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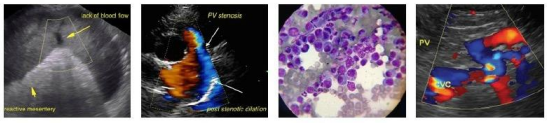

Portable Animal Western Sonography, Inc.
IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Shadow Jones

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

16yr

WEIGHT

8.5lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

VCA Feline Animal Hospital

REFERRING VET

Dr. Fleming

INVOICE

13059ag

DATE

02/22/2023

PRESENTING CLINICAL SIGNS

sedation torb/midazolam/alfaxalone- weight loss- CKD IRIS stage 3, Hyperthyroidism- Would like to start SQ fluids at home but concerned about the heart. Arrhythmia.

Abnormal PE/Chem/CBC/UA Results: Urinalysis - USG 1.015 protein 2+ occult blood 2+ RBC 11-20 else unremarkable Urine culture - No growth- Chemistry profile - BUN 77 Creat 4.3 Phos 8.4 else unremarkable; Thyroid hormones - T4 2.8; CBC - Eosino 1344 else unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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.

Subnormal kidney size and marked asymmetrical renal margination were present. The bilateral kidneys exhibited variable yet significant non-uniform hyperechoic cortical hypertrophy, marked loss of corticomedullary definition and reduced medullary volume. Intermittent cortical infarcts were present. The left kidney measured 2.9 cm in length. The right kidney measured 2.9 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The bilateral adrenal glands were normal in size and contour. Pinpoint areas of mineralization were present without capsular distortion or overt tumors. This is an age-related finding and not pathological. The left adrenal gland measured 0.39 cm width and the right adrenal gland measured 0.39 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. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease. The spleen measured 0.86 cm in width at the level of the hilus.

Liver/Gallbladder

The liver presented 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. Intermittent non-disruptive variably echogenic to microcystic nodules were present, an example measured 1.5 cm in diameter. 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 primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

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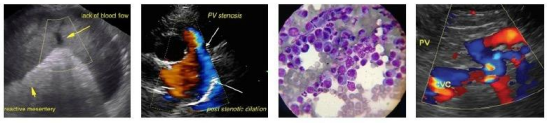

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact borderline mild prominent wall layering with borderline prominent muscularis layer. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The jejunum wall measured 0.26 cm width. The ileocolic wall measured 0.31 cm width.

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

Pancreas

Variably prominent to asymmetrical pancreas exhibiting non-homogenous hypoechoic parenchyma with evidence of pancreatic duct dilation was present.

Free Abdomen

No omental masses or peritoneal effusion was present.

Transdiaphragmatic pleural effusion was present.

Focal, mildly prominent to enlarged mesenteric 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 of a lymph node measured 1.4 cm x 0.4 cm.

ULTRASONOGRAPHIC FINDINGS

- Severe chronic degenerative kidneys exhibiting subnormal size, cortical infarcts and dystrophic medullary mineral-subjective marked end stage chronic renal disease
- Chronic active pancreatitis pattern
- Intact mildly prominent small intestinal walls with concurrent minor benign/reactive mesenteric lymphadenopathy-probable chronic inflammatory enteropathy
- Non-specific subjectively benign hepatic nodules-suspect hyperplasia, granulomas or cystic biliary adenomas
- Transdiaphragmatic pleural effusion

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A baseline UPC level given evidence of 2+ proteinuria with quiet urinary bladder sediment and assessment of systemic BP warranted. The eosinophilia is suspected to correlate with chronic inflammatory enteropathy in conjunction with chronic active pancreatitis and chronic renal disease as contributing factors to the patient's weight loss. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

No overt evidence of intra-abdominal neoplastic criteria. Pending echocardiographic assessment, evidence of pleural effusion and renal presentation is consistent with marked to end stage chronic renal disease. An extremely guarded prognosis is indicated.

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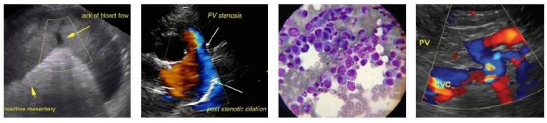

