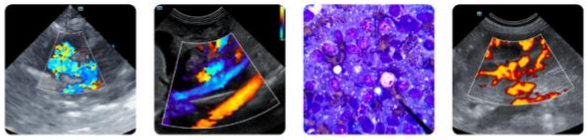


PATIENT

Smokie Stroud

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

5 Years

WEIGHT

14.8 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Animal Hospital of Lake Brandt

REFERRING VET

Dr. Smith

INVOICE

14051

DATE

03/05/26

PRESENTING CLINICAL SIGNS

- P presented for double cavity US due to not eating for 3 weeks, indoor only cat, previously healthy cat except for being overweight, typically weighs 20#. Will go to food bowl like interested in food and then start shaking head and won't eat.
- persistent low-grade fever 102.8-103
- Previous ER visit dx FUO possible UTI
- at RDVM today- Temp 103.2 Grade 2-3/6 murmur

Abnormal PE/Chem/CBC/UA Results: ER visit HCT 36% Carolina Vet Specialists: ALT had to be diluted but then came back as <60, Crea 1.8, BUN 178, TP >12, urine WBC 27/hpf, cocci present, struvite 6-20, HCT 28.8% rDVM Today ALT had to be diluted again and then showed 58, CL 63, TP >12, BUN 42, Crea 5.5, HCT 26.4

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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney is borderline enlarged in size (4.72 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal. There is no significant perirenal fluid but the perirenal fat appears hyperechoic and reactive.

The right kidney is borderline enlarged in size (4.48 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal. There is no significant perirenal fluid but the perirenal fat appears hyperechoic and reactive.

Adrenal Glands

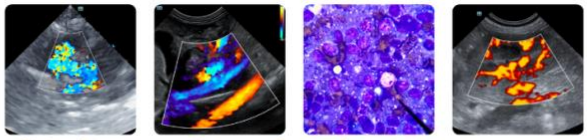
The left adrenal gland is normal in size measuring 0.31 cm. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.42 cm. 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 0.96 cm.

Liver



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The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is subjectively mildly 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 gall bladder 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 proximal common bile duct appears slightly prominent measuring 0.33 cm. It is lost to visualization distally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36 cm 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 uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis: mucosa layer ratio. The duodenum measured 0.27 cm in diameter, and the jejunum measured 0.31 cm in diameter. 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 left limb of 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

There is no free fluid present.. Occasional prominent lymph nodes are visualized. The iliac lymph nodes are prominent and measure 0.36 cm and 0.38 cm. The omentum is hyperechoic around both kidneys.

ULTRASONOGRAPHIC FINDINGS

- Borderline large kidneys with surrounding reactive mesentery/fat- findings could be consistent with acute renal injury, pyelonephritis, FIP, less likely early neoplastic infiltration.
- Subjectively mildly heterogenous liver- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy.
- Diffusely “ropey” small intestine with areas exhibiting a prominent muscularis- The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Prominent/mildly enlarged iliac lymph nodes- findings are most consistent with reactive lymph nodes although an early neoplastic change cannot be ruled out.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

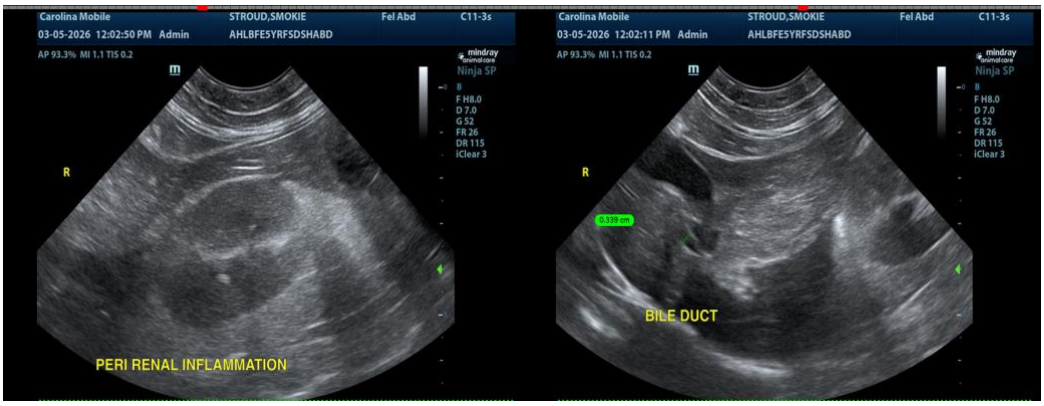
Both kidneys are borderline enlarged with surrounding reactive mesentery. The appearance is concerning for possible acute renal injury, possibly an acute on chronic episode? Additionally, pyelonephritis, FIP, etc. could have a similar presentation. Recommend blood pressure, urinalysis, culture +/- urine protein creatinine ratio, diuresis, and supportive care.

Based on the history provided, I'm concerned that this has started as a fever of unknown origin. Further workup (if not already done) should include thoracic radiographs, potentially vector-borne disease testing, FIP testing, evaluation for joint pain, etc. in addition to the urine cultures and empirical treatment for pyelonephritis once cultures are obtained.

The small intestine appears somewhat “ropey” with some areas exhibiting a prominent muscularis layer. This could be consistent with mild inflammatory type change. If there's concern for an underlying gastrointestinal issue, you could consider a GI panel to Texas A&M for a qualitative FPLI, TLI, cobalamin and folate looking for additional evidence of underlying small intestinal disease which may warrant further workup such as biopsies.

