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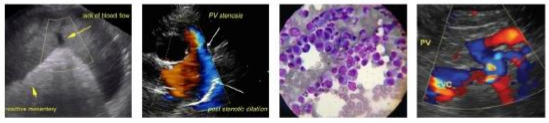


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

DejaVu Shaw

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

6.5 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Brighton Green VH

REFERRING VET

Dr. Robin Janeway

INVOICE

37398

DATE

5/4/22

PRESENTING CLINICAL SIGNS

Adopted from shelter in february. Prev diagnosed chronic renal disease. Mycoplasma haemominutum postive, tx with doxycycline no change to anemia and continued positive on recheck PCR. Decreased appetite. Weight loss of approx 0.23 lbs since last December. Senior panel results: BUN @ 53 mg/dL, Creatinine @ 3.3 mg/dL, mild decrease in serum magnesium @ 1.1 mEq/L, elevated Precision PSL @ 51 U/L, NNN anemia with HCT @ 24%, mild lymphopenia @ 1008/uL, 1+ proteinuria, but 3+ hematuria, renal tech positive Considering dental. Screening for causes of weight loss other than renal disease. CUrrently on mirtaz which is helping with appetite.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, and ureteral papillae appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi. There is a small amount of prominent tissue visualized at the cystourethral junction, measuring approximately 0.49 cm x 0.16 cm. I suspect this is prominent due to lack of bladder distention, but atypical tissue cannot be ruled out. Consider recheck evaluation with a fuller bladder in approximately 4-6 weeks.

The left kidney has a normal shape and size (3.21 cm) with pyelectasia at 0.19 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. Renal vasculature is normal.

The right kidney has a normal shape and size (3.22 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.42 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.

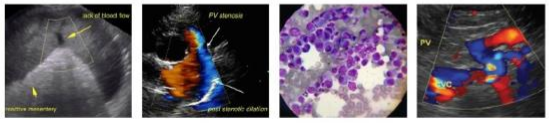
The right adrenal gland is normal in size measuring 0.41 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature appear



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prominent, which could be consistent with congestion or sedation with Dexdomitor. No focal nodules or cystic lesions are observed.

The gallbladder 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 cystic and common bile ducts are normal/not visible.

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 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. Jejunum wall measured 0.34 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. 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 large and hypoechoic to surrounding mesentery. The parenchyma is irregular and nodular, consistent with either hypoechoic nodules or irregular regenerative changes and inflammation. There is evidence of mild mesenteric inflammation. Consistent with moderate to severe pancreatitis.

Free Abdomen

There is scant free fluid visualized between bowel loops. Occasional prominent mesenteric lymph nodes are visualized. Two are measured at 0.28 cm and 0.31 cm. The omentum is of increased echogenicity in the cranial abdomen, particularly around the pancreas.

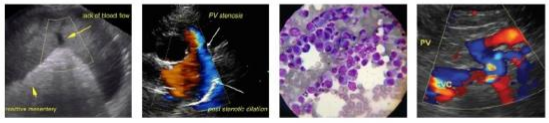
Other

A brief view of the heart was submitted. No significant pericardial effusion was seen.

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.

- Prominent, large, hypoechoic pancreas with nodular parenchyma – Findings could be consistent with chronic inflammatory changes and remodeling, but neoplastic change



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cannot be excluded as a possibility. Recommend a fine needle aspirate.

- Prominent muscularis layer to the small intestine – 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 mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

SECONDARY FINDINGS

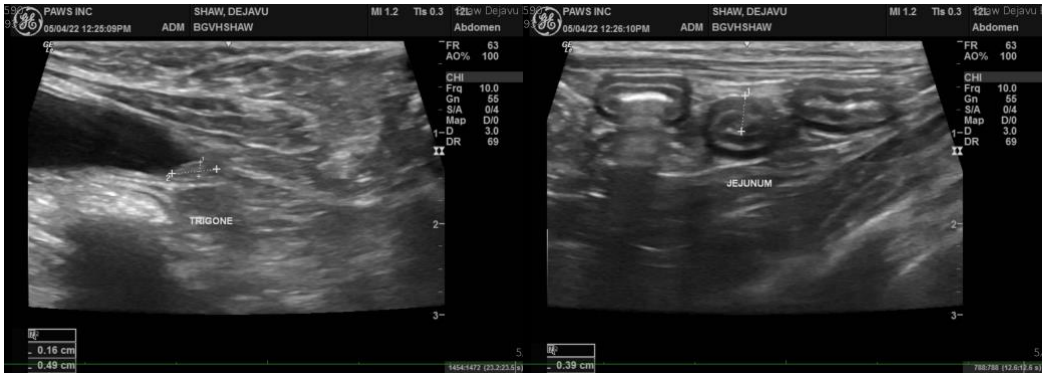
- Prominent tissue at the cystourethral junction – I suspecet this due to lack of significant urine distention, but recommend reevaluation in the near future (4-6 weeks)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are renal changes visualized on today's scan, which are consistent with the chronic renal disease reported. Recommend urinalysis, culture and blood pressure evaluation to obtain a baseline. This could be sufficient for the weight loss reported. There are other subtle lesions seen, the most significant of which is observed in the pancreas. The pancreas is large, hypoechoic, and somewhat nodular in appearance. These nodules can be seen with regeneration and scarring after previous episodes of pancreatitis, or they could be seen with an active neoplastic process, current inflammation, etc.