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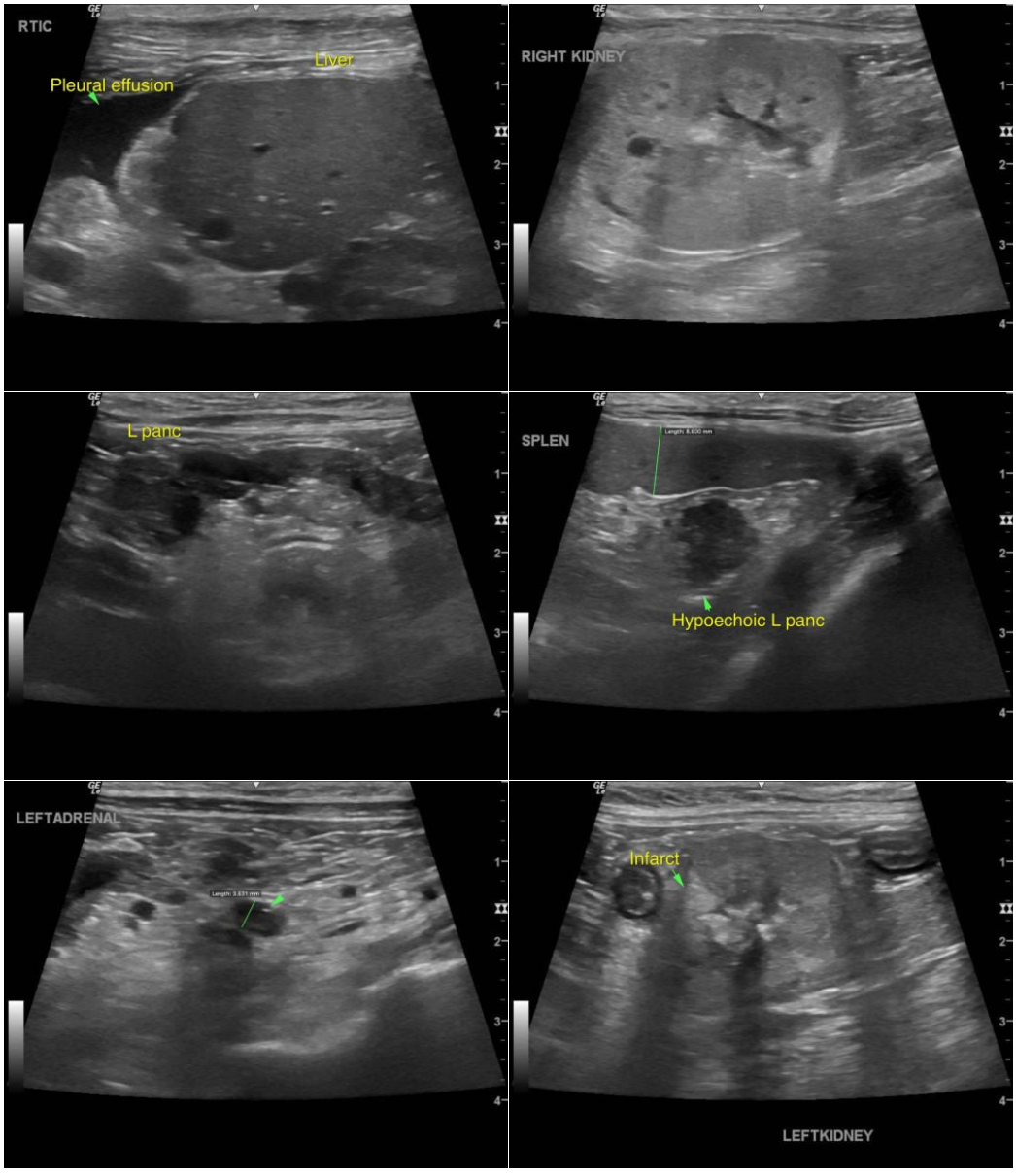

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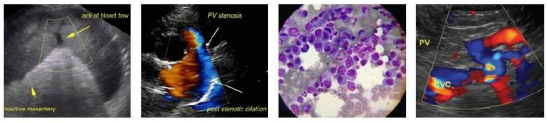

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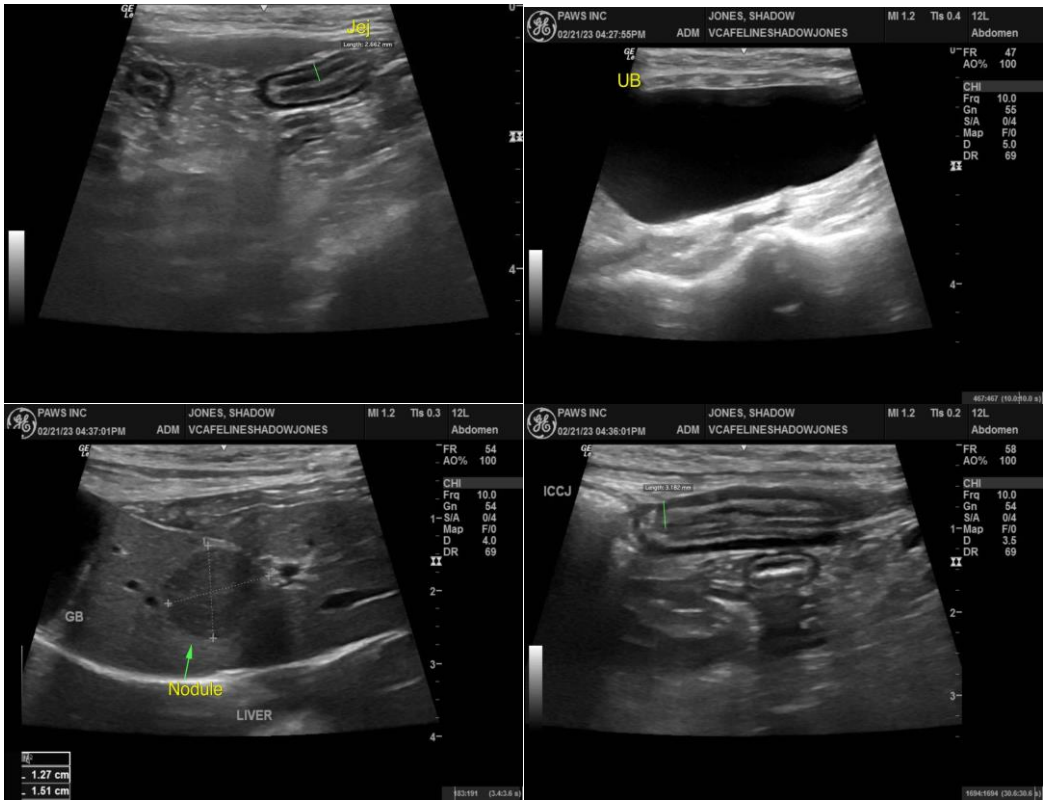

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com