Changes observed associated with the liver are mild. Differentials such as neoplastic infiltration, cholangiohepatitis, and/or an atypical presentation for lipidosis are possible. Consider sending out the ALT for an accurate read if significantly elevated you could consider a fine needle aspirate of the liver (provided coagulation parameters are normal) and possibly an esophagostomy tube for nutritional support.

If symptoms are persistent despite efforts at diagnostics and treatment, you could consider repeat imaging in the future looking for the possible progressive changes to the kidneys, etc.



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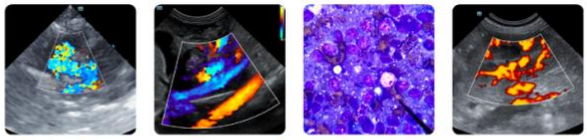

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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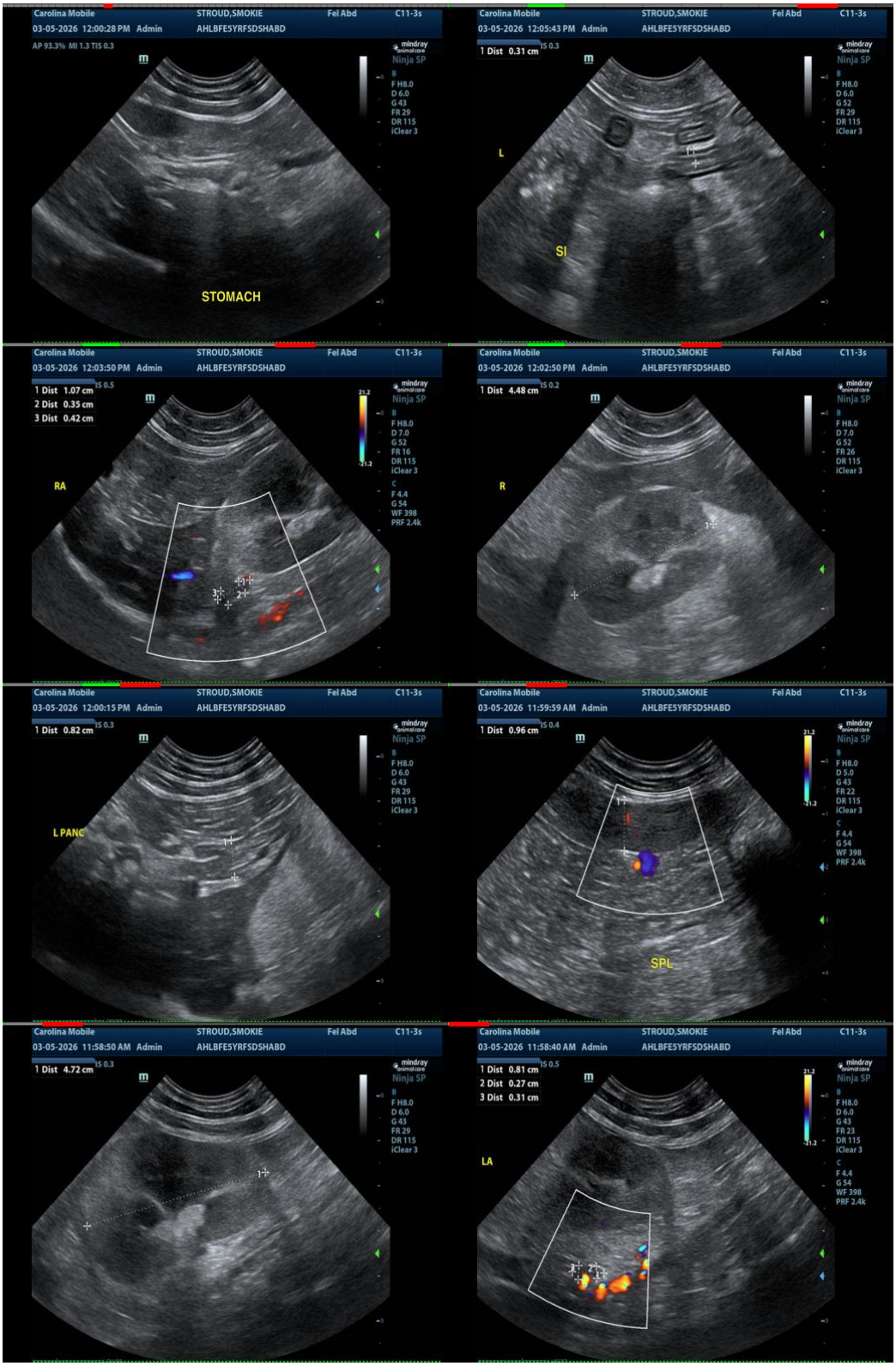

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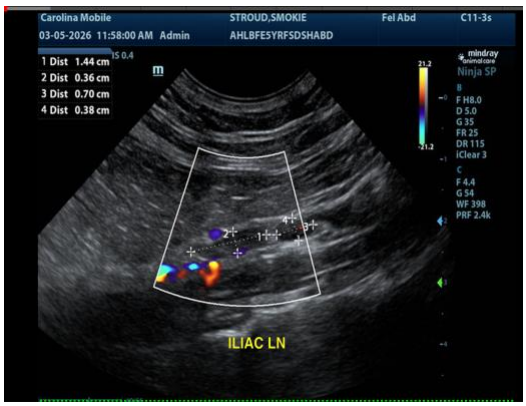

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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