



PATIENT PRESENTING CLINICAL SIGNS

PATIENT Beakay Geary
SPECIES Feline
BREED DSH
SEX Spayed female
AGE 16 years 10 months
WEIGHT 9.5 pounds

History: 3/31 - Had a dental w/ 2 extractions at rDVM. 4/1 - Returned to rDVM for inappetence. Received SQF, injections of Cerenia & Vitamin B, and started Elura (entyce). 4/2 - Presented to wilvet, ate a small amount Friday night after receiving entyce, but still very quiet & dull. O worried about lack of calorie intake. Previous history = hyperthyroid, cardiomyopathy, some biliary issues (O unsure of what exactly). Current meds = Ursodiol, Atenolol, Amlodipine, Felimazole, Onsior.

Abnormal PE/Chem/CBC/UA Results: On exam, P is QDR, MM pale pink, tacky, dental extraction sites (108 & 208) appear to be healing normally. Grade 3-4/6 parasternal systolic murmur. Abd mildly distended. CBC - HCT 20%, WBC 37.93k, Neut 14.8k, Lym 14.43k (suspect bands based on slide review), Mono 7.15k, Baso 0.98k, rest wnl. Chem10 - Glu 236, Creat 0.7, rest wnl EPOC - iCa 1.16, Glu 250, Na 144, LAC 2.29 (wnl), HCT 20% Three-view whole body rads - moderate cardiomegaly, does not appear to be in CHF. Mineralized objects in region of gall bladder.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with minor non dependent sediment primarily in the cranial lumen without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and mild age related loss of corticomedullary border demarcation. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. A hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. The left kidney measured 3.6 cm in length. The right kidney measured 3.8 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 0.3 cm width. The right adrenal gland was 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 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

The liver was subjectively normal in size, structure, and contour. The liver parenchyma exhibited normal to subtly reduced parenchyma echogenicity with a moderate coarse echotexture. Lobar to diffuse biliary

INTERPRETED BY

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DVM, DABVP
(Canine and Feline)

IMAGING PERFORMED BY

Dr. Couser

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tree mineral was present in the left mid and right liver. A moderately sized thinly walled cyst was present in the left liver containing anechoic fluid measuring 3.0 cm in diameter. Smaller intraparenchymal cysts noted in the mid caudal liver. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls containing nonobstructive choleliths primarily in the caudal lumen and in the area of the gallbladder neck. Concurrent hypoechoic sediment was present with no evidence of peri gallbladder inflammation. The cystic and common bile ducts were normal.

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

SEX

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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 jejunum wall measured 0.25 in width. The ileocolic wall measured 0.37 cm in width.

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

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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.

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Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Minor UB sediment - cells, crystals, mucus
- Mild chronic kidneys with subtle nonspecific medullary rim sign - incidental, kidneys normal in size
- Biliary tree mineralization with concurrent non obstructive cholelithiasis - biliary tree mineral and GB stones are often incidental but may be associated with chronic cholangitis / cholangiohepatitis which may be present even with lack of liver enzyme elevation given the short half life of liver enzymes in cats.
- Overtly normal GI with mild subjective gas distended stomach
- Mild heterogeneous pancreas

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, no significant pathology i.e. effusion, lymphadenopathy, masses, etc. Low grade pancreatitis or structurally insignificant inflammatory bowel episode possible and may be considered if cranial abdomen / subxiphoid discomfort on palpation and/or abnormal fPL. A definitive cause of the anemia was not overtly evident in the abdomen. Empirically, supportive care for chronic cholangiohepatitis, gastrointestinal inflammation or low-grade pancreatitis would be reasonable.

