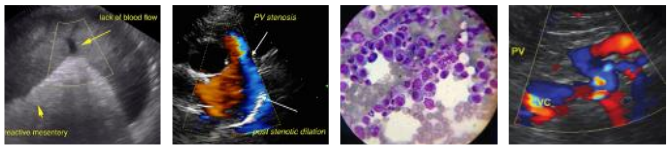
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Rocky Wood

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

11yr

WEIGHT

4.5

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ebert

HOSPITAL NAME

Wilvet Salem

REFERRING VET

Dr. Ebert

INVOICE

12091ag

DATE

11/02/2022

PRESENTING CLINICAL SIGNS

P hasn't ate in 4-5 days. P isn't drinking either. P was a kitten with URI from OHS. Has had a couple flare ups in past. P started getting congested last week and o could hear his breathing. P vomited 2x on Sunday but not since. O took to VCA salem yesterday, they told O they did an U/S and saw fatty liver. Gave SQF, cerenia, sent home metronidazole and Denamarin. They ran BW , ALT is 488 and AST is 90. P did sneeze during vitals. P had yellow discharge on bed, the size of a pea. O are very concerned about him not eating, they have tried multiple kinds of foods over the last few days without any luck.

Abnormal PE/Chem/CBC/UA Results: Radiographs 3 view chest with consultation- Adequate position of NG tube has secondary dilated gas-distended esophagus. Mild diffuse broncho-interstitial pattern consistent with age-related changes or chronic bronchitis. Moderate splenomegaly, asymmetric kidneys with nephroliths on left side compatible with chronic kidney disease and slight renomegaly. CBC- all values within normal reference range- neutrophils on upper end of reference range Chem 17- slight hyperglycemia 167 mg/dL, hypophosphatemia, P 2.9 mg/dL, ALT 319 U/L, amylase 475 EPOC 1230am - p02 201 H, cOS2 99.8 H, pco2 26.1 L, pH 7.433 H, BE -6.8, K+ 3.0 L, glu 154 L T: 100.2 P: 210 R: 30 QAR to obtunded, mm pink and slightly tacky CRT < 2 seconds, no discharge noted from nose at this time did have on presentation and nasogastric tube in place, grade II periodontal disease. Heart rate and rhythm regular. No crackles or wheezes noted. Abdomen palpates soft and non-painful. Able to ambulate all four limbs. Appears neurologically appropriate at this time .

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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.

Borderline increased left kidney size was present with the right kidney mildly increased in size. 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. Left kidney medullary renoliths were present. Focal areas of non-obstructive medullary mineral were present in the right kidney. The left kidney measured 4.3 cm in length. The right kidney measured 4.9 cm in length.

The area of the aortic trifurcation was free of pathology.

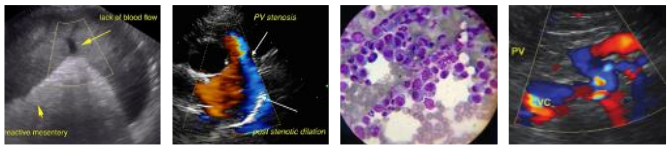
Adrenal Glands

No obvious pathology was present in the area of the bilateral adrenal glands.

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.

Liver



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The liver exhibited potential for mild enlargement. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. 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 and mild echogenic non-organized luminal debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. 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 with no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.24 cm in width.

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 small intestinal wall measured 0.21 – 0.22 cm in width.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic interstitial nephrosis renal pattern with non-obstructive left kidney renolithiasis and minor right kidney medullary mineral
- Hepatopathy-subjectively benign
- Mild gallbladder debris (non-mucocele)
- Unremarkable GI tract/pancreas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the liver was not classic for hepatic lipidosis. Given the ALT elevation underlying inflammatory hepatopathy or hepatobiliary process i.e. cholangiohepatitis in light of concurrent gallbladder debris could be present. Potential for infiltrative neoplasia considered less likely. Assuming normal clotting status and using a 25g needle, a hepatic FNA for screening cytology is warranted for further assessment to identify inflammatory cell type or for evidence of lipidosis. In addition to lipidosis therapy, empirical therapy for cholangiohepatitis pending hepatic cytology if elected with as needed GI support would be reasonable. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Occult intestinal or pancreatic pathology i.e. triad disease is a potential contributing factor to the patients clinical signs.

