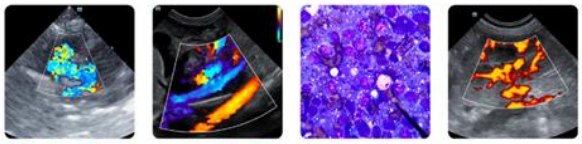


PATIENT

Chi Chi Chattin

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

15yr

WEIGHT

2.63kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing, ER

REFERRING VET

Blue Pearl Wyomissing, ER

INVOICE
23352

DATE
12/29/2025

PRESENTING CLINICAL SIGNS

AUS to further evaluate cachexia, elevated liver values, anorexia. Currently hospitalized. Severely cachexic patient presented 12/27 for straining to defecate, weight loss despite a good appetite, and vomiting. Indoor only. Diagnosed as hyperthyroid in hospital with severe dehydration, electrolyte derangements, and likely CKD. - Hospitalized on 0.45 NaCl w/ KCl, started methimazole and appetite stimulants, as well as ampicillin. Seems brighter, but no interest in eating.

Abnormal PE/Chem/CBC/UA Results: - Thin, constipated. Single lateral rad obtained. - CBC: WBC 19.6, neut 18.77, lymph 0.57, plt 316k - Chem: alb 3.1, glob 3.8, creat 1.5, BUN 65 (H), tbili 1.1 (H), BG 130, Na 160 (H), Cl 130 (H), K 2.4 (L), P 8.5 (H), ALT 714 (H) - UA (off floor): USG 1.018, pH 6, 2+ cocci

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal renal size with asymmetrical margination was present in both kidneys. 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. Mild bilateral pyelectasia was present. The left kidney measured 3.4 cm in length. The right kidney measured 3.5 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

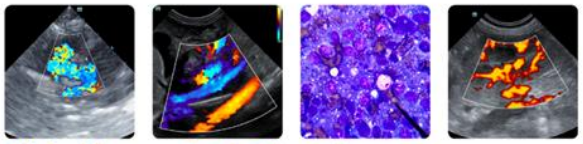
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.45 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.36 cm width.

Spleen

The spleen exhibited subnormal size, consistent with volume contraction measuring 0.5 cm in width at the level of the mid spleen. Finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma was present. 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/Gallbladder

The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with mild non-organized debris. The proximal to mid common bile duct was dilated and mild to moderately tortuous without overt post hepatic



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obstruction. The common bile duct measured 0.38 cm diameter. Mild non-mineralized common bile duct mucus was present.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild variably echogenic non-shadowing ingesta with no signs of obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained generally mild non-shadowing ingesta and mild gas to level the colon. The ileocolic wall measured 0.30 cm in width. The jejunum wall measured 0.21 cm in width.

Normal visible colon wall layers were present with apparent formed to semi formed feces in lumen. The colon was non-distended in size.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. Mildly prominent left limb pancreatic duct was present.

Free Abdomen

Intermittent mildly prominent to enlarged primarily colic lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example measured 2.2 cm x 0.96 cm.

Very scant pockets of peritoneal effusion were present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Bilateral chronic nephropathy exhibiting mild pyelectasia
- Volume contracted spleen.
- Hepatopathy
- Mild gallbladder debris, common bile duct dilation with mild mucoduct
- Probable chronic pancreatitis
- Overall sonographically normal gastrointestinal tract with mild gastric and segmental intestinal ingesta
- Mild non-homogenous colic lymphadenopathy.
- Non-distended colon containing formed to semi-formed fecal matter

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine C/S on sterile urine sample +/- UPC for renal staging if non-inflammatory proteinuria is recommended. Cholangiohepatitis is suspected with potential concurrent secondary hepatopathy owing to hyperthyroidism. No obvious evidence of neoplastic criteria. Further assessment may include assuming normal clotting status, using 25ga needle, hepatic and accessible lymph node FNA cytology. Chronic triaditis may be a consideration in this patient. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Hepatogastrointestinal and renal support with clinical and as needed sonographic monitoring is recommended.

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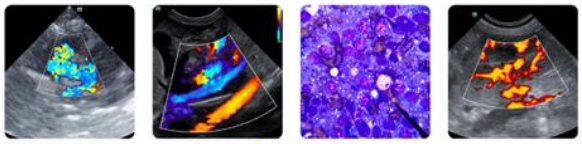

