IMAGING PERFORMED BY

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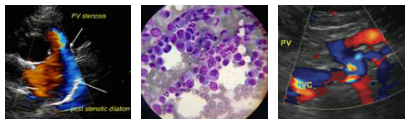

SonoPath
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DATE
8/12/21

PATIENT
Zoe Bachman

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Spayed Female

AGE
7/26/06

WEIGHT
13 lbs

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

HOSPITAL NAME
Veterinary Housecall Services

REFERRING VET
Dr. Ruth

INVOICE
91176

PRESENTING CLINICAL SIGNS

History: History of thickened area of jejunum and 1 mesenteric LN last year. Was started on prednisolone, but prednisolone STOPPED in November. Now we have elevated BUN (80) & Creatinine (5.5) with low Usg (1.021).
Current Medications: SQ fluids 150 ml SQ SID until eating better - started 8-6-21
Cerenia started 8-6-21 -- 15 mg SID
Vitamin B12 0.25 ml SQ once per week started 8-6-21
Famotidine 5 mg BID
Miratz PRN
Lab Results: elevated BUN (80) & Creatinine (5.5) with low Usg (1.021).
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Gabapentin 100mg prior to drop-off.
Stat Report: STAT report not requested by the veterinarian.

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 an irregular shape, but normal in size (3.28 cm). There is severe pyelectasia/hydronephrosis present measuring 1.3 cm. The remaining cortical rim is approximately 1.0 cm in thickness. There is no evidence of perinephric inflammation or effusion. There are no obvious obstructive nephroliths and there is moderate hydroureter measuring (0.39 cm) and can be followed several cm from the kidney. An obvious obstruction is not visualized. Renal vasculature is normal.

The right kidney has a normal shape and size (4.24 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 mild pyelectasia measuring 0.21 cm and a small 0.18 cm stone in the renal pelvis that does not appear to be causing an obstruction. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.38 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 0.43 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 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 fluid/luminal contents, but it appears to have a distinct, shadowing structure within it. This creates a soft shadow that is most consistent with either hairball or fabric type material. The stomach wall appears normal in 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.

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 jejunum measures 0.28 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 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. There is a (mild) lymphadenomegaly present (the mesenteric lymph nodes are visualized and measured 0.57 cm and 0.61 cm). There was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS
PRIMARY FINDINGS:
Severe, left-sided renal pyelectasia/hydronephrosis with mild hydroureter. The proximal hydroureter is visualized, but an obvious obstruction is not seen. This could indicate a stricture, previous pyelonephritis or a stone that is not evident on ultrasound.

Decreased corticomedullary distinction in the right kidney with mild pyelectasia and a small nephrolith. Mild loss of corticomedullary distinction in the right kidney could be consistent with chronic degenerative disease or interstitial nephrosis.

Hypoechoic, prominent pancreas with mildly hyperechoic mesentery surrounding. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

Shadowing structure in the stomach most consistent with a hairball. This structure does not currently appear to be causing a complete obstruction as there is no evidence of fluid dilation.

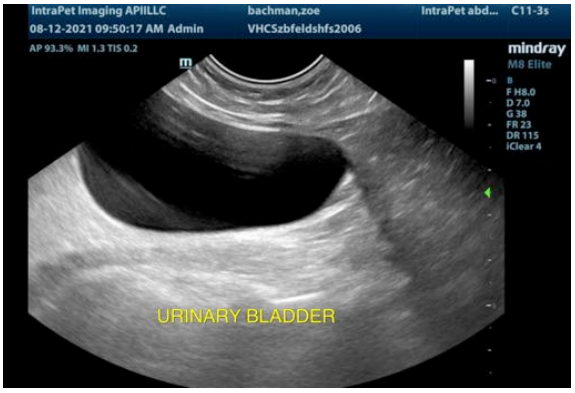
SECONDARY FINDINGS:
Prominent muscularis layer of the small intestine. The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

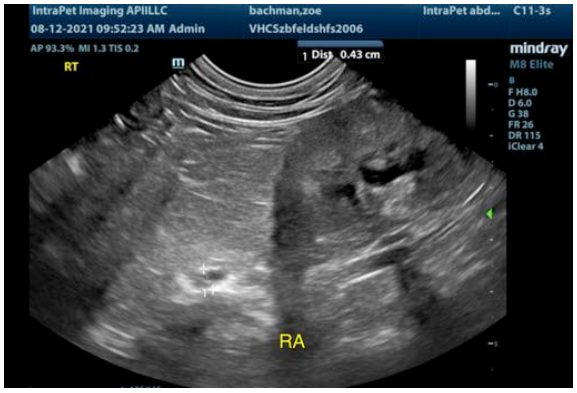
Mild mesenteric lymphadenopathy. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

