



PATIENT

Rosco Adolphsen

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

13 Years

WEIGHT

12.81 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Amanda Crook - SDEP
Certified Clinical
Sonographer

HOSPITAL NAME

Rivers Edge Pet
Medical Center

REFERRING VET

Dr. David Gray

INVOICE

48350

DATE

11-15-21

PRESENTING CLINICAL SIGNS

Left w/ pet sitter and appears patient was not checked on. Dehydrated 7-8%. Possibly 4 days with no water. Thyroid disease, on transdermal methimazole for 1 year. P already drinks a lot in general per O. Howling (has always been vocal.) Lethargic, sore/stiff. Also matted haircoat. Heart murmur 3/6 left systolic. Was open mouth breathing when presented. Spiked a fever during hospital stay. Started on gabapentin and 1/2 maintenance of fluids due to dehydration. Has been in oxygen cage over night. Abnormal PE/Chem/CBC/UA Results: See attached lab work - CBC Neutro 12.98, Eos 0.01 CHEM - BUN 41, Sod 170, Pot 2.7, ALT 448, ALP 272, T bili 1.0. No T4 ran as was in house labwork. See attached radiographs - thorax unremarkable, no pulmonary edema or pleural effusion, aerophagia visible in stomach

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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.

The area of the residual prostate appeared normal and free of pathology.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild to moderate loss of corticomdullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.5 cm in length. The right kidney measured 4.3 cm in length.

Adrenal Glands

Both adrenal glands were mildly prominent in size with subtle asymmetrical capsule contour yet maintained capsule integrity and uniform hypoechoic adrenal parenchyma without evidence of mineralization. The left adrenal gland measured 0.62 cm width. The right adrenal gland measured 0.69 cm width.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. Mild asymmetrical medial capsule contour was present. The spleen was normal in size without overt neoplastic criteria measuring 0.85 cm width. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling.

Liver / Gallbladder

The liver was mildly enlarged with symmetrical capsule contour. Subtle subjective decreased hepatic parenchyma echogenicity generally with maintained primarily uniform echotexture and without evidence of hepatic masses or nodules. 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



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The stomach presented intact and sonographically unremarkable wall layering. A mild to moderate amount of retained anechoic to echogenic fluid along with subtle to progressive shadowing areas of ingesta or potential hairball densities were present. An example of a potential hairball density or ingesta measured 1.2 cm diameter. No evidence of mechanical pyloric outflow obstruction. The gastric body wall width measured 0.22 cm.

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall width measured 0.22 cm and the jejunum wall width measured 0.21 cm.

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

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The pancreas was normal in size and mild asymmetrical contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. Minor pancreatic duct dilation was present. No signs of active inflammation or neoplasia.

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Pancreas

Potential for very scant pockets of perisplenic free fluid possible yet not definitive.

No overt lymphadenopathy was present.

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ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic renal changes.
- Hypomotile stomach with potential nonobstructive hairball density.
- Hepatopathy, sonographically unremarkable gallbladder and common bile duct.
- Subtle heterogeneous pancreas with minor pancreatic duct dilation - age related pancreatic changes, potential for low grade or chronic inflammation which may present essentially sonographically normal possible.
- Subjective mild prominent bilateral adrenal glands - nonspecific, not overly consistent with neoplastic criteria.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The overall appearance of the liver was nonspecific yet suggestive of acute on chronic criteria, vacuolar hepatic changes, and cholestasis, given the ALP elevation, with primary concern for nonspecific hepatitis/cholangiohepatitis, or hepatopathy, secondary to uncontrolled hyperthyroidism, given the primarily elevated ALT. Hepatotoxicosis or occult hepatic neoplasia considered less likely.

Assuming normal clotting status, hepatic FNA using a 25-gauge needle warranted for screening cytology and potential identification of inflammatory cell type. Spec fpl may be considered. Screening blood pressure recommended. If persistent hypokalemia despite electrolyte supplementation, screening aldosterone levels could be considered.

