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Clinical Sonography & Telecytology
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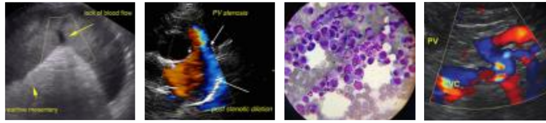


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT
Inky Dink Stanley

SPECIES
Feline

BREED
DSH

SEX
FS

AGE
15 years

WEIGHT
5.19 lbs.

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Jenna Walsh, CVT

HOSPITAL NAME
West Eugene AH

REFERRING VET
Dr. Powers

INVOICE
15942

DATE
1/25/23

PRESENTING CLINICAL SIGNS

Presented 1/19/23 for vomiting, hyporexia, and decreased drinking for 2 days. P has been a chronic vomiter for the past year, but the vomiting increased within the last few days. No known exposure to toxins. No known dietary indiscretion. Exam: moderately dehydrated; the right kidney palpates enlarged; the left kidney palpates small; sinus tachycardia; no murmur/arrhythmia ausculted; oligodontia. Stage 4 renal failure noted on BW. P no longer vomiting and is eating better since starting Cerenia, mirtazapine, Epakitin, SQF, and k/d. Current Medications Cerenia, mirtazapine, Epakitin, SQF twice weekly Primary Question/Differential to Be Answered in This Exam Work up kidney failure and elevated ALT

Abnormal PE/Chem/CBC/UA Results: BUN 136, Creatinine 7.9, SDMA 57.9, Phosphorus 16.4, ALT 217, Amylase 1826, Neutrophils 12,240. T4 WNL (0.8). Urinalysis: USG 1.017, Protein 1+, RBCs 11-20/hpf

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mildly distended in size with normal tone. Anechoic urine was present in the lumen with very minor particulate sediment, which may indicate cellular debris / protein, crystalline debris, lipid, or mucus. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted. The urethra exhibited normal structure and tone to a depth of 2.0 cm.

The area of the aortic trifurcation was free of pathology.

The left kidney was markedly subnormal in size with asymmetrical contour and marked loss of corticomedullary border demarcation with indistinguishable corticomedullary architecture. Mild mineralization was also noted. The left kidney measured 1.3 cm length.

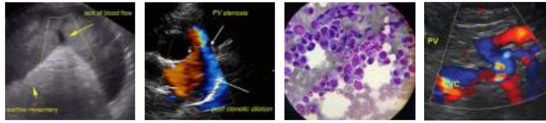
Normal size was noted in the right kidney with moderate loss of corticomedullary border demarcation. Pinpoint medullary mineral was noted with mild pyelectasia and a solitary, medial cortical cyst in the right kidney. The right kidney measured 4.1 cm.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.39 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.48 cm width.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.7 cm width at the level of the hilus.



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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of gastric stasis, retained ingesta, fluid or foreign material. The gastric body wall width measured 0.24 cm.

The small intestine presented intact wall layering and maintained a 1:3 muscularis/mucosa ratio without evidence of mural hypertrophy, loss of intestinal wall layering, or intestinal masses. The jejunum wall measured 0.22-0.25 cm width.

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

Pancreas

The left limb of the pancreas exhibited normal size with mild capsule asymmetry and mild hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

No omental masses, lymphadenopathy, or evidence of peritoneal effusion were noted.

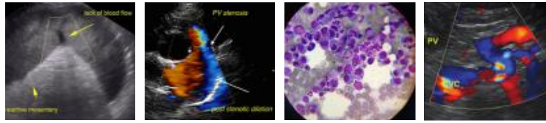
ULTRASONOGRAPHIC FINDINGS

- Severely dystrophic left kidney exhibiting subnormal size and minor medullary mineral
- Right kidney normal size exhibiting moderate chronic changes, mild pyelectasia, and cortical cysts
- Overtly normal gastrointestinal tract
- Suspect low-grade left pancreatitis
- Low-grade hepatopathy exhibiting minor parenchymal remodeling - subjectively benign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The functionality of the left kidney is highly questionable with moderate chronic right kidney changes consistent with progressive to significant renal disease in conjunction with the degree of azotemia and inadequate urine concentration.

The vomiting in this patient may be primarily secondary to renal disease, although some contribution owing to suspected low-grade pancreatitis or less likely structurally insignificant inflammatory bowel is possible.



