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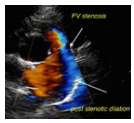
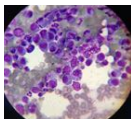
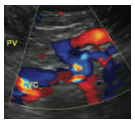

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**DATE**
8/11/21

**PATIENT**
Kitty Boy Hilton

**SPECIES**
Feline

**BREED**
Domestic Shorthair

**SEX**
Neutered male

**AGE**
2002

**WEIGHT**
13.2 lbs

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

**HOSPITAL NAME**
Eastern AH

**REFERRING VET**
Dr. Kaufman

**INVOICE**
91141

## PRESENTING CLINICAL SIGNS

History: Progressive Pelvic Limb paresis - heart murmur, Hypertension, Sudden blindness, history of elevated Creat (2.9). History of Idiopathic Hypercalcemia.
Current Medications: Amlodipine 2.5 mg - 1/4 po sid, SQ r fluids - 100ml 2x/week, Royal Canin Renal diet.
Lab Results: Malignant Hypercalcemia panel , Feline Healthcheck Plus , UA , urine culture.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not needed.
Stat Report: Not requested/declined.

## 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 has a normal shape and size (3.74 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There are occasional, small, renal cortical cysts observed. There is no evidence of 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 (3.27 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/borderline enlarged in size measuring 0.47 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 norma/borderline enalrgedl in size measuring 0.49 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. There are numerous, hyperechoic nodules observed within the spleen measuring 0.2-0.3 cm. They do not appear to deform the capsule.

### *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 and biliary tract appear normal. 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 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 and the jejunum measured as normal (0.26 cm and 0.22 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 prominent and hypoechoic as compared to the surrounding isoechoic 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.

### *Other*

There is a 0.9 cm shadowing, round structure in the midabdomen that does not appear to be associated with any other abdominal structures.

## ULTRASONOGRAPHIC FINDINGS

**PRIMARY FINDINGS:**

- Decreased corticomedullary distinction in both kidneys with rare cortical cysts. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

- Hypoechoic pancreas with prominent, dilated pancreatic duct. The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

- Hyperechoic nodule/foci in the spleen. Appearance favors a benign process, but cannot rule out a neoplastic process without histopathology or cytology.

**SECONDARY FINDINGS:**

- Shadowing free nodule in the midabdomen. Suspect Bates body. Correlate with abdominal radiographs.

- Borderline bilateral adrenomegaly. The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of an aortic thrombus was visualized. Changes to the kidneys are likely largely age related and chronic progressive changes associated with chronic kidney disease. This could be a possible cause for the hypercalcemia as well. Evaluation with the pending malignancy panel will be helpful. Additionally, underlying renal disease could be possible cause for the reported hypertension.

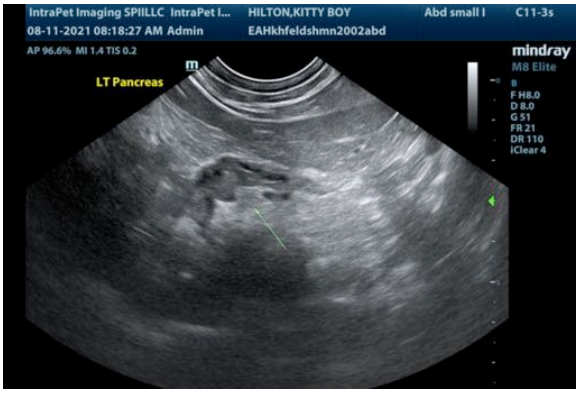
The adrenal glands are borderline enlarged, but this may be an incidental finding in a larger cat. Most cats with Cushing's disease have diabetes so it is unlikely to be rewarding to pursue at this time but should be kept in mind if the patients status changes.

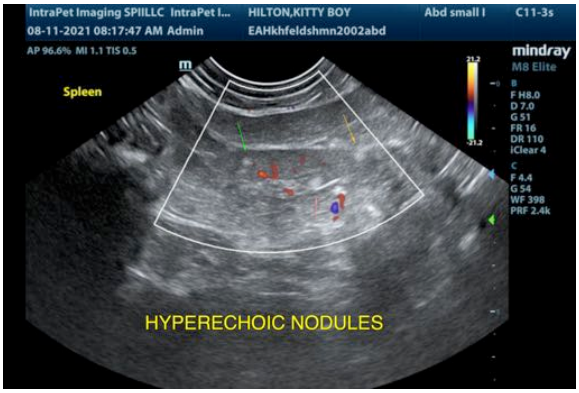
The pancreas is prominent and may be a source of systemic inflammation, pain, etc. Additionally the changes observed could be consistent with a previous episode of pancreatitis and some remodeling.

