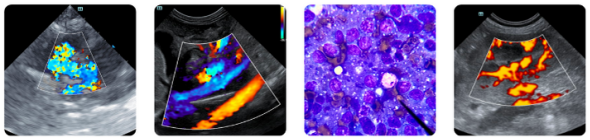


PATIENT

Patches Kreiser

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

6 years

WEIGHT

4.1 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

12017

DATE

5/28/2026

PRESENTING CLINICAL SIGNS

LHL has necrotic tissue (few weeks), was found as a stray. Initially treated with mirtazapine and prednisolone. Began to decline after meds were being weaned. Bathed in tumeric recently. Anemic on presentation, received pRBC transfusion.
Oral Cavity: Mucous membranes pale pk/tacky, CRT <2s, mod tartar/gingival erythema, sublingual clear Cardiovascular: No murmurs/arrhythmias, pulses sl weak, sl bradycardia. Abdominal: abdomen distended, doughy. Integument: generalized dermatitis and crusts over body; LH tarsus and distal swollen and necrotic with sig odor, sig yellow discoloration noted over haircoat and body (o bathed in tumeric), unkempt haircoat. Musculoskeletal: Ambulatory x 4 limbs, no lameness, PROM x 4 limbs WNL, generalized muscle wasting.

Abnormal PE/Chem/CBC/UA Results: 5/18 @ rDVM: Chem: Cl 100 (L), BG 273 (H), Lipase 3337 (H), Phos 2.9 (L), K 3.0 (L), Na 145 (L) CBC: HCT 22.6 (L), HGB 9.1 (L), MCHC 40.3 (H), WBC 25.76 (H), Lymph 10.44* (H), Mono 2.47* (H), Neut 12.39* (H) 5/27 HAEC Intake: Triple: Negative Chem: BG 316 (H), BUN 15 (L), Glob 5.2 (H) CBC: RBC 3.49 (L), HCT 13.4 (L), HGB 4.8 (L), RDW 32.1 (H), Retic 236.3 (H), WBC 22.61 (H), Neut 12.46 (H), Lymph 8.85 (H), Mono 1.13 (H), Eos 0.15 (L) EPOC: pCO2 26.4 (L), Bicarb 12.4 (L), TCO2 12.4 (L), BE -13.6 (L), Na 142 (L), K 2.6 (L), iCa 1.18 (L), BUN 14 (L), BG 319 (H), HCT 16 (L) Recheck PCV: PCV/TS: 16%/8.0.

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/borderline large in size (4.17 cm) and appears slightly rounded and borderline swollen. 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 mild pyelectasia measuring 0.14 cm. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

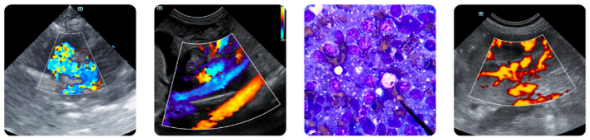
The right kidney is normal/borderline large in size (4.43 cm) and appears slightly rounded and borderline swollen. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. In some areas around the cortex there is a thin hypoechoic rim. There is no evidence of focal perinephric inflammation or effusion. Mild pyelectasia measuring 0.13 cm. There is no evidence of 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 0.37 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



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The spleen is subjectively normal in size (0.62 cm), 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 large in size, and hyperechoic. The parenchyma is 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 mild and likely incidental at this time. The bile duct appears dilated and tortuous tapering to approximately 0.28 cm where it is lost to visualization.

Gastrointestinal

The stomach contains minimal luminal contents. 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.

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 (0.3 cm in wall thickness) and the jejunum measured as normal (0.2 cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 particularly in the left limb. 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

- Subjectively mildly “swollen” appearance to the kidneys with mild pyelectasia. Pyelectasia of the kidney(s)could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Pancreatic changes in the left limb most consistent with pancreatic remodeling or chronic pancreatitis.
- Hyperechoic, heterogenous liver. Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.

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- Dilated/tortuous bile duct. Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

