**PATIENT**

Manson Riehl

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

17yr

WEIGHT

11.75lb

INTERPRETED BYR. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)**IMAGING
PERFORMED BY**

Amy Mayhew LVT

HOSPITAL NAMESVS Imaging
Michigan**REFERRING VET**Family Pet Practice
Dr Craig**INVOICE**

12654ag

DATE

01-10-2023

PRESENTING CLINICAL SIGNS

Patient History: urgent exam for V for 3 days D friday, no BM in the last 24 hours. increased water, decreased urine - ok out put, no straining will not eat canned food right now. poss due to 2 new types offered - Weruva and sheba - P had D the next day then would not eat canned/soft foods. Vomiting started this past Sat - 1 time food. then again on Sat 1x liquid with small kibbles. No vomiting today. P eating treats well Sunday. P urinated 1-2 times today. No pine needles noted within the last week - previously ingested.

Abnormal PE/Chem/CBC/UA Results: CBC Stress leukogram, BUN 41.7, CREAT 1.8, Ca 9.5, liver wnl. AMYL 1681 1. BAR, vocal, hissed initially for exam 5. Moderate tartar, Moist MM 6. Normal thoracic auscultation 9/10. Soft abdomen, small/medium sized soft bladder- non-reactive on palpation. 12. Painful on palpation over TL spine, generalized muscle atrophy- worse over spine, rear limbs- reviewed prev recommendations for solensia or gabapentin O declined solensia See Attached bloodwork Dx: Gastroenteritis - OPEN Hyperthyroidism

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. The left kidney measured 3.4 cm in length. The right kidney measured 3.9 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.34 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.41 cm width.

Spleen

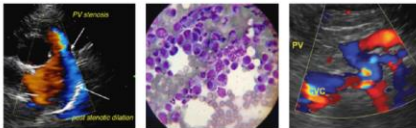
The spleen exhibited normal size and subtle medial capsule asymmetry and generalized mild heterogenous parenchyma. A solitary non-disruptive mildly irregular hyperechoic nodule was present in the mid spleen measuring 0.26 cm in diameter. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

Liver/Gallbladder

The liver presented enlarged in size. A moderately sized non-homogenously hyperechoic focally cystic mass was present in the caudal liver with mild associated asymmetrical capsule distortion measuring ~ 7.0 cm x 4.4 cm. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.27 cm in width.

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The small intestine presented intact wall layering with primarily a 1:3 muscularis/mucosa ratio. Subjective mildly prominent segmental muscularis layer was present. No evidence of loss of intestinal wall layering, significant mural hypertrophy or significant altered wall layer ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.29 cm width. The jejunum wall measured 0.25 cm width. The ileocolic wall measured 0.42 cm width.

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Normal visible colon wall layers were present with apparent formed feces in lumen.

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Pancreas

The pancreas was variably prominent with asymmetrical capsule contour and non-homogenous hypoechoic to mixed echogenic parenchyma.

Free Abdomen**AGE**

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No omental masses or peritoneal effusion was present.

Focal, mildly prominent to enlarged mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of a lymph node measured 0.47 cm.

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ULTRASONOGRAPHIC FINDINGS

- Heterogenous to cystic liver mass-biliary cyst adenoma, biliary cyst adenocarcinoma or other possible
- Suspect mild chronic inflammatory enteropathy
- Generalized prominent mildly irregular heterogenous pancreas-consistent with probable chronic/chronic active pancreatitis pattern with parenchymal remodeling and likely benign nodules, neoplastic criteria considered unlikely
- Bilateral chronic renal changes
- Benign splenic nodule-consistent with myelolipoma, previous infarct or potential emerging mineralization
- Focally to intermittent benign/reactive mesenteric lymph nodes

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Monitoring for evidence of cranial abdominal or subxiphoid discomfort on palpation in the area of the pancreas is suggested. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Three view chest radiographs are recommended if not done to assess for occult thoracic pathology.

Empirically as needed GI support, potential hydrolyzed diet trial and possible empirical therapy for chronic inflammatory enteropathy/pancreatitis and assessment of clinical response would be reasonable.