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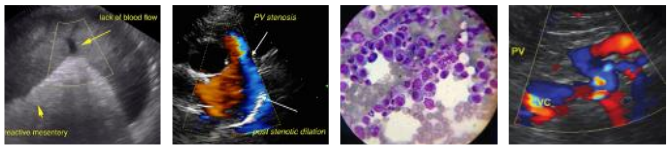

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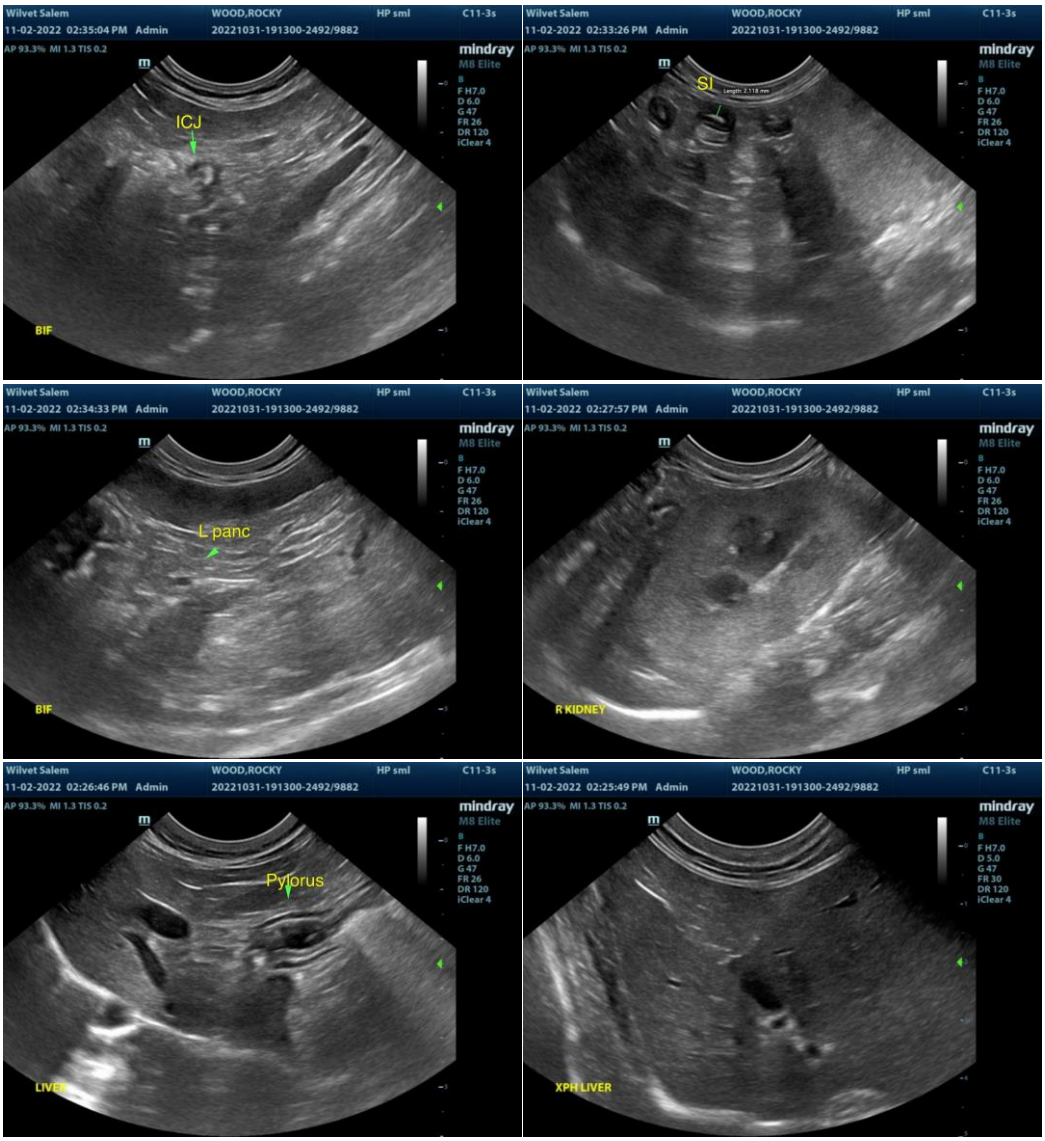

