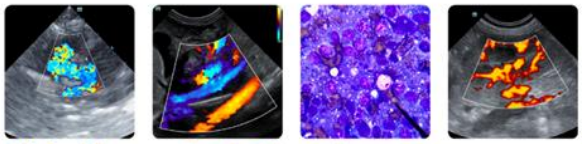

PATIENT

Lionel Gallier

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

9yr

WEIGHT

7.2

INTERPRETED BY

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

IMAGING PERFORMED BY

Anna Wepprich

HOSPITAL NAME

Wilvet Salem

REFERRING VET

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INVOICE
24423

DATE
04/08/2026

PRESENTING CLINICAL SIGNS

Presented 4/6 to VCA for lethargy and not eating. He had disappeared for 24hours and then refused to move 5 hours after being found. Fever 104, painful inexpressible bladder on presentation. Treated for urinary obstruction (passed ur cath) and transferred for hospitalization 4/6 night. rDVM found bacteruria on UA. Fever has decreased in last 24 hours to 102.6F, eating very small amount of dry food today. Concern for fluid overload overnight 4/7-4/8. He has been on IVF, buprenorphine, gabapentin, ampicillin, cerenia, ur cath management.

Reason for ultrasound: persistent icterus, fever, low appetite, painful kidney/bladder palpation.

Abnormal PE/Chem/CBC/UA Results: VCA 4/6: CBC: HCT 33.3% WBC 7.69, Lymph 0.15 (L), Plt 125 Chem: BUN 20, Creat 1.1, TP 6.9, Gluc 184, ALT 103 (H), ALP 25, Tbili 1.4 (H), Na 149, K 3.2 (L), Cl 111 UA (in house): USG >1.050 (H), pH 6.0, Bilirubin crystals 2-3/hpf, Bacteria rods and cocci 50-100/hpf, erythrocytes 0-1/hpf, Casts 2-3/hpf 4/7: 3pm EPOC: pH 7.72(H), iCa+ 1.15(L), BUN 15(N), Cre 1.34(N), K+ 3.6(N), Glu 139(H) TBIL: 2.0(H - increased from 1.4) PCV/TS: 36%/6g/dL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was subnormal to empty in appearance, prohibiting full evaluation of the urinary bladder wall. The visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. A urinary catheter was present at the level of the cystourethral junction and trigone. Minimal anechoic urine present with minor dependent lumen mineral.

Normal size and margination were present in the kidneys. 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. A small non-obstructive pelvic renolith was present in the left kidney. Minor bilateral pyelectasia was present. The left kidney measured 3.8 cm in length. The right kidney measured 4.4 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

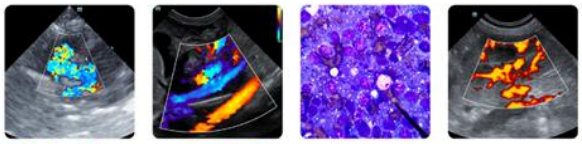
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.36 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland subjectively measured 0.30 cm width at the caudal pole.

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/Gallbladder

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. Normal vascular volume. The liver



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parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. No visualized masses or nodules were present. 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. Primarily generalized mild torturous common bile duct dilation without evidence of post-hepatic obstruction or visualized duodenal papilla pathology.

Gastrointestinal

The stomach presented intact borderline prominent jejunal wall measuring 0.26-0.27 cm in width. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

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 mechanical/metabolic 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 was evident.

Free Abdomen

Scant peri hepatic effusion.

Intermittent mildly enlarged colic 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 present. An example of lymph node size was 1.2 cm x 0.45 cm.

