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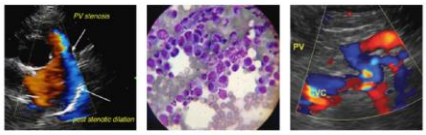
fredgromalak@gmail.com



SonoPath
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PATIENT

Penny Kita 54548A

SPECIES

Feline

BREED

DMH

SEX

FS

AGE

13yr

WEIGHT

4.33kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Veterinary Specialists-Dr. Maller

INVOICE

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DATE

11/09/2022

PRESENTING CLINICAL SIGNS

~ 2 weeks Owners switched dry food from Fromm dry food to Wellness Dry food. Penny was refusing to eat the old dry food. She was still eating food and treats and drinking water. End of last week she started refusing food, Owners were still able to get her to eat the dry food. Started vomiting up undigested food Saturday and continued through Sunday. Blood work was run Monday through Primary Vet. When she got home, at 5pm she vomited up everthing. 6am Tuesday she vomited up bile, went in for X-Rays (which were normal), recived SQ fluids and anti nausa injection. She was perscribed Hills I/D food, she was fed 1/5 can Tuesday night, after she ate she was put in one spot and did not move for 12 hours. She would not eat, drink, and was hiding starting Tuesday at midnight. She is a indoor only cat. Has not urinated or deficated since yesterday @ 10 am.

Abnormal PE/Chem/CBC/UA Results: T- 105.4 °F PCV - 30% HCT - 28.8 WBC - 20.27 LYM - 12.85 Mono- 2.25 EOS - 0.15 PLT - 89 GLU- 200 CREA- 1.1 BUN- 14 PHOS- 2.5 Feline Leukemia - negative FIV - negative Heartworm - negative

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.

The right kidney was mildly subnormal in size compared to the left kidney. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Bilateral focal cortical infarcts were present. The left kidney measured 3.6 cm in length. The right kidney measured 3.0 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 0.4 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.33 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 in width at the level of the hilus.

Liver

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

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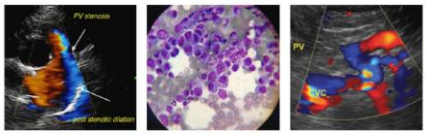

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild retained non-shadowing echogenic fluid/chyme with no signs of ileus, obstruction or foreign material. The pylorus wall measured 0.20 cm in width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Mild duodenal corrugation which may indicate mild duodenal hypercontraction or spasm was present. Subjective subtly prominent jejunal muscularis layer was present although no evidence of intestinal mural hypertrophy, loss of wall layering or mechanical obstructive pattern. The duodenum wall measured 0.30 cm width. The jejunum wall measured 0.21 cm width. The ileocolic wall measured 0.30 cm width.

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

Pancreas

The parenchyma of the pancreas was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if there is a previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

No peritoneal effusion was present.

Intermittent mildly enlarged mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was ~ 1.0 cm.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic renal changes with cortical infarcts
- Chronic pancreatitis pattern
- Gastroenteritis pattern including mild gastric hypomotility and associated duodenitis
- Probable intermittent mild mesenteric lymphadenitis-likely secondary to inflammatory bowel episode

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential for chronic pancreatitis as a primary clinical player may be suspected if evidence of discomfort on cranial abdominal or subxiphoid palpation. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. A definitive cause of the patient's anemia was not obvious. No overt evidence of intra-abdominal neoplastic criteria was observed. Triad disease may be a consideration in this patient if evidence of weight loss or recurrent/persistent GI signs. Hospitalization with 24-48 hour IVF / GI support, empirical therapy for inflammatory bowel episode and chronic pancreatitis with assessment of clinical response would be reasonable. A CBC pathology review could be considered.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

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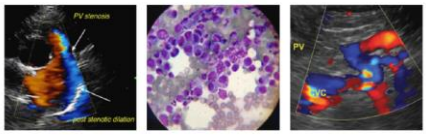

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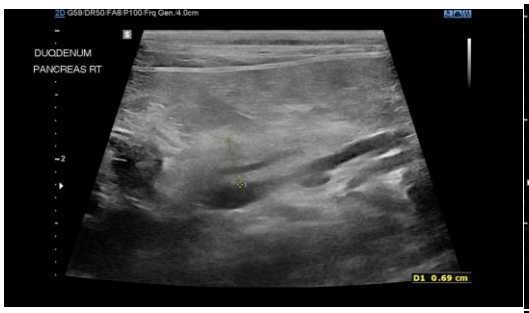