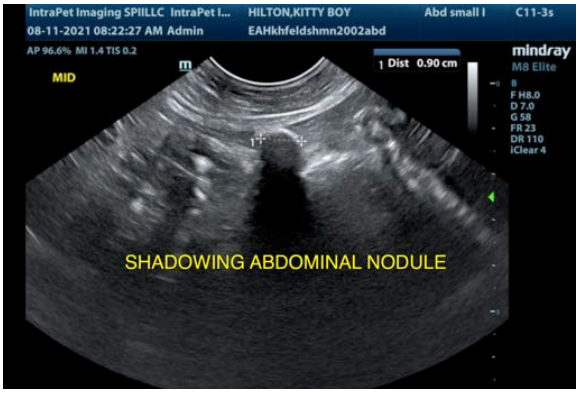
There are hyperechoic foci within the spleen. I suspect this is a benign change, but a FNA would be necessary to rule out a neoplastic process.

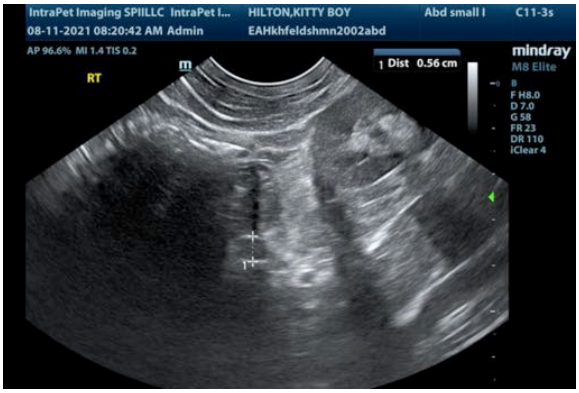
The free standing shadowing structure in the midabdomen is suspicious for a mineralized Bates body. I recommend abdominal radiographs to confirm. A bates. Body is a benign calcifictation of fat.

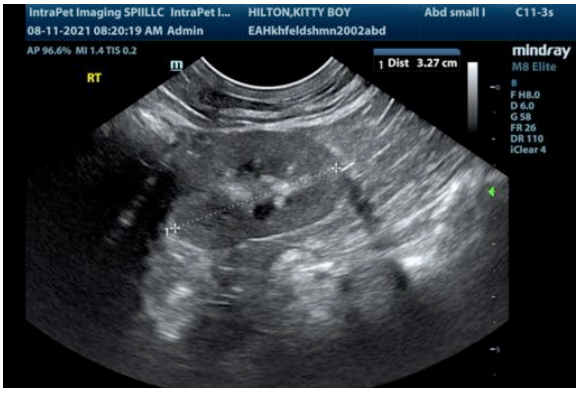
A cause for the reported rear limb paresis was not identified. If the heart is normal then consider either a neurologic issue, hypotension, etc..



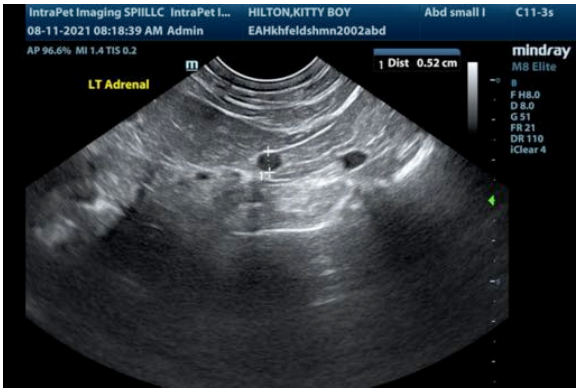



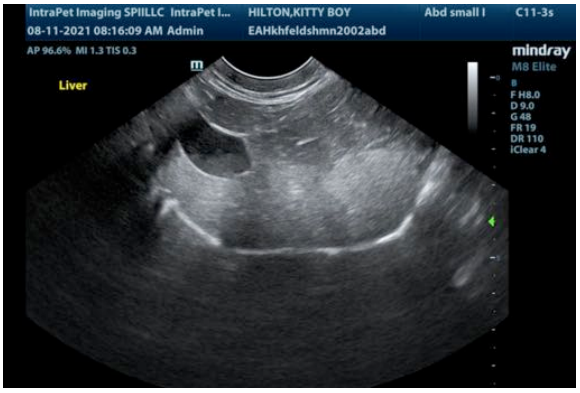








**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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