ULTRASONOGRAPHIC FINDINGS

Primary

- Empty urinary bladder with minor dependent lumen mineral, urinary catheter present
- Mild age-related renal changes with minor pyelectasia and non-obstructive left kidney renolith
- Hepatopathy
- Gallbladder debris with non-obstructive common bile duct dilation
- Normal area of pancreas
- Structurally unremarkable gastrointestinal tract with borderline prominent jejunum wall
- Mild colic lymphadenopathy- suggestive of mild hyperplasia or lymphadenitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status and using a 25ga needle, hepatic FNA cytology is warranted primarily to assess for inflammatory cell type with acute cholangiopathy suspected. No overt evidence of abdominal neoplastic criteria. Mild colic lymphatic hyperplasia or lymphadenitis secondary to concurrent inflammatory bowel episode possible. Potential for emerging IBD or triaditis not definitively excluded. No evidence of mechanical gastrointestinal obstruction or foreign material. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. A recheck sonogram if non-responsive or

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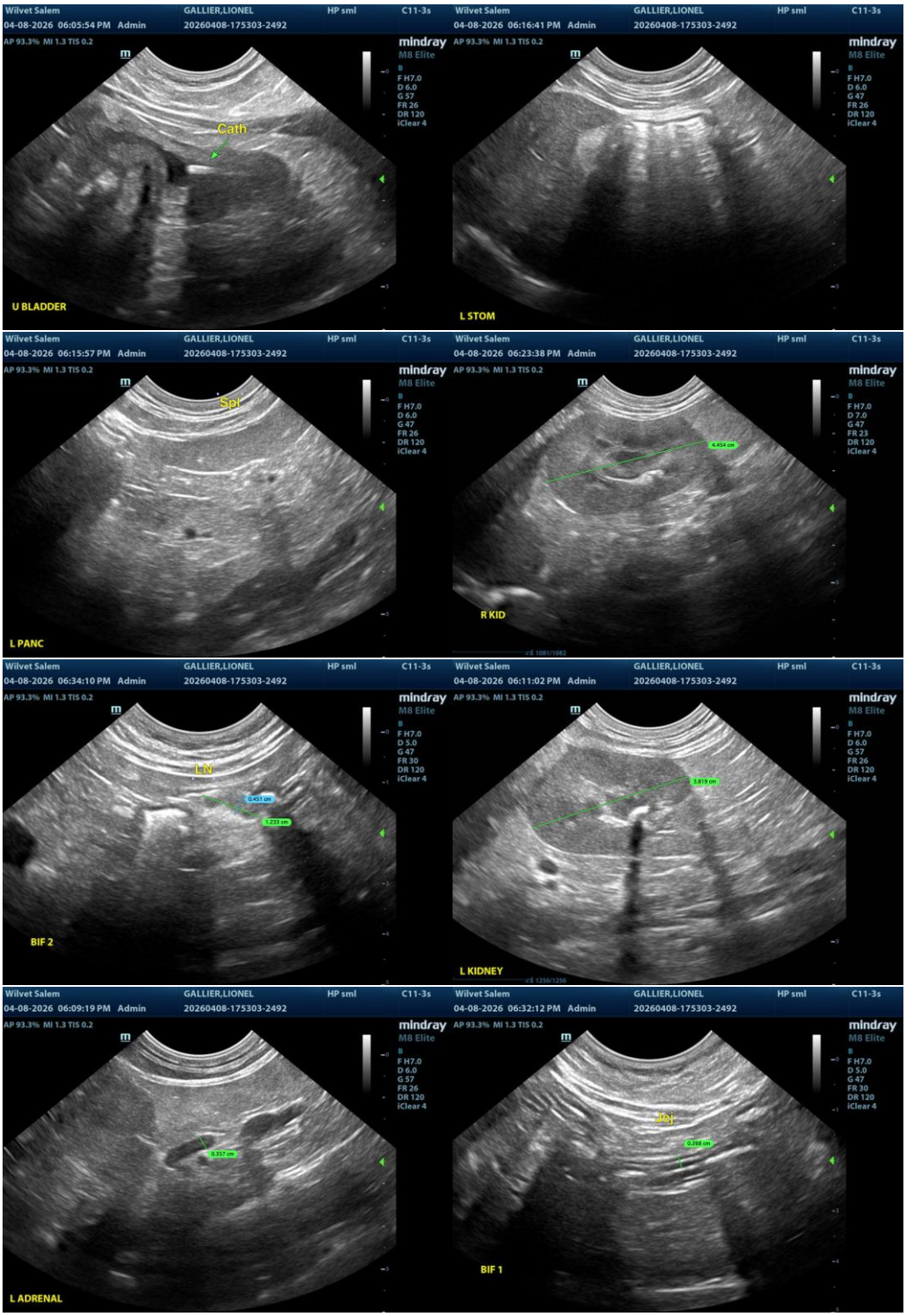
progressive gastrointestinal signs or hepatopathy is recommended. A leptospirosis titer / PCR may be considered if clinically applicable.