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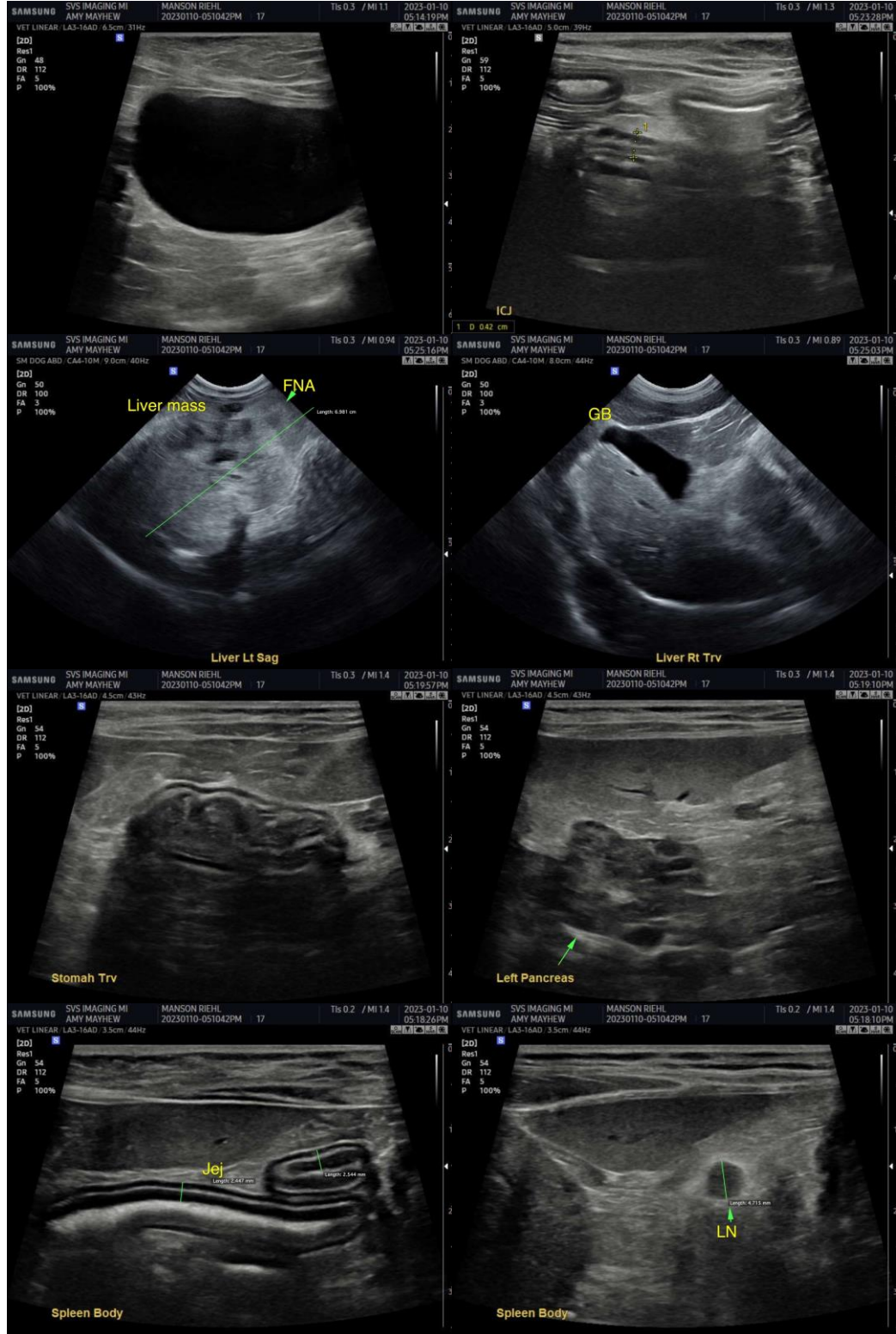
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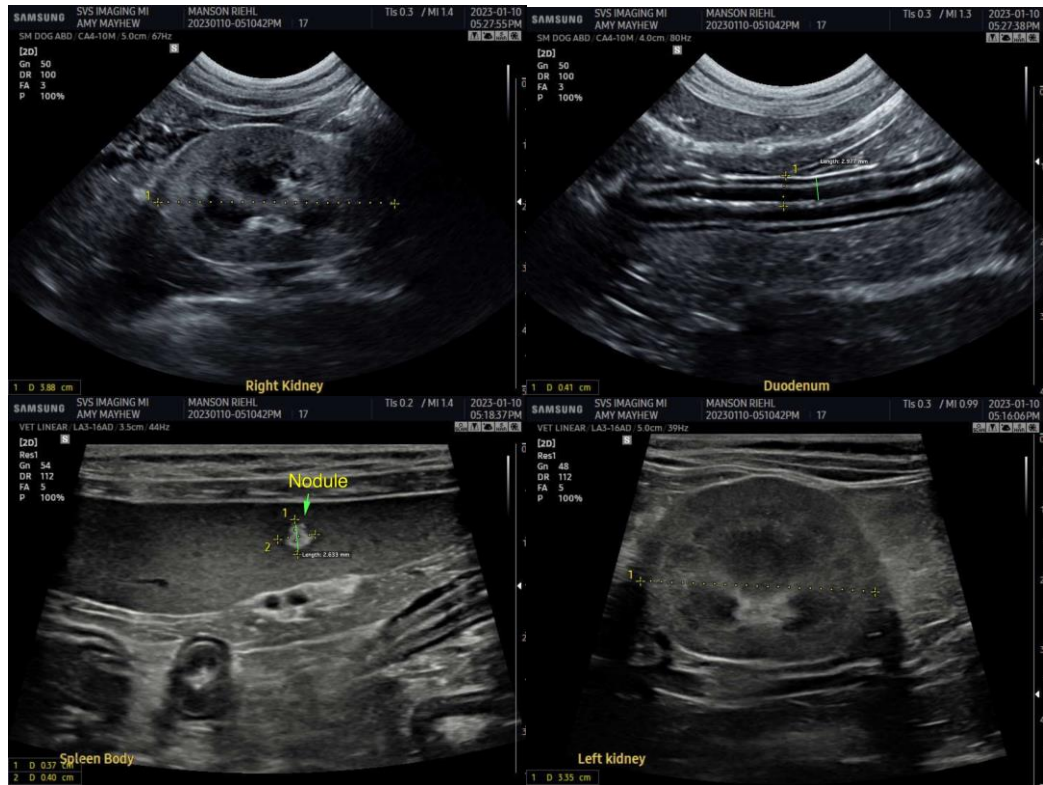
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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info@SonoPath.com

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