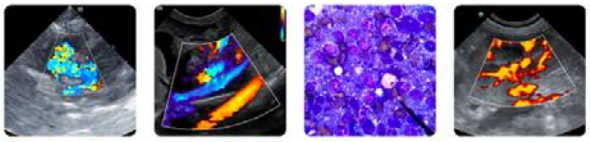


PATIENT

Chunky Zeiger

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years

WEIGHT

8.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Shally Gastelu

INVOICE

73398

DATE

3/5/26

PRESENTING CLINICAL SIGNS

Recently hospitalized from 3/2 - 3/4 for naive DM with ketosis, and alkalosis (no acidosis). P treated w intermittent Lantus protocol, IVF, analgesia, abc, and GI support. Ketones and BG improved (not resolved) prior to discharge. Represented 5 hours later after being acutely lethargic. Repeat assessment displayed hyperglycemia, and progressive ketosis. Patient was re-admitted for further work up and treatment. Urogenital: bladder is moderately sized but soft, pliable; unable to be expressed at this time. Musculoskeletal: Overconditioned.

Abnormal PE/Chem/CBC/UA Results: 3/2 Intake Diagnostics: ketones: 6.7 EPOC: Na 145, Ca 1.17, GLU 439 CBC: unremarkable CHEM15: GLU 479, ALB 4.2, ALT 335, GGT 6, TBIL 1.3, CHOL 236 Pancreatic lipase: WNL xrays 1. Mild hepatomegaly. 2. Moderate splenomegaly. 3. Multiple (at least 6) small cystic calcul 4. Mild diffuse bronchial pattern 3/2 O/N Magnesium: 2.06 (n) Phosphate: 4.6 (n) 3/3 Day: BG q2h - 208, 231, 176, 150, 165, 155 ketones 6pm - 4.1 Phos 6pm - 2.0 (L) 3/3 O/N: BG: 169, 188, 133, 228, 329, 390 3/4 Day: BG q2h - 421, 410, 492, 472, 495 ketones - 2.6 TODAY 3/5 at re-presentation: EPOC: cSO2 82.1 (H), pH 7.447 (H), Na 147 (L), BG 417 (H) BG: 365 Ketone: 4.1 CBC: RBC 6.47 (L), HCT 25.0 (L), Lymph 0.47 (L) Chem+CPL: BG 432 (H), ALT 240 (H), TBili 1.1 (H), CPL 2.3 (WNL), Mg 1.87 (WNL)

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, or masses. In the dependent portion of the urinary bladder there are numerous small, focal mineralizations/stones.

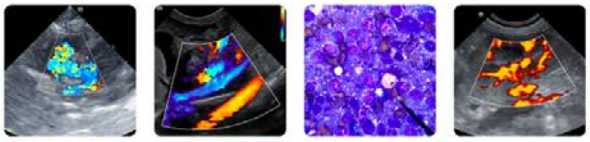
The left kidney has a normal shape and size (4.37 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.76 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 0.34 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 0.48 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 borderline large at 1.22 cm. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is large in size 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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild/moderate fluid. 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.

Most of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to 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. Duodenum wall measures 0.31 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. There are occasional focal sections of small intestine that exhibit mild fluid/ingesta distention and corrugation, possibly consistent with mild enteritis.

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, 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.

PRIMARY FINDINGS

- Small dependent stones visualized in the urinary bladder.
- Large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Moderate fluid distention of the stomach and some sections of small intestine – Correlate with feeding history. This could be consistent with a post-prandial patient or possibly generalized ileus/mild enteritis.

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SECONDARY FINDINGS

- Borderline large spleen – I suspect this is normal for this very large cat. Recommend continued monitoring.

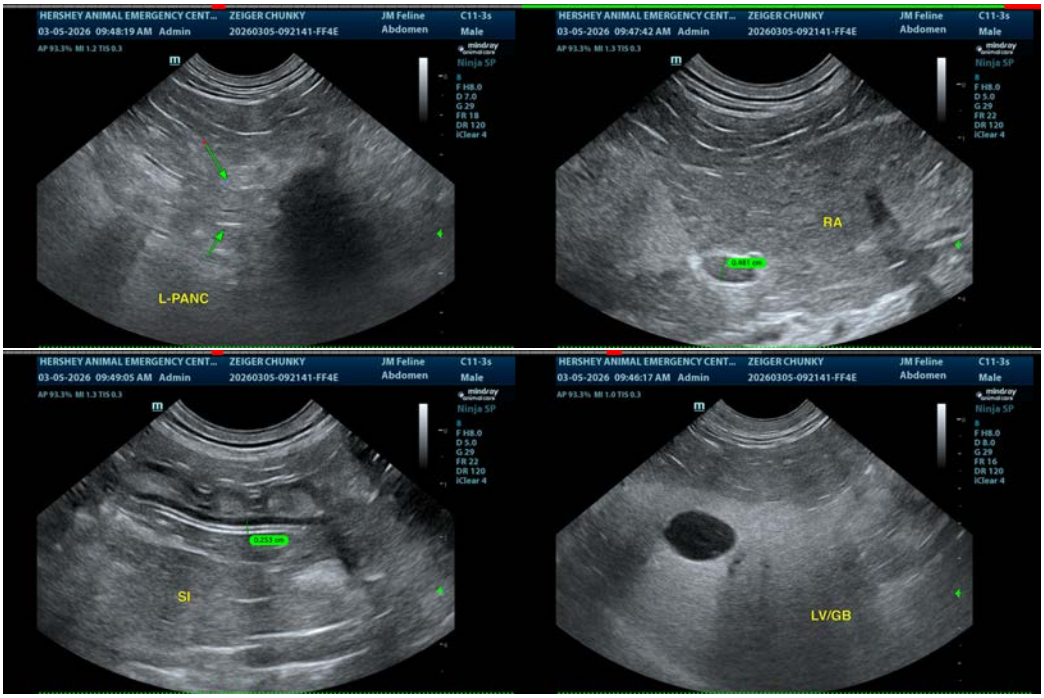
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is large and hyperechoic. Given the elevation in bilirubin reported, this could be concerning for lipidosis, less likely infiltrative neoplasia or other hepatopathy (cholangiohepatitis, etc.). Additionally, fatty deposition in the liver can increase echogenicity. A fine needle aspirate of the liver could be considered (as long as coagulation parameters are normal), and if the patient is not eating well, assisted feeding with a feeding tube could be considered.