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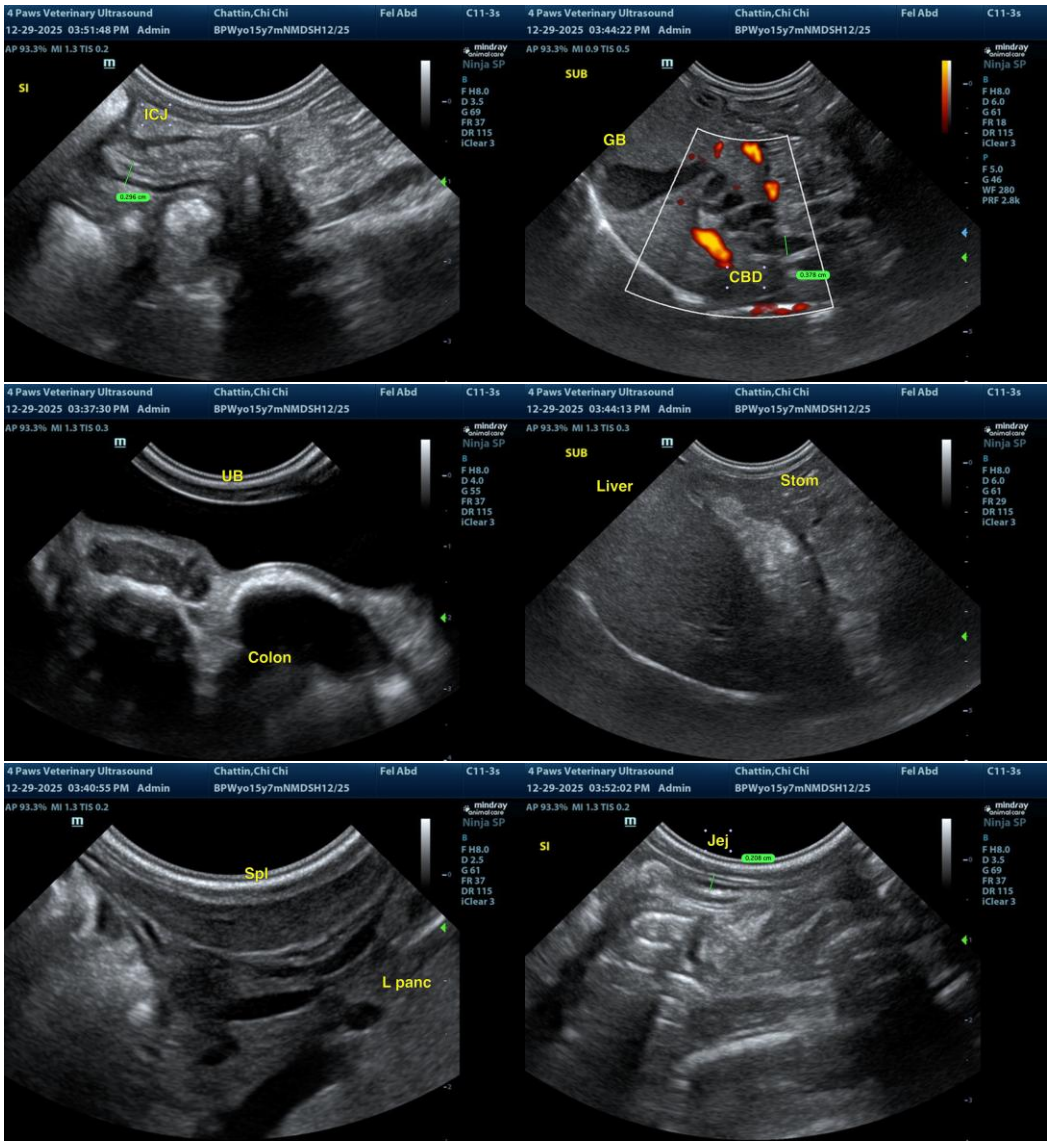

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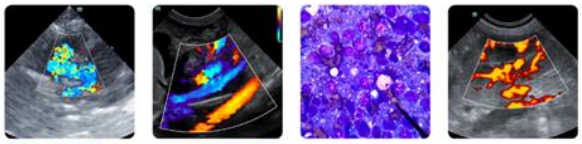

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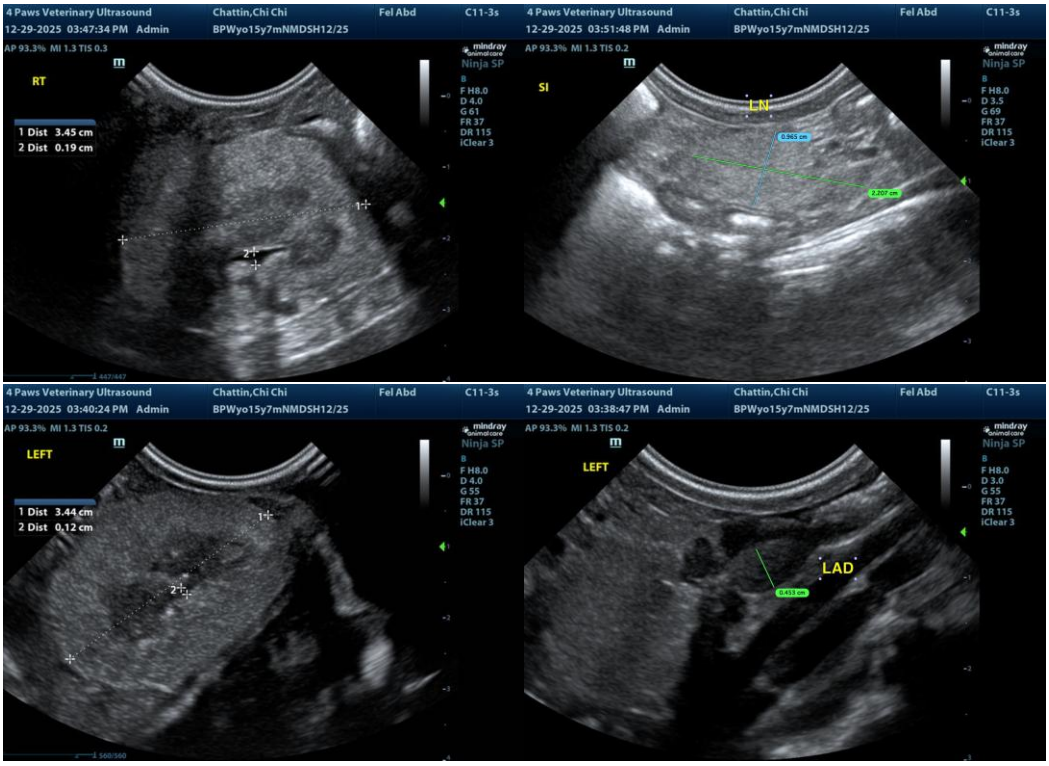

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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