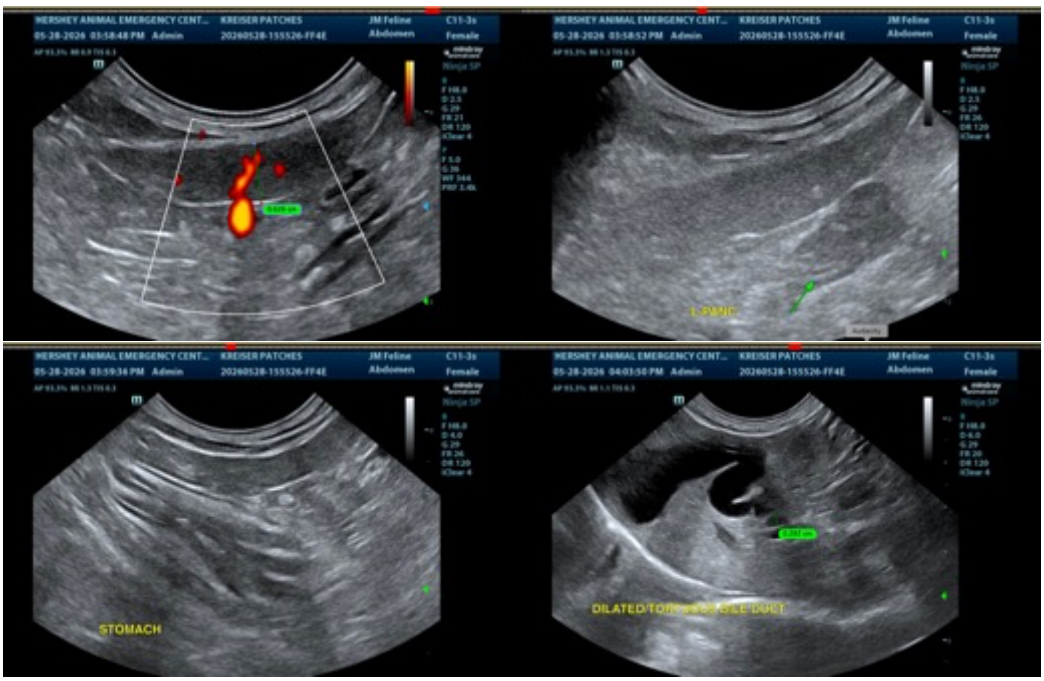
The liver appears slightly hyperechoic with a coarse echotexture and the gallbladder has a dilated and tortuous bile duct. The parenchymal changes are non-specific but could be consistent with mild lipidosis, cholangiohepatitis, even neoplastic infiltration. The significance is uncertain in the absence of liver enzyme elevations but if symptoms are persistent a fine needle aspirate could be considered.

NO evidence of a bile duct obstruction is visualized although this cannot be definitively ruled out. Recommend continued monitoring.

The left limb of the pancreas is prominent and hypoechoic possibly consistent with remodeling due to previous episodes of pancreatitis or mild chronic active pancreatitis. Correlate with a quantitative fPLI level.

Subjectively, the kidneys have somewhat of a swollen appearance. This could be normal for this individual, but additionally you could consider the possibility of mild acute renal injury, pyelonephritis, early infiltrative disease (FIP, round cell neoplasia, etc.) Correlate with a urinalysis and current renal values. Recommend continued monitoring of the kidneys.

Consider the possibility of sepsis or endotoxemia secondary to the necrotic wound described. Recommend aggressive supportive care including nutritional and if stabilized, debridement of the wound.



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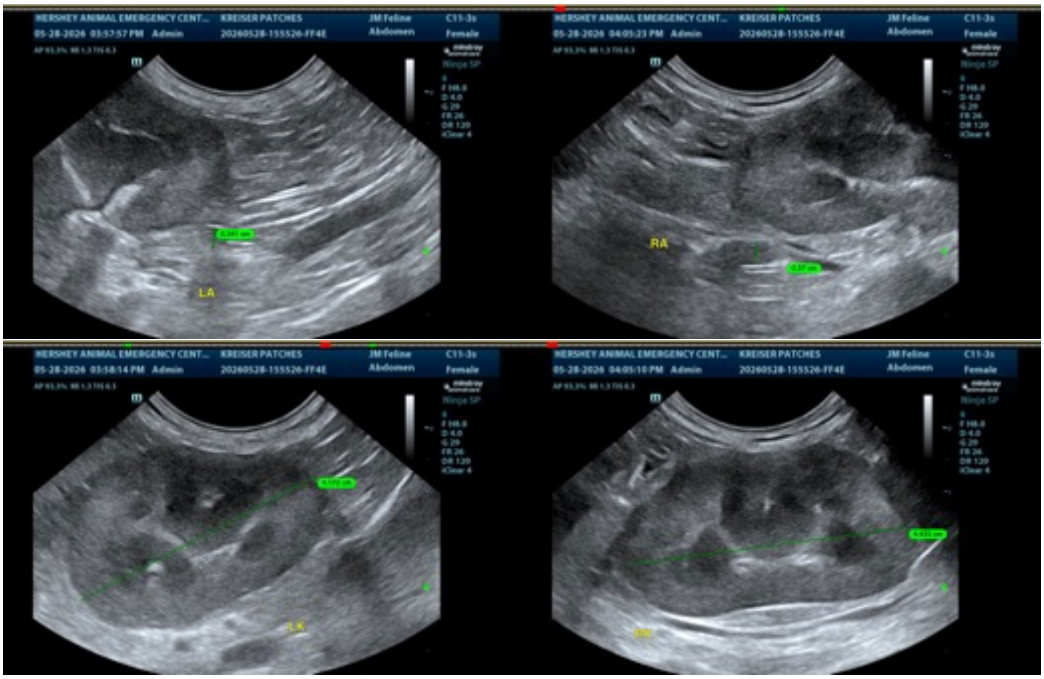

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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