The stomach and some sections of the small intestine appear moderately fluid distended, likely consistent with a non-fasted patient. If the patient has significant gastrointestinal symptoms, this could represent ileus/enteritis. No focal lesions are observed at this time.

If not already done, recommend a urine culture and radiographs to better assess the size and number of stones visualized in the urinary bladder.

Based on the history provided, it is likely that this individual needs more time for stabilization prior to discharge. I don't see evidence of severe pancreatitis. You could consider a PLI level to further evaluate. Additionally, based on the size of this individual, if insulin resistance is strongly suspected, you could consider evaluation for a growth hormone excess.



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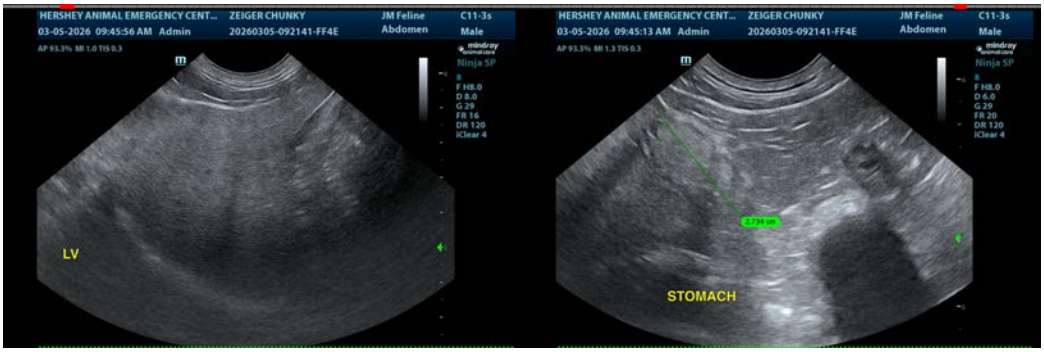

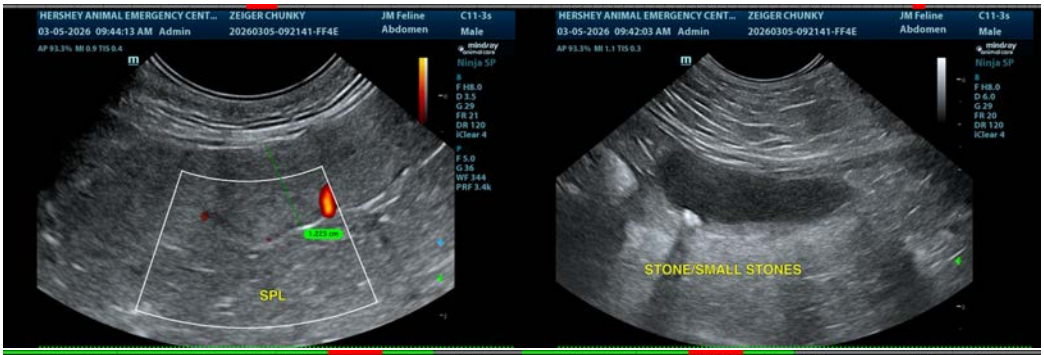

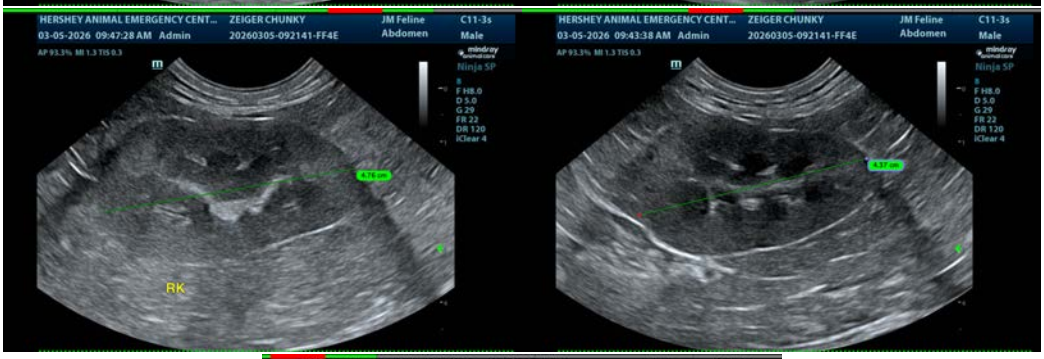

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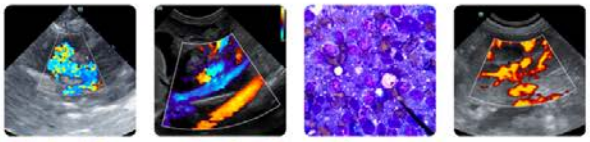

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com