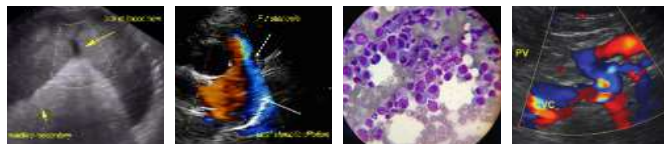
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Pending echocardiographic assessment, judicious rehydration, appropriate electrolyte supplementation, acute on chronic cholangiohepatitis protocol, assessment of T4 levels, and as needed gastrointestinal support if evidence of inappetence or vomiting would be appropriate.

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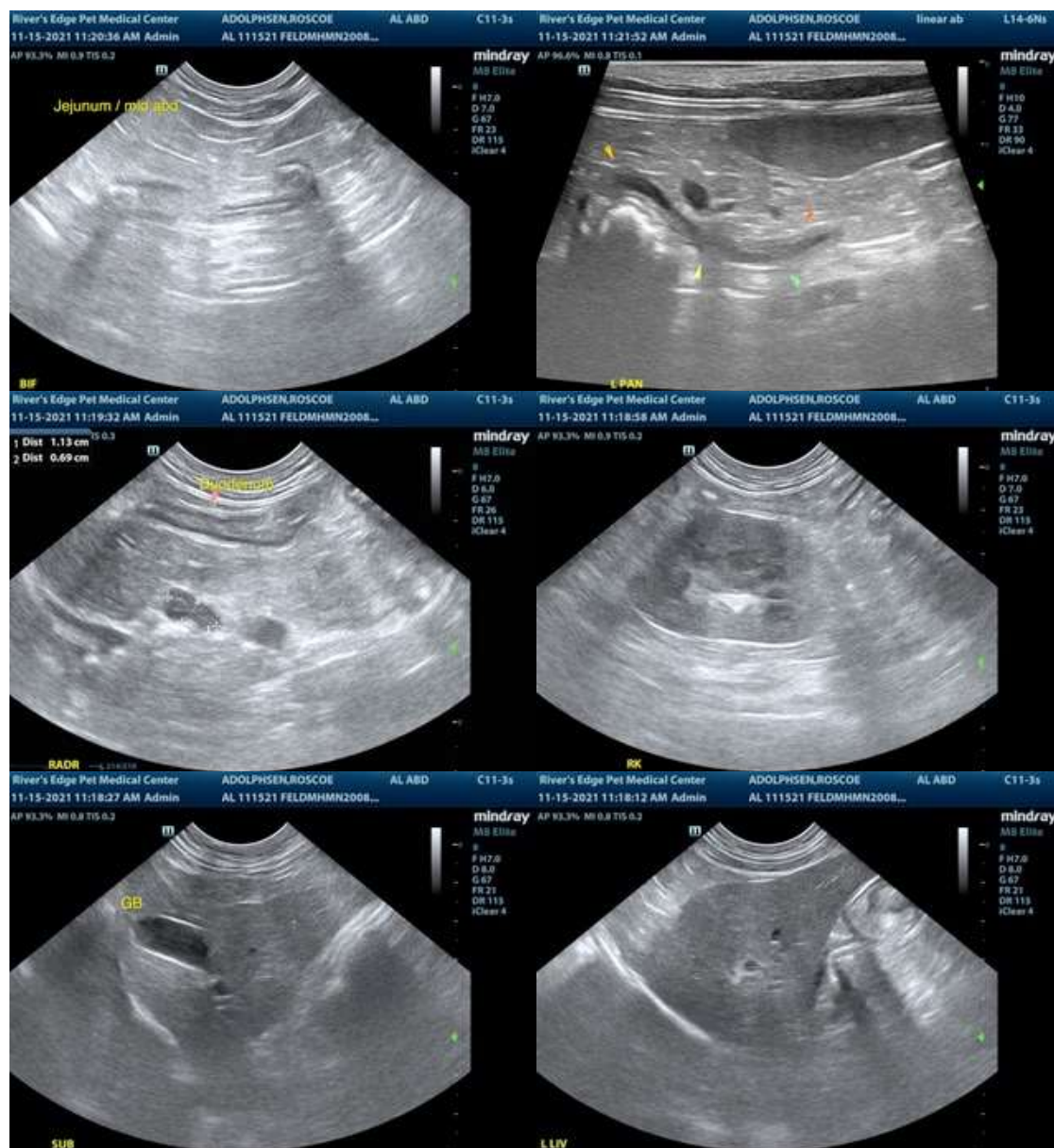
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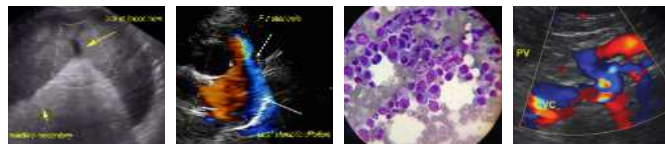
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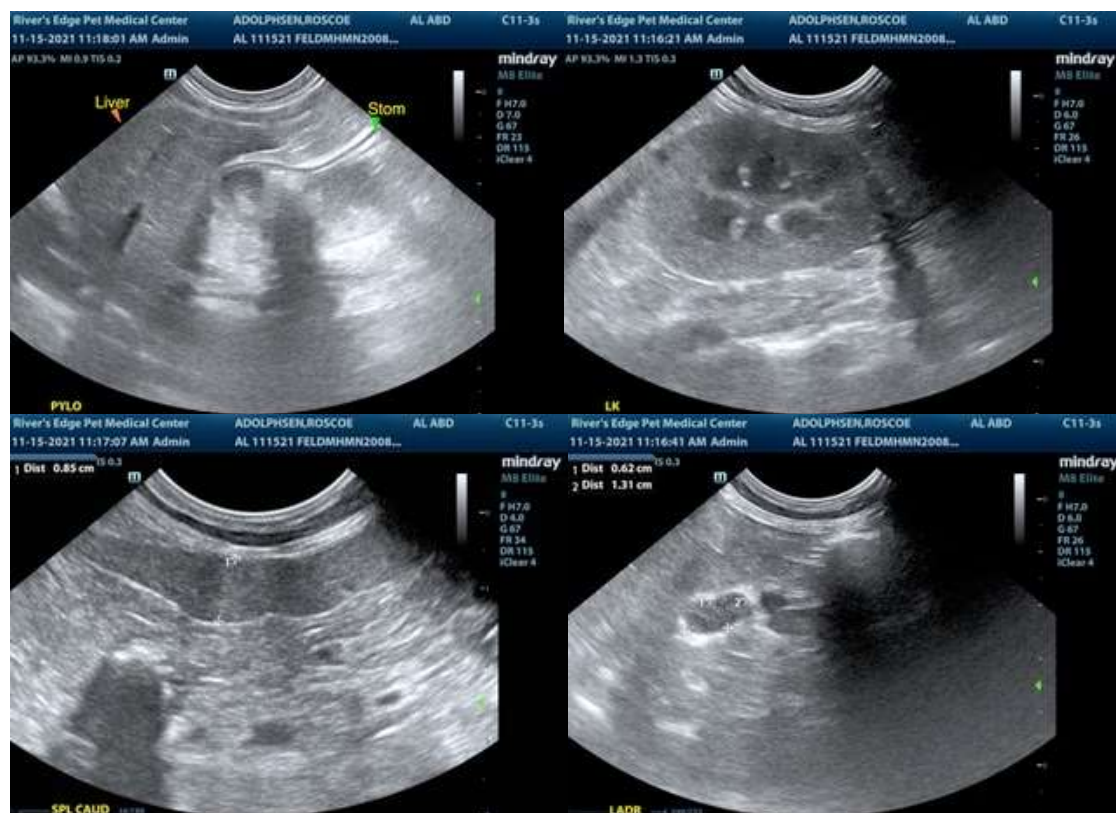
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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