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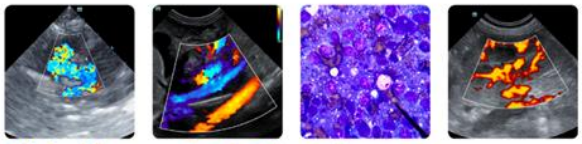

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Educational Teleconsultation Services™

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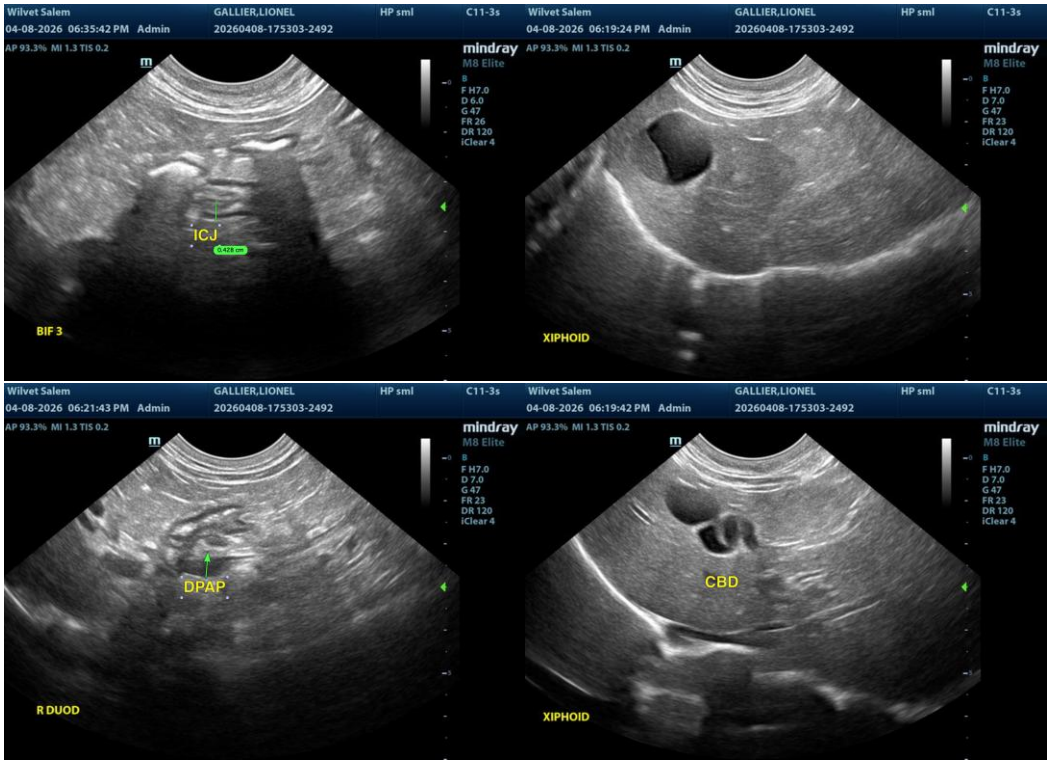

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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