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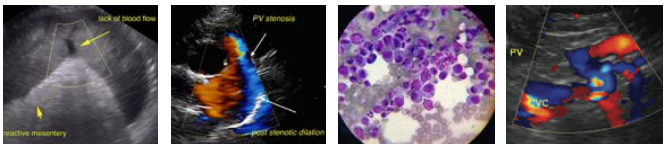


PATIENT

Ember Tollok

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Female

AGE

Unknown

WEIGHT

7.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Mengine

INVOICE

97908

DATE

3/29/22

PRESENTING CLINICAL SIGNS

History: Patient was found outside 1 month ago, congested, otherwise appeared healthy. Sprayed urine twice when first inside, otherwise no estrus signs. No visible spay scar. At rDVM had a CBC / mini-chem which showed an ALT of 432. BUN 42, Creat 1.6. FeLV / FIV neg. Patient is fractious, and when sedated for ultrasound, her dental exam was more typical of a geriatric cat. Urinalysis, full chem and T4 pending.
Abnormal PE/Chem/CBC/UA Results: Patient was found outside about 1 month ago.

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 (4.0 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 nephroliths, infarcts or hydroureter. Pyelelctasia was noted and measured 0.24 cm. Renal vasculature is normal.

The right kidney has a normal shape and size (4.08 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. Pinpoint, non-obstructive nephroliths were noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.37 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.

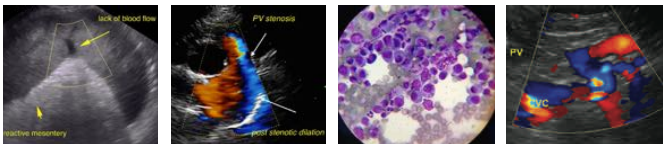
The right adrenal gland is normal in size measuring 0.38 cm at the caudal pole It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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. The spleen measured 0.88 cm at the level of the hilus.

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



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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 <0.7cm 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 (0.33 cm) and the jejunum measured as normal (0.23 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 (0.14 cm). 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 hypoechoic as 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.

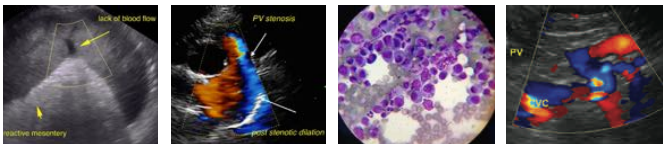
Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Decreased corticomedullary distinction in both kidneys with mild, left-sided pyelectasia. 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.
- Hypoechoic prominent pancreas. The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Heterogenous liver. Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other



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hepatopathy.

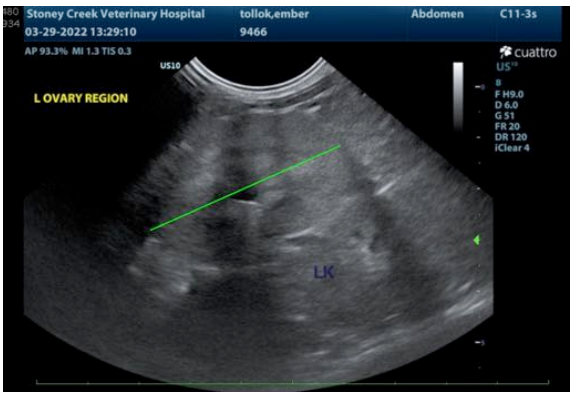
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

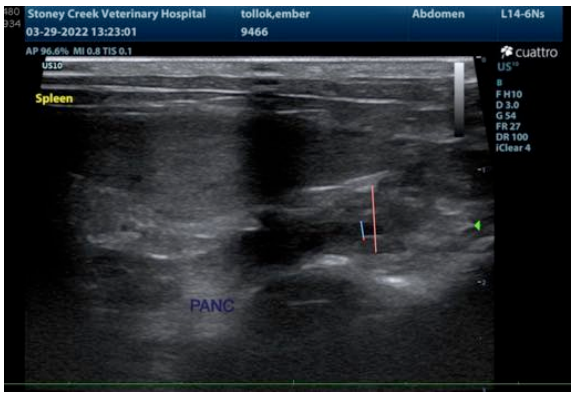
No focal lesions are visualized associated with the liver. Unfortunately the sonographic changes do not always reflect the severity or cause of the hepatopathy present. Consider systemic causes such as hyperthyroidism, infection, toxicity, etc. If these conditions are unlikely then a primary hepatopathy (infectious, inflammatory, lipidosis, neoplasia, etc.) is suspected.

- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc.
- Recommend thyroid evaluation (if not already done)
- If not already done consider pre and post prandial bile acids to evaluate liver function
- If cytology is not helpful and there is no response to therapy, consider liver biopsy with samples obtained for histopathology and culture.
- If triaditis is suspected consider therapy for cholangiohepatitis (fluids, antibiotics , +/- Ursodiol,+/- steroids), testing for pancreatitis and evaluation for IBD (GI panel to Texas A&M GI lab)

Correlate these recommendations with the patient's degree of clinical symptoms. If this is a stray you can consider testing for Toxoplasmosis and other potential infectious organisms. Additionally consider three view thoracic radiographs.

The changes in the kidneys are most consistent with chronic progressive renal disease. I recommend urinalysis, culture and blood pressure evaluation (if possible considering temperament).