Consider a quantitative fPLI, TLI, cobalamin and folate (Texas A&M University GI panel) to further evaluate the pancreas and small intestine, and a fine needle aspirate of the pancreas. There are subtle changes associated with the GI tract that could be seen with chronic inflammation. If primary GI disease is thought likely after further evaluation of the pancreas, etc., then you could consider a novel protein/hydrolyzed protein prescription diet, and GI biopsies if there is no response to dietary change.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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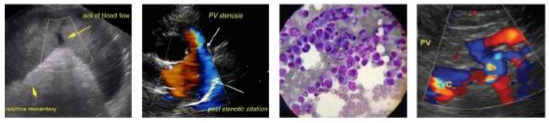

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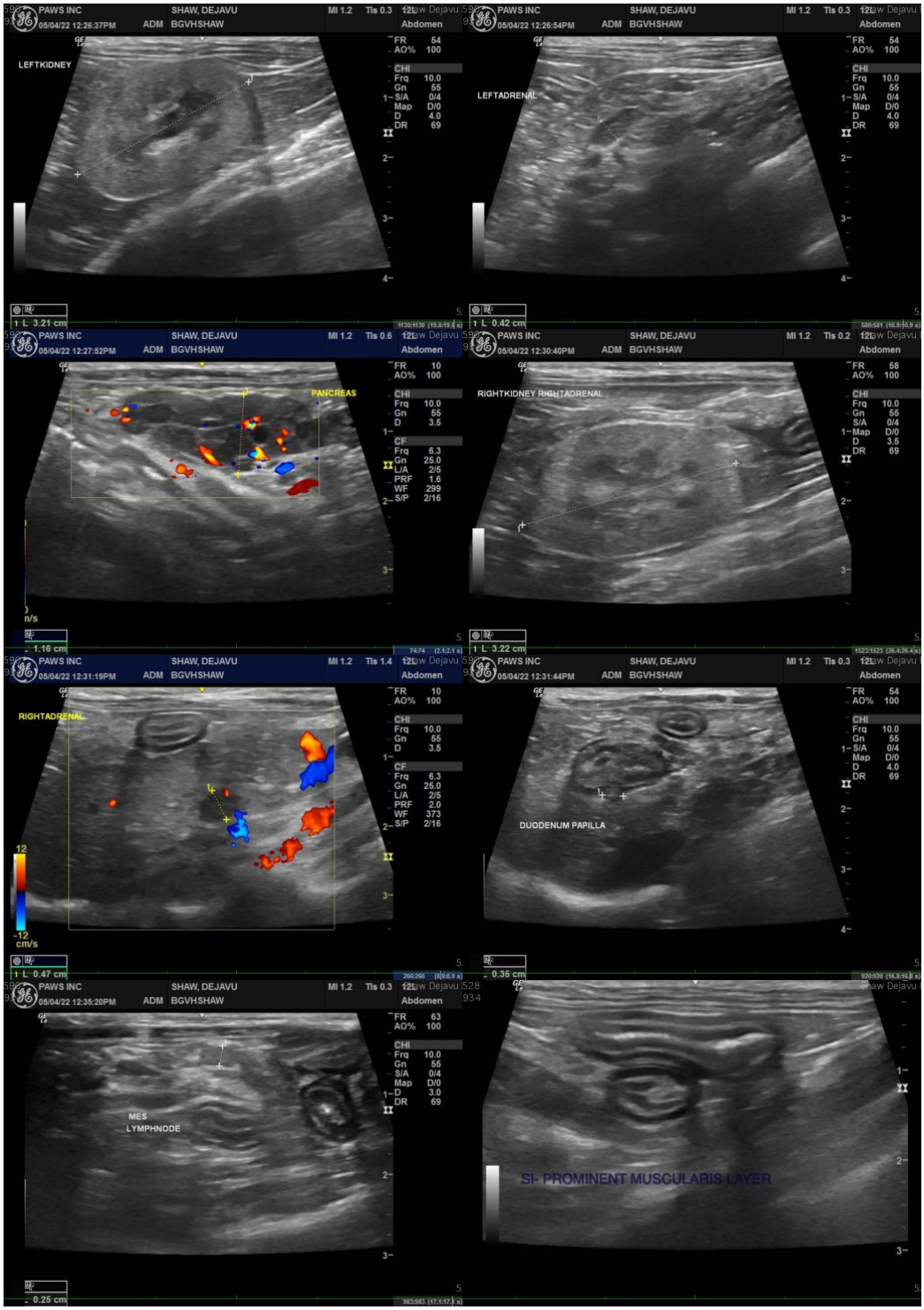

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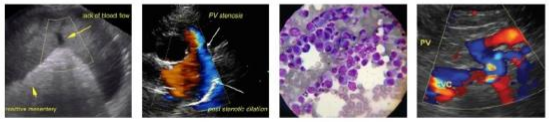

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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