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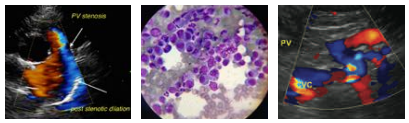

SonoPath
Clinical Sonography & Telecytology
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DATE
11/26/21

PATIENT
Kit Kat Casole

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Spayed Female

AGE
9/20/06

WEIGHT
6.3 lbs

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

IMAGING PERFORMED BY
Andi Parkinson RDMS

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Thompson

INVOICE
94129

PRESENTING CLINICAL SIGNS

11-23-2021 Notes: Kit Kat is a 15 y/o FS DSH who presents for not eating and drinking for 2 days, weight loss and decreased appetite over last 1-2 weeks - no C/V/D - did sneeze after resting near water bowl - not observed to eat or drink for the last two days - noticeable weight loss within the last week - decreased appetite for last 1-2 weeks - indoor only - vocalizing more often, no usually a vocal cat - still moving around normally, however, is not acting like self - Overdue on vaccinations Medications: - none, no preventatives. Current Medications: Methimazole, Oral Buprenorphine, Methimazole, Maropitant, Potassium Chloride.
Lab Results: Attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. 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 cystic calculi.

The left kidney has a normal shape and size (3.68 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. Rare pinpoint nephroliths were noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.75 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. Rare pinpoint nephroliths were noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of the left adrenal gland (cranial to the left renal artery) is unremarkable but the adrenal is not distinctly visualized-likely due to gas in the area.

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 is seen.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. 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 heterogenous in echotexture with subtle, indistinct focal mottling. 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 gallbladder is not thickened and has a smooth mucosal surface. Luminal contents are 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 and the jejunum measured as normal (0.21 cm). 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 normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. The mesenteric lymph nodes are visualized and measured 0.26 cm and 0.3 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Mildly reduced corticomedullary distinction in both kidneys with rare, small, non-obstructive nephroliths. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

SECONDARY FINDINGS:

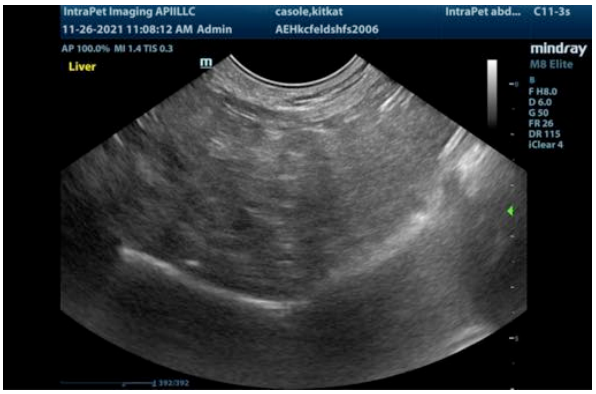
- Prominent, but not enlarged mesenteric lymph nodes. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

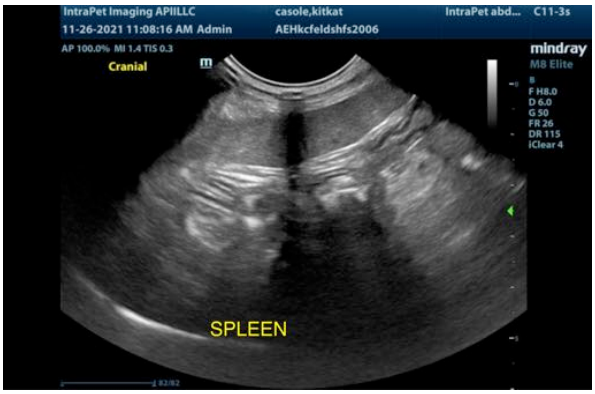
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

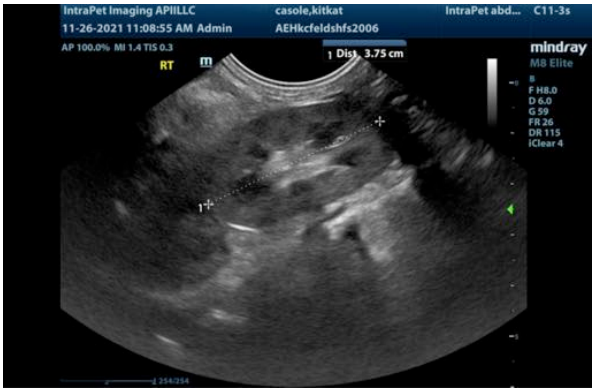
Todays scan appears relatively normal and the changes observed are consistent with age related change. An obvious cause for the anorexia and vomiting reported is not visualized. In the lab work provided the sodium is very high with a low potassium. This can be seen with anorexia and dehydration, but it can also be associated with hyperaldosteronism. I recommend blood pressure measurements to look for evidence of hypertension. If hypertension is evident then I recommend running aldosterone levels. Adrenal pathology was not noted on todays scan, but visualization was impaired by some shadowing gas in the area. If aldosterone levels are elevated I would recommend a CT scan of the adrenal glands or recheck ultrasound of this area when the patient is better hydrated.

Other potential causes of anorexia and vomiting would be primary GI disease which sometimes does not produce significant ultrasonographic lesions. You can consider a GI panel to Texas A&M with a qualitative fPLI, TLI, cobalamin and folate to further evaluate for pancreatic and small intestinal disease. You can also consider a liver function test to further evaluate the ALT elevation. Lab work provided shows an elevated T4.

If this is persistent consider treatment for hyperthyroidism.







The information and recommendations provided are based on the images presented by the referring veterinarian. 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)
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