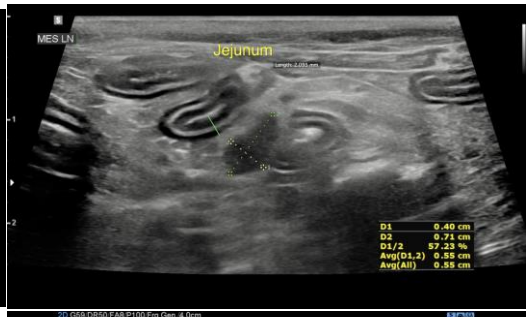

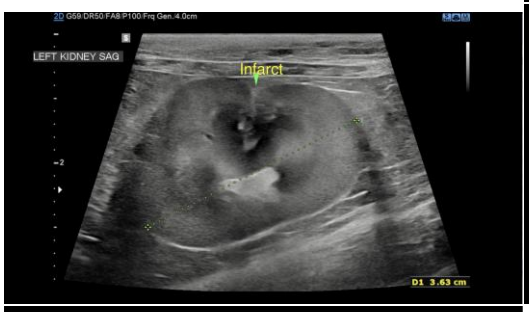

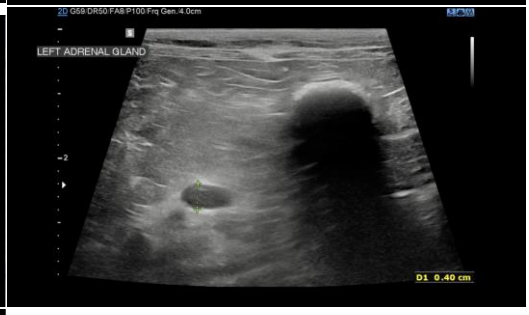

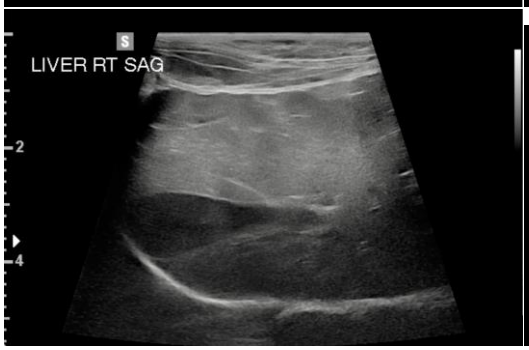

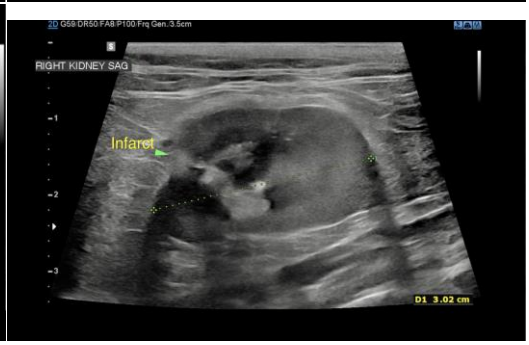

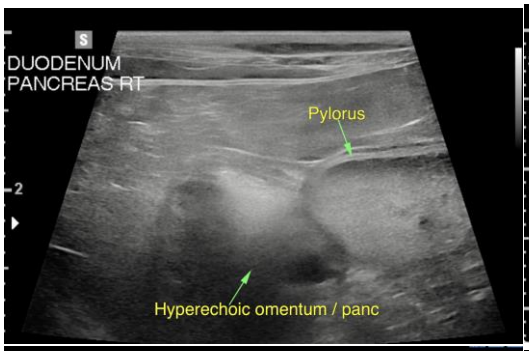

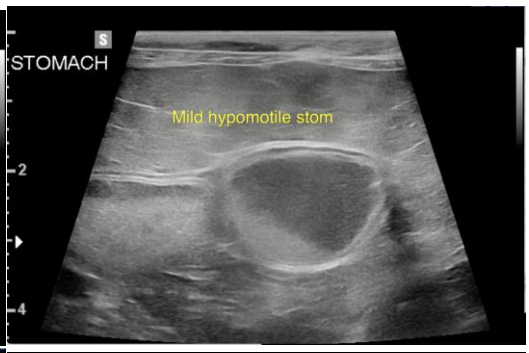

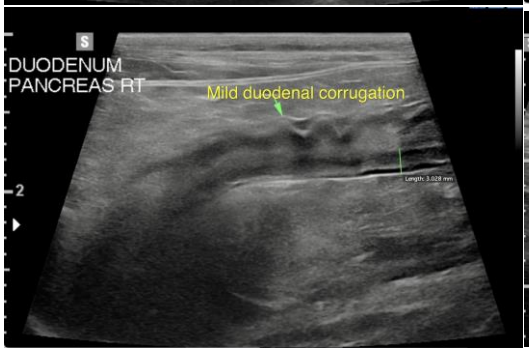

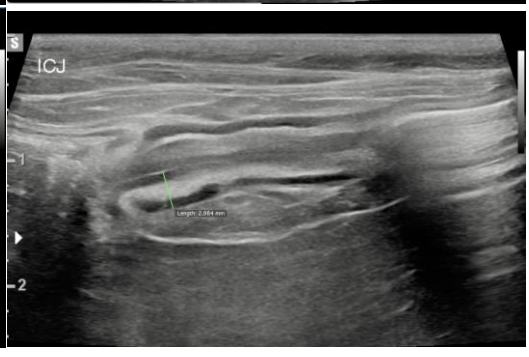

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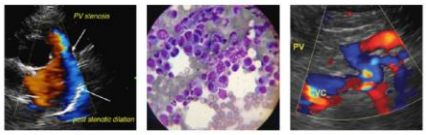

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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