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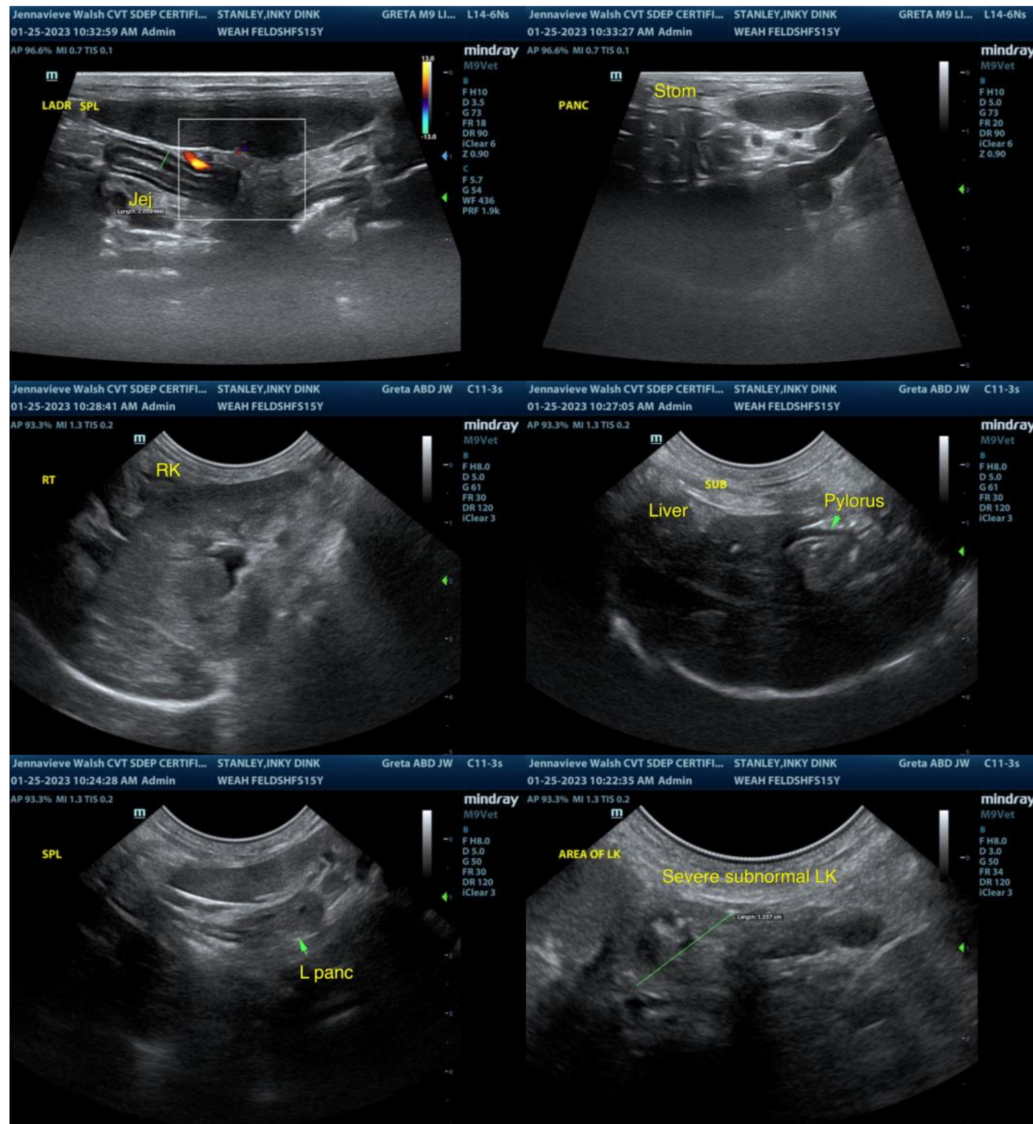
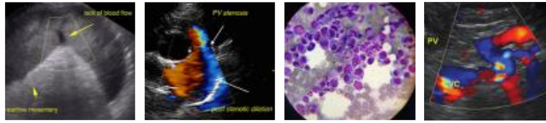
A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Continued likely long-term CRD therapy with as-needed gastrointestinal support would be reasonable. However, a very guarded prognosis, given the renal presentation in conjunction with the degree of azotemia, is indicated.





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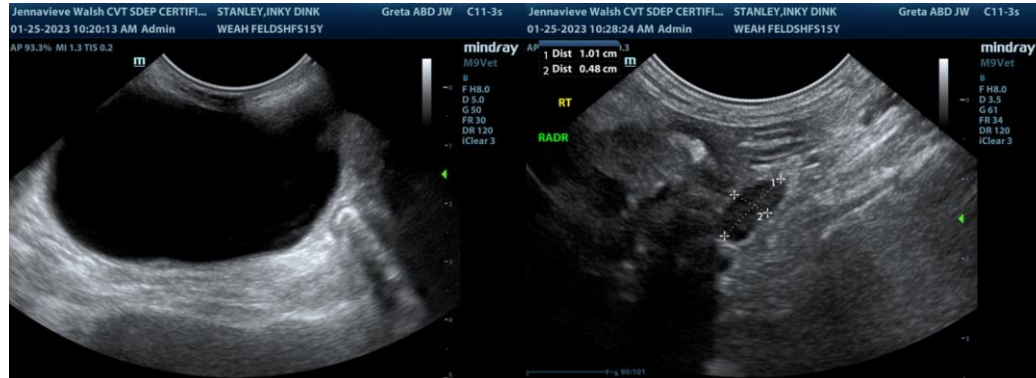

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com