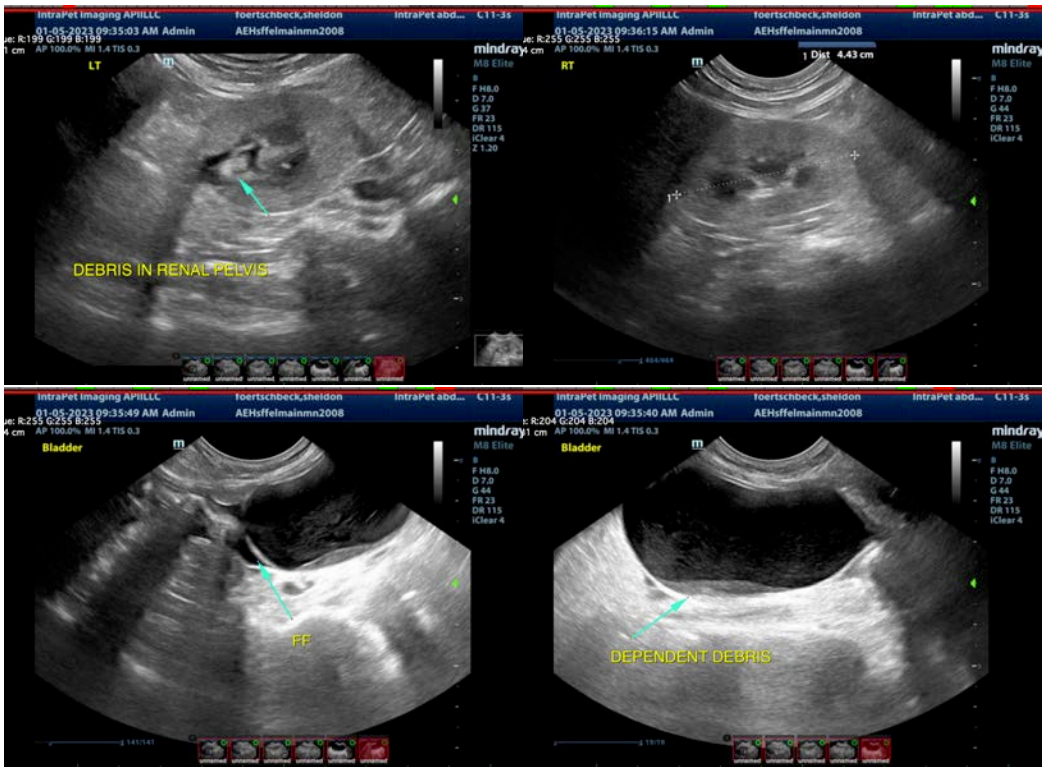
No definitive cause for the anemia reported is observed on today's scan. The left kidney does appear somewhat dilated with some debris visualized within the renal pelvis. Recommend a urinalysis, culture, and blood pressure evaluation.