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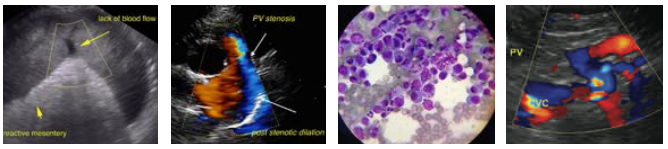

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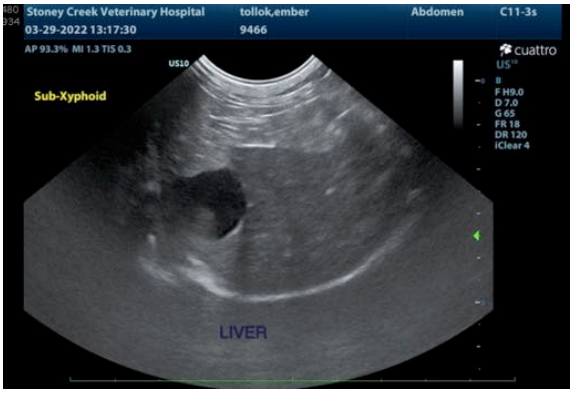

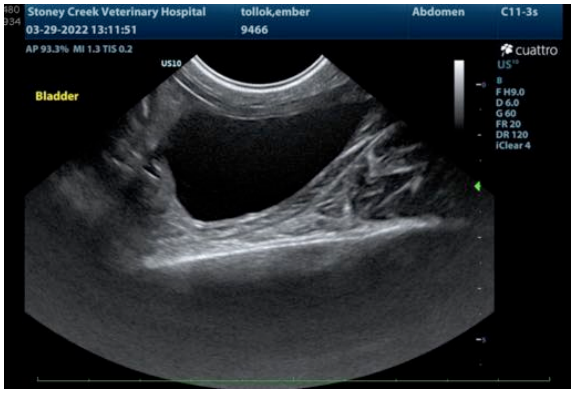

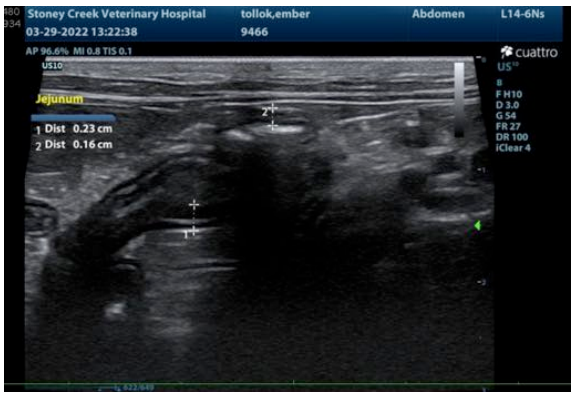

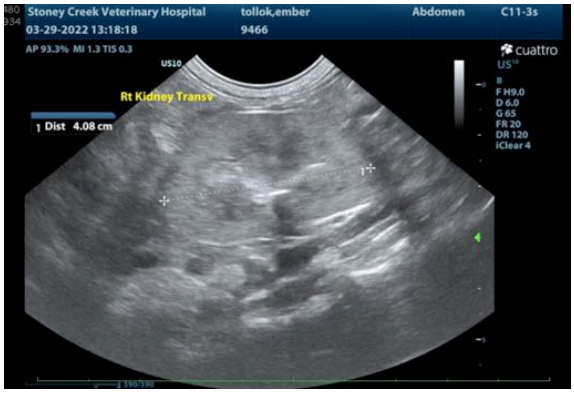

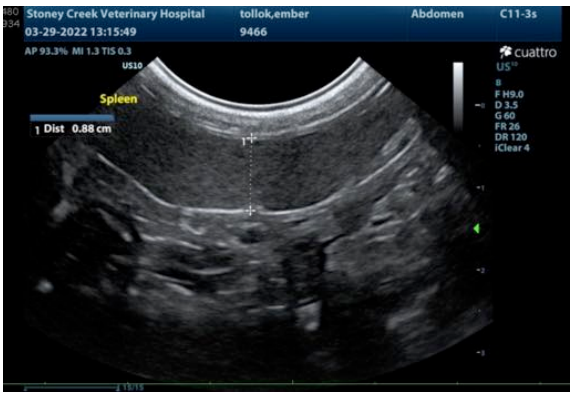

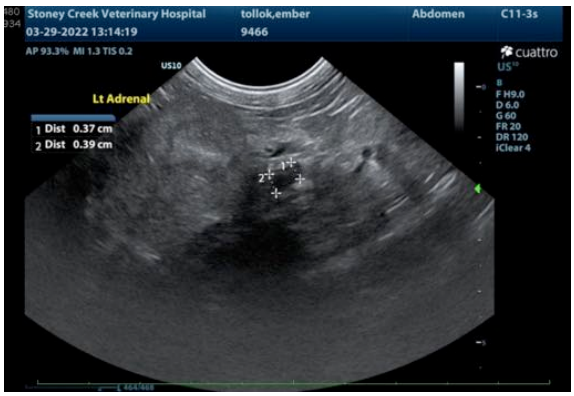

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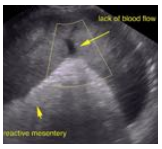

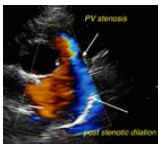

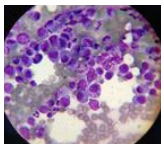
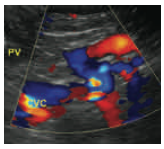

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com