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Clinical Sonography & Telecytology
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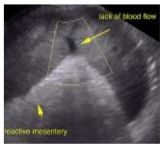

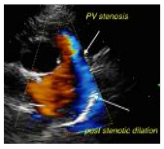

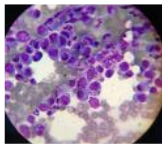
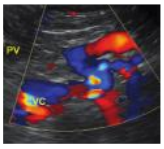

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Jack Staiger

SPECIES

Feline

BREED

DLH

SEX

MN

AGE

7 yr 2 mos

WEIGHT

4.98 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue VC

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

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11/23/22

PRESENTING CLINICAL SIGNS

History: Dental O thinks full mouth extraction Premeds are on board No other medications Jk Spoke to Bethany about findings Eating well at home. Same cat. No changes to litterbox at home. No increased thirst. Occasional hair ball. No other changes. Urinating- not noticing constant drinking or urinating. Physical Exam: General Appearance: Bright, alert and responsive Hydration: Hydration appears normal Eyes: Corneas clear, pupils normal size, symmetrical, sclera white, no ocular discharge Ears: No exudate observed, no redness present Oral Cavity: Tartar severe Nasal Cavity: No obvious abnormalities observed Cardiovascular: Regular rhythm; no murmur detected Respiratory: Lungs auscultate clear bilaterally; trachea clear Abdomen: Abdomen palpates normally; no pain, tenderness or masses on palpation Rectal: Did not perform rectal exam Musculoskeletal: Normal ambulation Integument: Normal amount of shedding; skin looks normal; hair coat in good condition

Assessment: Pre-anesthetic bloodwork- Severe azotemia, hyperphosphatemia Elevated SDMA 22, normal T4 Urine Spg 1.016, no overt bacteruria. Pending Uricult Plan: Onsior had been given PO at intake in prep for dental extractions. Given bloodwork findings gave PO UAA 5ml and plan to start IV fluid support. Disc with Bethany and no noted change at home, n signs of concern Pending abdominal ultrasound. Plan to discontinue COHAT (will be near/or full mouth extractions) and continue IV fluid support. jme

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. Primarily anechoic urine was present in the lumen. Mild, non-dependent, particulate sediment, which may indicate cellular debris / protein, crystalline debris, lipid or mucus, was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic urinary bladder criteria were noted.

The area of the aortic trifurcation was free of pathology.

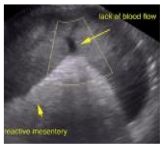
Normal size and margination were present in the kidneys. Both kidneys exhibited a uniform cortical hypertrophy with normal cortical echogenicity. Mild to moderate loss of corticomedullary border demarcation with subjective reduced medullary volume was present. Pinpoint areas of medullary mineral were noted. No pyelectasia or evidence of left or right retroperitoneal inflammation was noted. The left kidney measured 3.8 cm in length. The right kidney measured 3.9 cm in length.

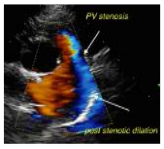
Adrenal Glands

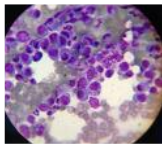
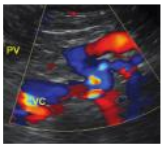
No overt pathology was noted in the area of the left or right adrenal glands, although not definitively visualized.

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





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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/ Gallbladder

The liver was subjectively normal in size, structure, and contour. 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. The cystic and common bile ducts were normal.

Gastrointestinal

The visualized gastric walls were sonographically normal. The lumen of the stomach contained mild to moderate variably echogenic ingesta / chyme without signs of obstruction or foreign material. No evidence of mechanical pyloric outflow obstruction was noted.

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.

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 were evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral nonspecific chronic nephropathy

Secondary Findings

- Gastric ingesta / chyme

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the kidneys is sonographically suggestive of chronic nephropathy / CRD, as opposed to acute kidney insult or injury, although the possibility of acute on chronic renal insult or disease is possible. Chronic renal disease, nonspecific nephritis such as interstitial nephritis, or other nephropathy possible. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Subjectively, the kidneys did not appear to be overtly end-stage, yet given reported severe azotemia, renal prognosis is likely dependent upon renal response to diuresis protocol with monitoring of BUN and creatinine levels, urinary output, and body weight, along with systemic BP.

Some degree of potential metabolic gastric stasis could be considered if documented NPO. As-needed GI support is recommended.