REFERRING VET

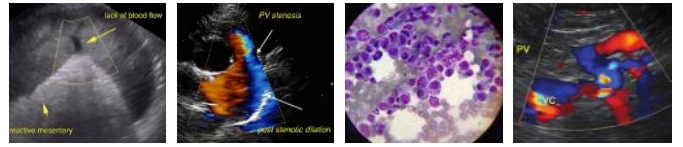
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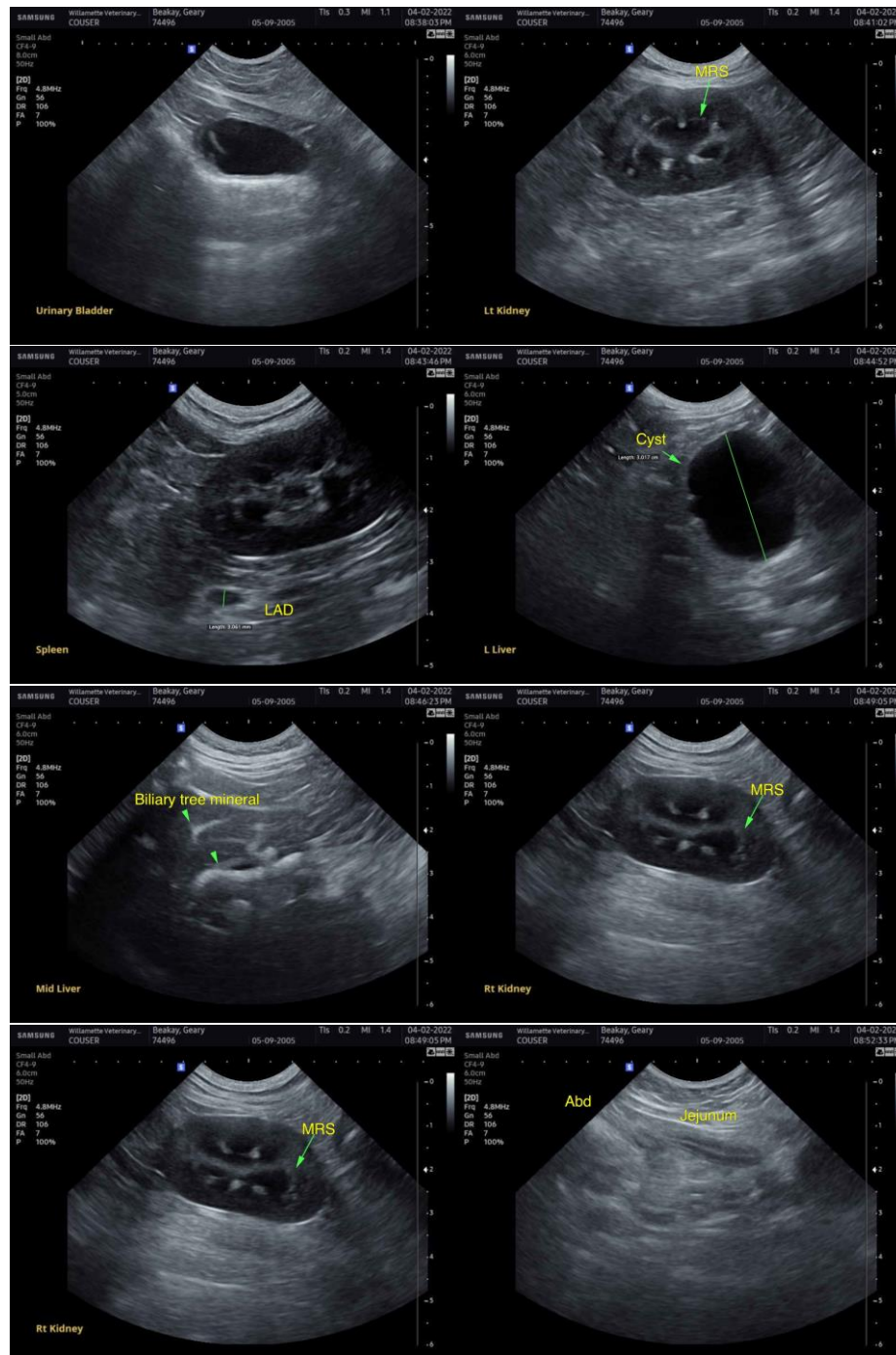
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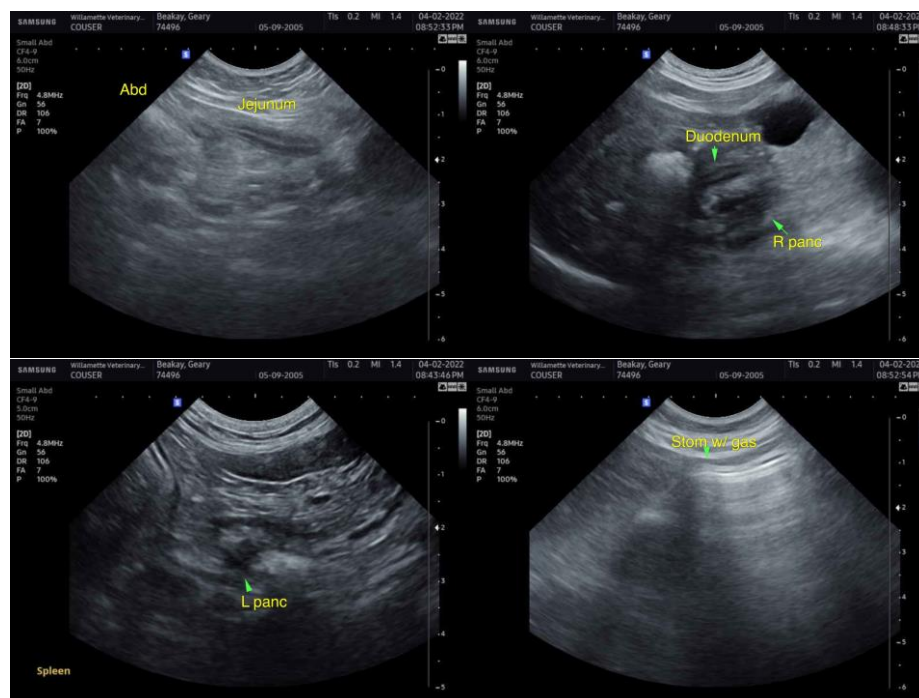
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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