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Clinical Sonography & Telecytology
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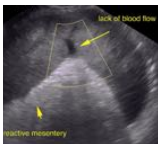
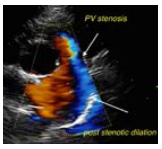
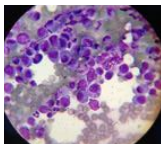
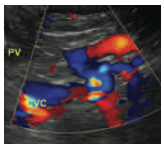

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Gizmo Hansen

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

8 years

WEIGHT

13.9 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sheldon

HOSPITAL NAME

Advanced PetCare of Oakland

REFERRING VET

Dr. Sheldon

INVOICE

96631

DATE

2/25/22

PRESENTING CLINICAL SIGNS

History: For the past year pet has hematuria/leukocytosis in her urine. Last year a culture was done and it was positive for enterococcus sensitive to amoxicillin, after 20 days of amoxicillin pet was still positive with no change in hematuria and pyuria . Pet was asymptomatic so no further treatment was pursued. Pet is still asymptomatic pet was here for dental procedure and recheck urine and an ultrasound. Pet still has a large amount of hematuria and pyuria in the urine. Culture is pending. Pet is also on prednisolone for suspected IBD.
Abnormal PE/Chem/CBC/UA Results: BG 314 HI(pet gets stress hyperglycemia at the clinic-we have checked at home UA negative for glucose and fructosamine levels are normal), WBC 22.7 HI, Neut 17797 HI, rest wnl. Urinalyisis: usg 1.025, 3+ blood, 20-30 wbc, possible rods, culture pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (4.49 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. Non-obstructive 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 (4.0 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. Non-obstructive nephroliths were noted. 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 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 enlarged and hyperechoic with rounded margins. 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.

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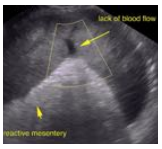

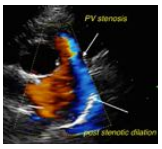

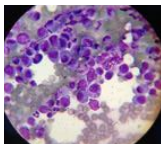
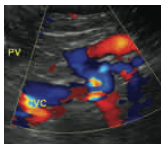

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Gastrointestinal

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 (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) 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, 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.

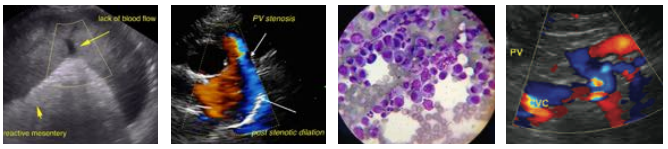
ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.
- Non-obstructive nephroliths in the kidneys. The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.
- Large, hyperechoic liver. Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No obvious lesions are visualized to explain the recurrent urinary tract infections reported. There are some focal mineralization within the kidneys that are most consistent with small nephroliths. If the infection is confirmed based on the culture results pending then I would consider an alternative strategies to systemic steroids in an effort to reduce the likelihood of immunosuppression and dilute urine contributing to the urinary tract infections. Additionally I would confirm that the hyperglycemia



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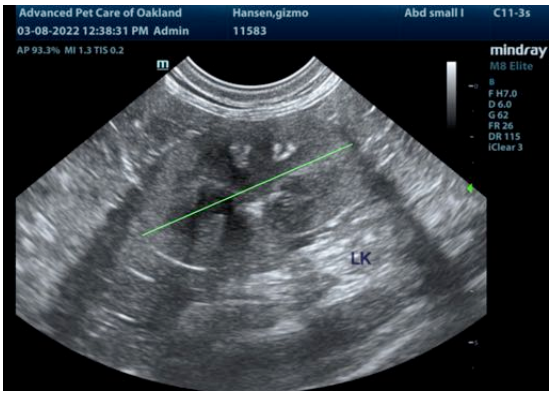
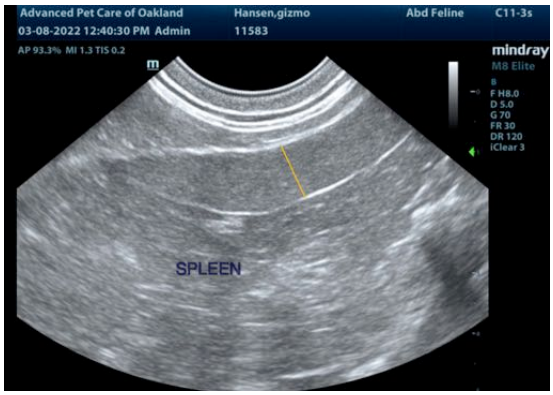
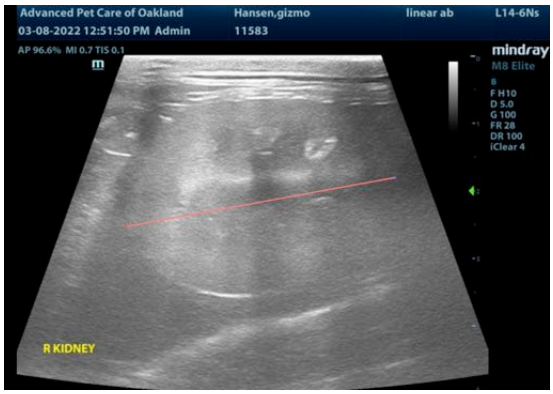
reported is not due to systemic diabetes mellitus (I believe you have already done this).

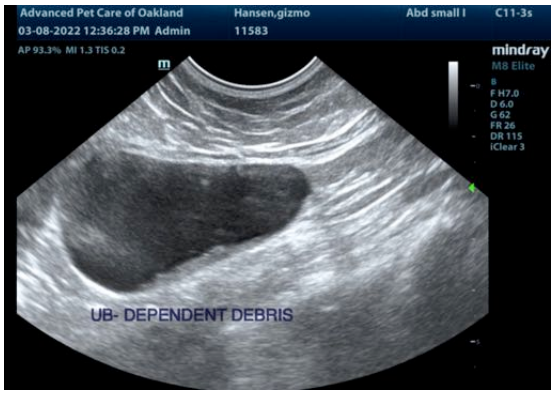
If this patient is not on a novel protein or hydrolyzed protein prescription diet, I recommend this therapy. Additionally consider weaning off the steroids, Budesonide, which may have less of a systemic effect or an alternative immunosuppressant to glucocorticoid such as chlorambucil, etc. particularly if the IBD has been confirmed based on GI biopsy results.

Additionally consider chronic probiotic therapy to try and replace a healthier flora and continued monitoring of blood and ultrasound to look for any evidence of developing pyelonephritis.









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.

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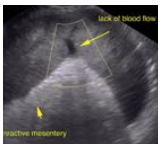

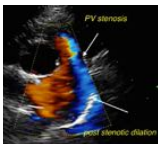

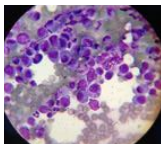
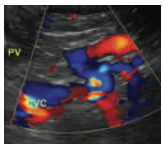

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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