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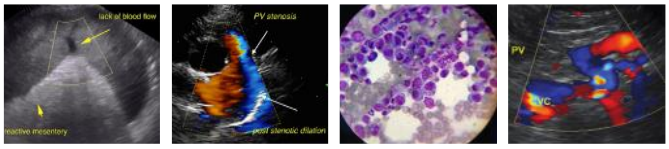

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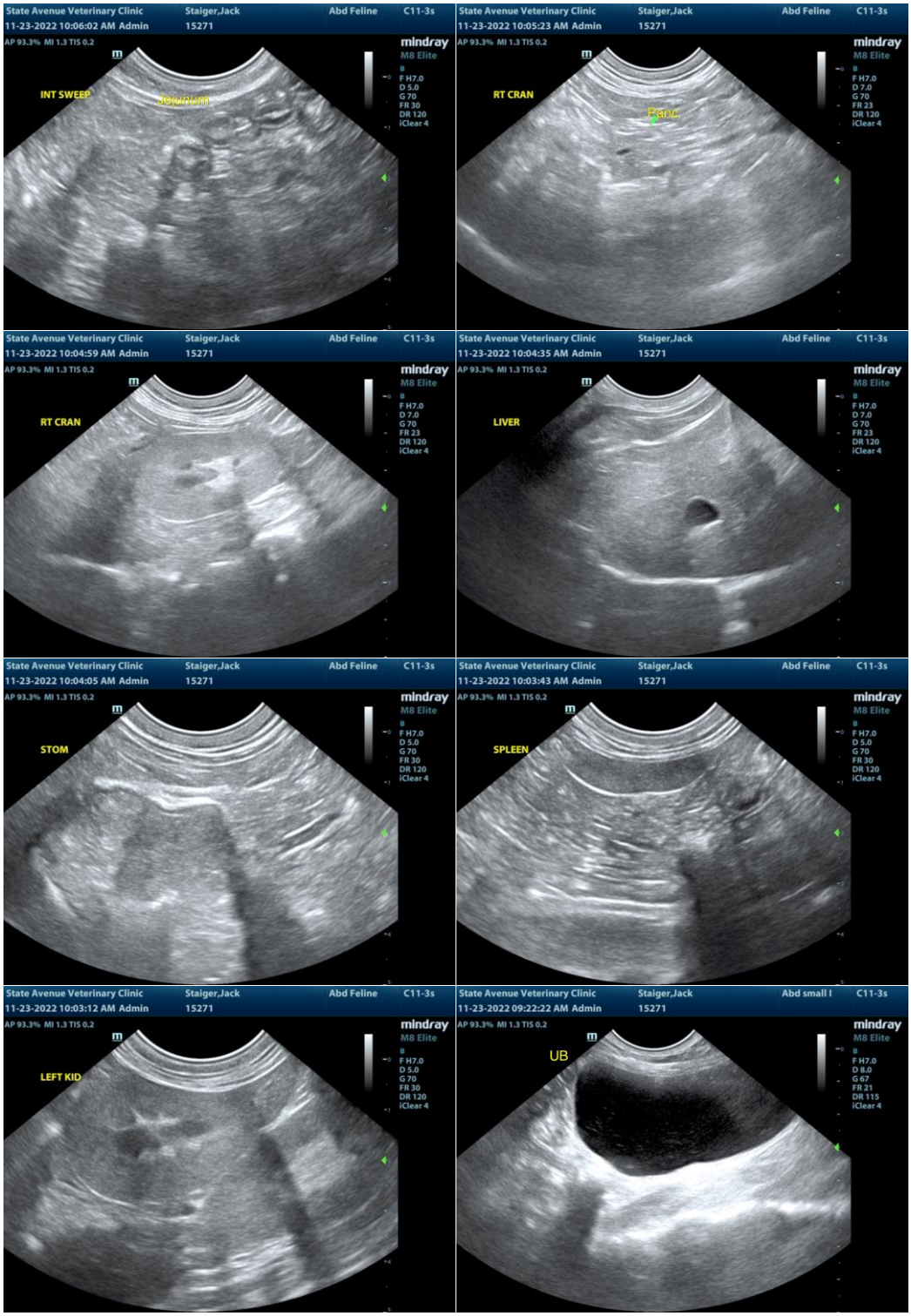

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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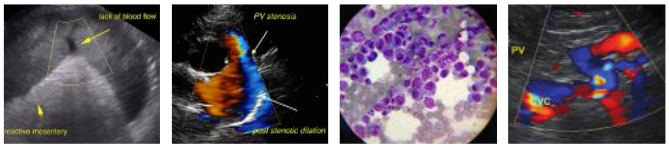

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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