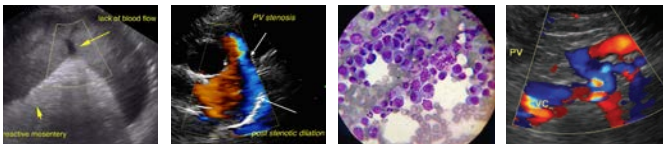
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Stewart Millard

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10 Years 4 Months

WEIGHT

9.04 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Katie Freson

HOSPITAL NAME

Kings Vet Hospital

REFERRING VET

Dr. Katie Freson

INVOICE

33788

DATE

12/28/21

PRESENTING CLINICAL SIGNS

Presented for not eating/acting well for a couple days. Drinking and urinating more recently. 2lbs weight loss over the past three months. History of suspected IBD, but no confirmation thus far. Significant azotemia that has since improved on IV fluid therapy. Urine culture pending. History of heart murmur, as well.

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 is normal in size (3.7 cm). It is irregular in contour (likely due to previous infarcts) with non-obstructive nephroliths, and pyelectasia at 0.25 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. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.3 cm) with non-obstructive nephroliths. 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. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. 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 not clearly visualized.

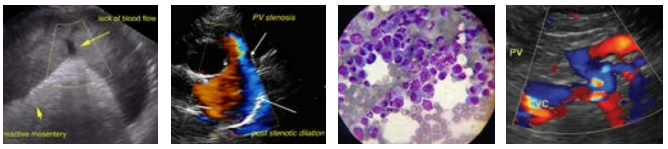
Liver

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 gallbladder lumen is moderately distended. The wall of the gall bladder 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 is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.



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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with moderate 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 area 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. There is a mild mesenteric lymphadenopathy visualized with lymph nodes measuring 0.35, 0.37 cm. The omentum is generally of normal echogenicity.

PRIMARY FINDINGS

- Decreased corticomedullary distinction in both kidneys with left-sided pyelectasia and bilateral non-obstructive nephroliths – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other. The hyperechoic mineralized foci observed at the corticomedullary junction of the left and right kidney are consistent with small, non-obstructive nephroliths.

- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

SECONDARY FINDINGS

- Moderately dilated gastric lumen with fluid dilation of the small intestine – Correlate with feeding history. This could be normal in a patient that was not fasted. Alternately, it could be consistent with delayed gastric emptying, enteritis, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal large mass lesions were visualized. The changes to the kidneys are consistent with the renal disease reported in the history. Recommend urinalysis and culture and blood pressure evaluation.

There is moderate fluid distention in the stomach and small intestine. Correlate with feeding history and abdominal radiographs. If the patient was adequately fasted, then consider generalized ileus, delayed gastric emptying, etc., and consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to look for further evidence of pancreatic/small intestinal disease.

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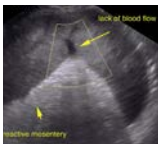
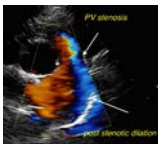
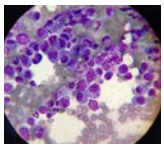
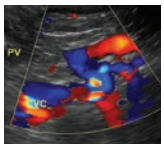

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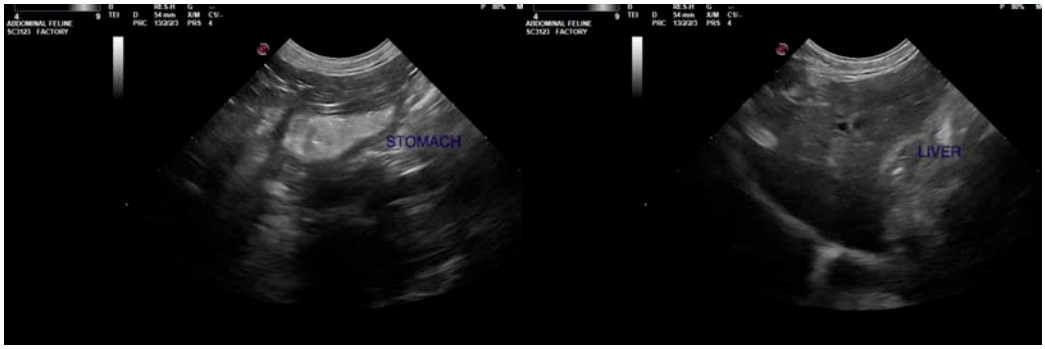