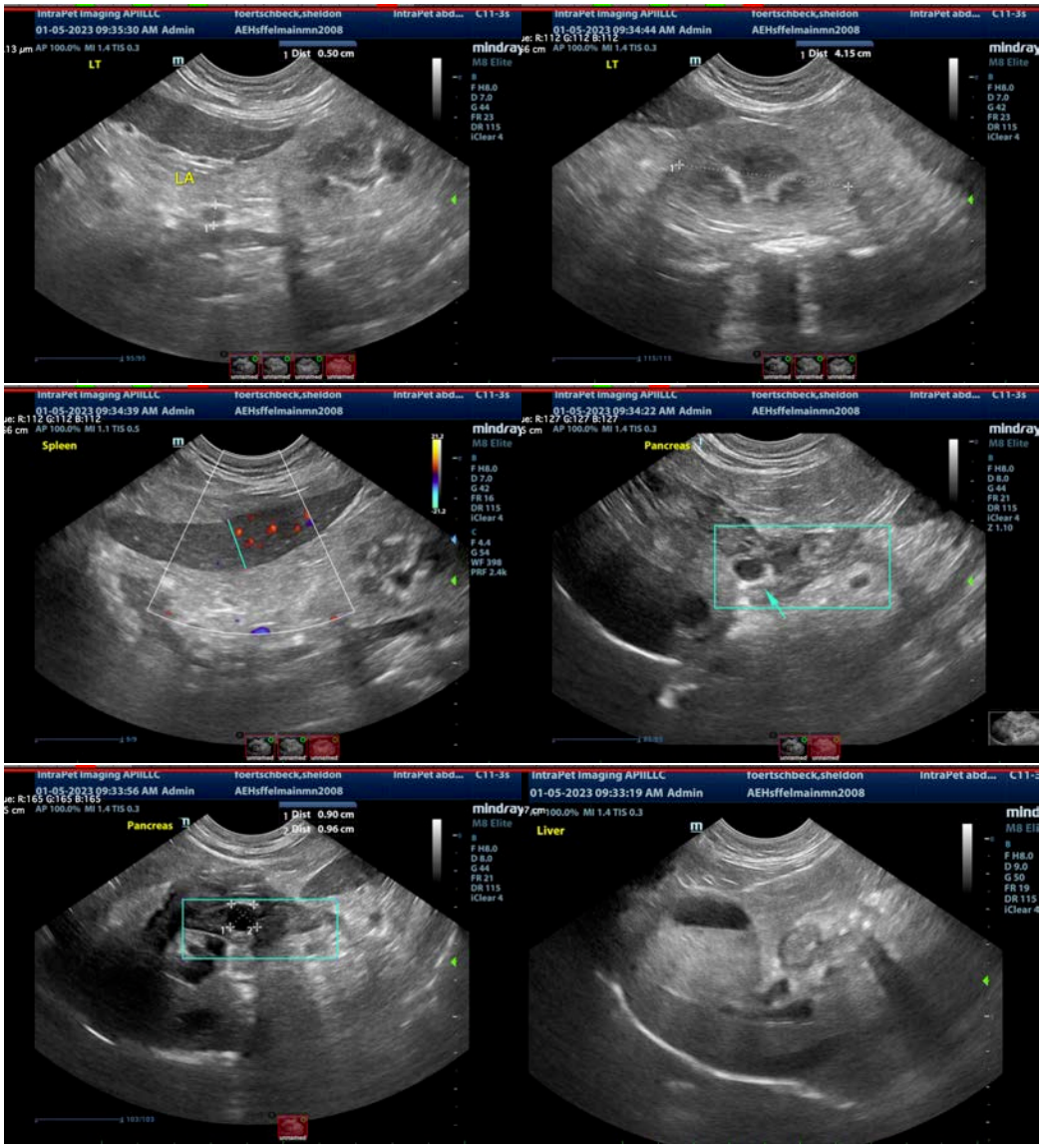
Both the liver and spleen are somewhat large. The spleen is hypoechoic. Recommend a fine needle aspirate. Additionally, the liver is somewhat hyperechoic compared to the spleen. If round cell neoplasia is high on your differential list, consider a fine needle aspirate.

The pancreas is prominent and hypoechoic with some mildly surrounding hyperechoic mesentery and an anechoic structure, most consistent with a pancreatic cyst. Recommend supportive treatment for mild to moderate pancreatitis and continued monitoring of the cystic structure. A fine needle aspirate could be considered if there is concern for enlargement, etc.

Recommend a pathologist review of the blood smear as well as testing for mycoplasma haemofelis, and questioning about any potential medications or substances that could cause hemolysis (zinc, Tylenol, onions, etc.). If this is truly a non-regenerative anemia, a bone marrow aspiration would be ideal along with fine needle aspirates of the spleen +/- liver. If a bone marrow aspirate is not possible, you could consider treatment with Prednisone and Doxycycline with the knowledge that an underlying neoplastic process could be missed.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.





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.

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