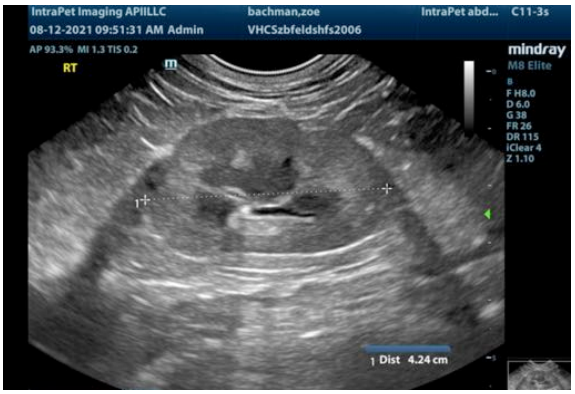
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

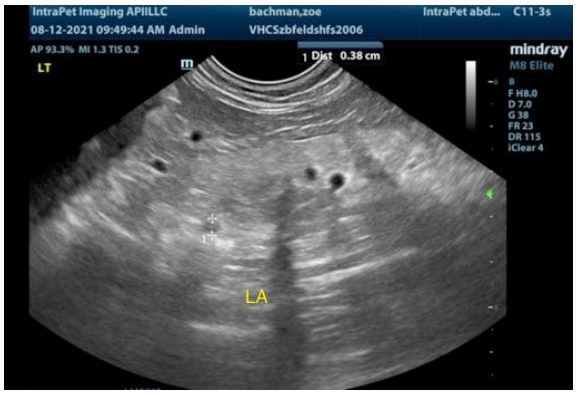
There is severe left sided pyelectasia/hydronephrosis present. I am unable to see a definitive obstruction, but there is concern for one. You can consider a contrast CT scan or IVP. Use caution with contrast agents and renal disease to try and identify the location of the obstruction. If an obstruction is present consider consultation with a veterinary surgeon regarding possible subcutaneous ureteral bypass. Urinalysis and culture should be submitted along with a blood pressure evaluation, IV fluid therapy and continued monitoring with ultrasound for progressive dilation if direct intervention is not pursued. The prognosis would be guarded as the right kidney appears abnormal and the patient is azotemic with a possible unilateral obstruction.

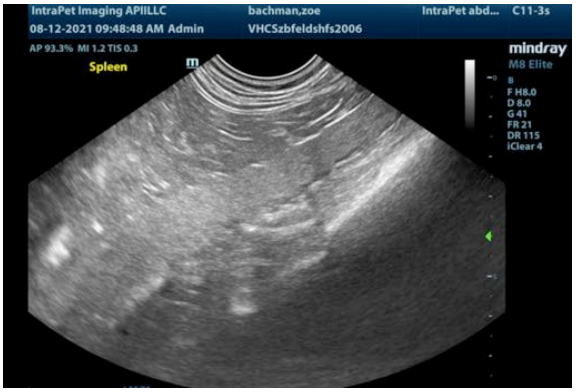
Additionally I suspect that there is a hairball present. This may or may not be causing clinical signs. There is no obvious evidence of a current obstruction. If ureteral bypass is considered you can consider upper gastrointestinal endoscopy at the same time to evaluate for possible hairball.

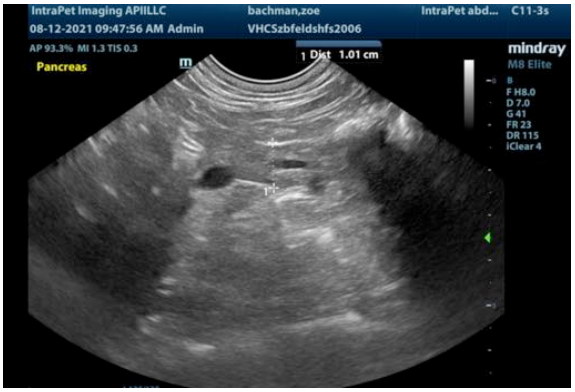


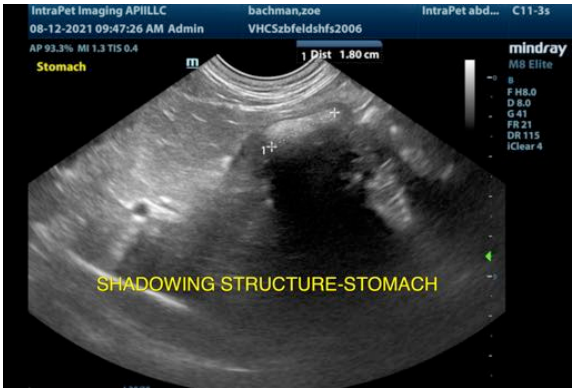


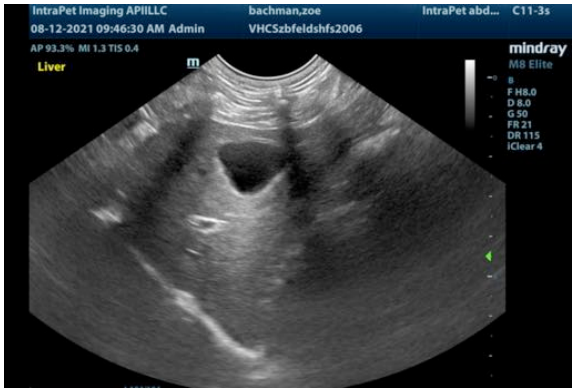












The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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