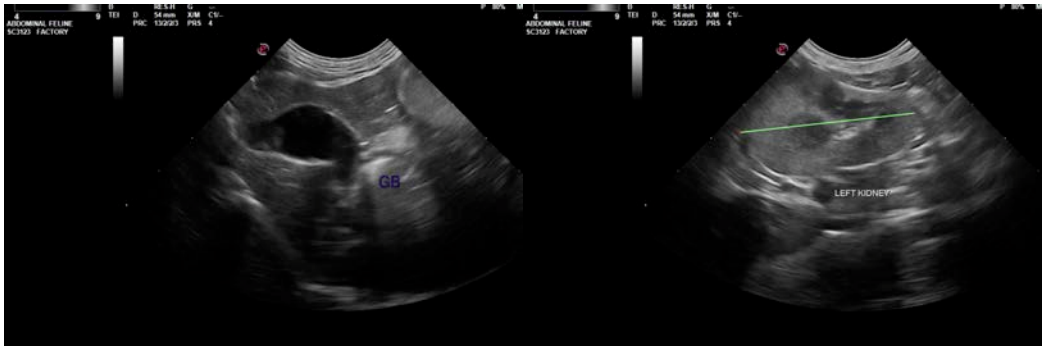

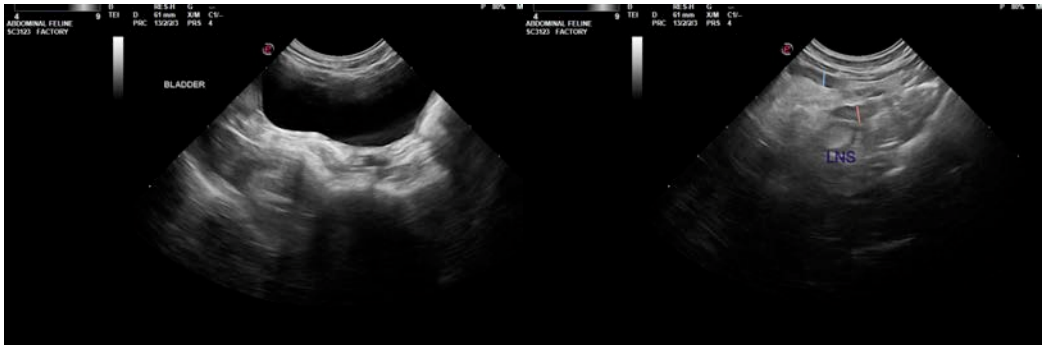

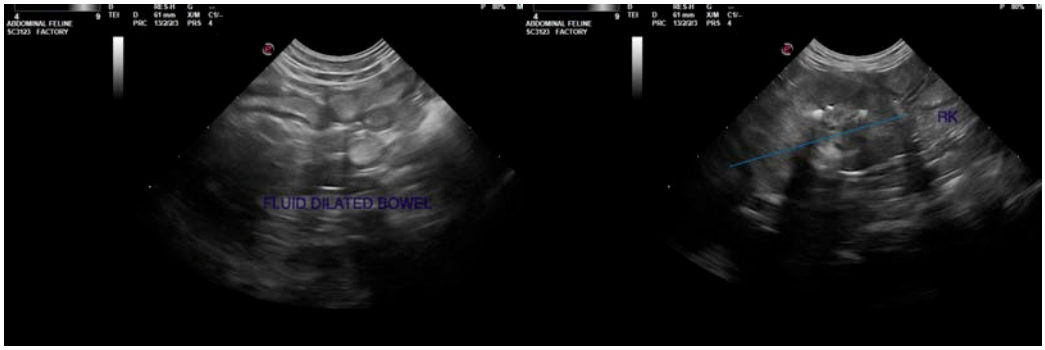

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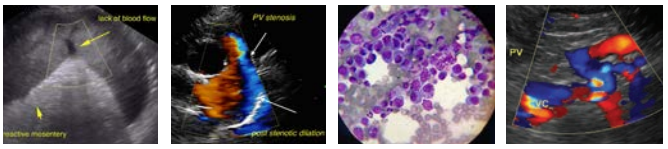

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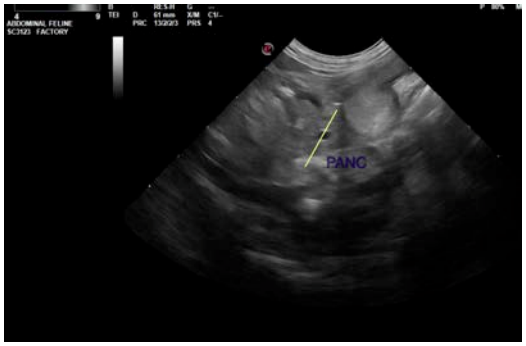

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
kathleen.sennello@sonopath.com