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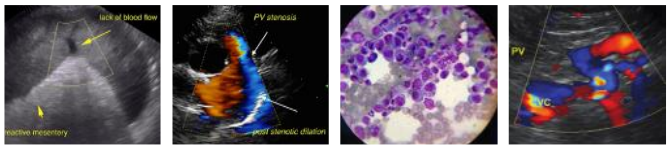

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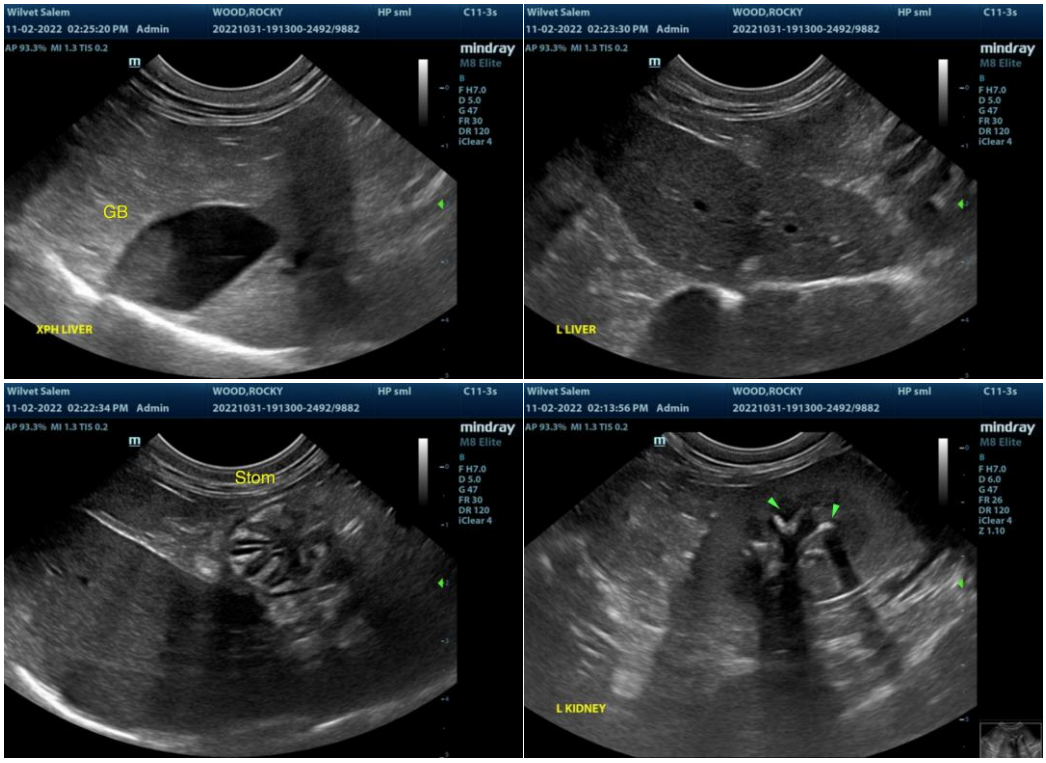

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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