



**PATIENT**

Tinker Dorken

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

2 years

**WEIGHT**

6.28 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Alejandro Vargas  
Lumbreras

**HOSPITAL NAME**

Central Island Vet  
Emergency Hospital

**REFERRING VET**

Dr. Mathew  
Guenther

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**DATE**

5/6/22

**PRESENTING CLINICAL SIGNS**

Recently seen in hospital for FIC on May 2 and April 25 - sent home w/ metacam, prazosin, buprenorphine. Buprenorphine reportedly made P very lethargic. Os have not given Metacam as P has not been eating.

Abnormal PE/Chem/CBC/UA Results: BCS 8/9 - General Panel: eosinopenia (stress), significant post-renal azotemia (significantly elevated SDMA, significantly elevated urea/BUN, creatinine unreadable - required dilution), elevated phosphorus, mild hypocalcemia, hyperkalemia - Urinalysis (free catch during U-cath placement): no crystaluria but UTI (cocci) - Therapies: - 3x maintenance IVFT to try to combat significant post-renal azotemia - 0.02 mg/kg buprenorphine IV q 4-6 hours - Prazosin 1 mg PO TID 24h => CBC revealed mild neutropenia, no other significant abnormal findings. Biochemistry revealed mild hypoglycemia, elevated SDMA, severe azotemia, hyperphosphatemia, and mild hypocalcemia. Added: 1. Meloxicam (6kg dose PO SID with food for 5 days) 2. Mirtazepine (1.85mg PO SID)

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder was normal to mildly subnormal in size exhibiting subjective normal tone with generalized variable yet primarily mild mural thickening primarily in the ventral to ventroapical urinary bladder, and mild asymmetrical luminal surface, as well as suspected mild adhered mineral / sand along the ventral to ventroapical luminal surface. Primarily anechoic urine was present with no evidence of macro calculi or neoplastic criteria. The ventral urinary bladder wall measured 0.35 cm. The visible proximal urethra exhibited subjective normal structure and tone to a depth of 2.0 cm.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. 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 pyelectasia, hydronephrosis, or left or right ureter dilation. Subtle evidence of mild increased left and right retroperitoneal echogenicity with potential for very scant retroperitoneal free fluid was present. The left kidney measured 3.8 cm in length. The right kidney measured 3.9 cm in length.

**Adrenal Glands**

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.33 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.



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***Liver/ Gallbladder***

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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.

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***Gastrointestinal***

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate nonshadowing ingesta / chyme.

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.

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 were evident.

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***Free Abdomen***

No overt lymphadenopathy or peritoneal effusion was present.

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**ULTRASONOGRAPHIC FINDINGS**

***Primary Findings***

- Overtly normal bilateral kidneys with potential for scant left and right retroperitoneal free fluid - no overt evidence of dysplasia, pyelectasia / pyelonephritis, left or right ureter obstruction, or hydronephrosis
- Chronic cystitis pattern with suspect mild adhered sand / mineral along ventral luminal surface

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***Secondary Findings***

- Gastric ingesta

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The kidneys did not appear to be end-stage and without evidence of significant pathology. Potential for nonspecific acute nephritis, given evidence of scant left and right retroperitoneal free fluid, cannot be definitively excluded.

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The bladder did not appear to be significantly distended with urine which potentially may be consistent with recent catheterization.

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Hospitalization with current diuresis protocol with consideration for placement of indwelling catheter if not currently instituted to measure ins/outs and monitoring of renal response is recommended.



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The presence of gastric ingesta is nonspecific yet may correlate with unknown recent meal ingestion. However, given the patient's reported inappetence, some degree of metabolic gastric hypomotility may be present.

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Continued conservative therapy for idiopathic cystitis would be warranted. Potential perineal urethrostomy may be indicated in this patient.

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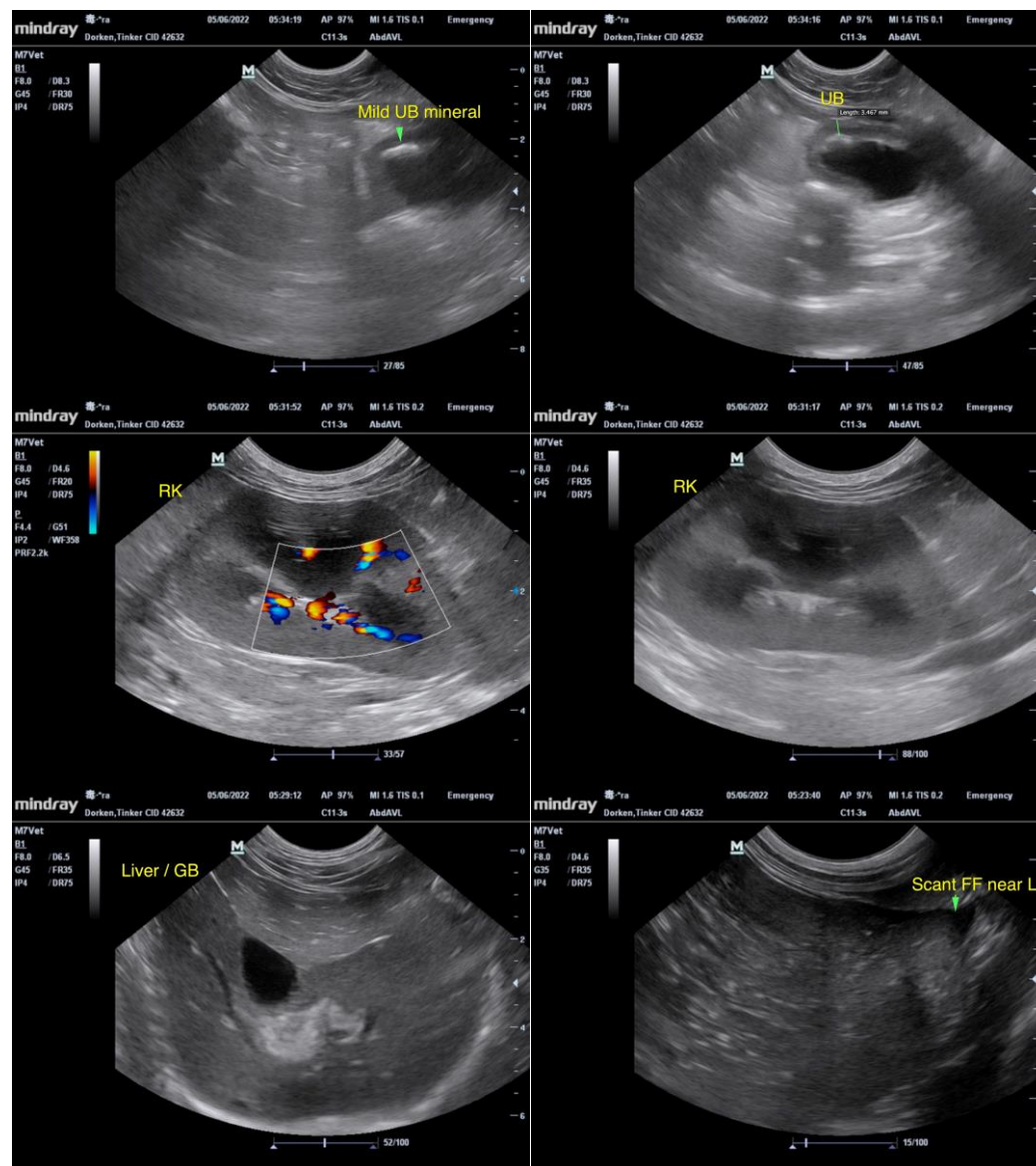
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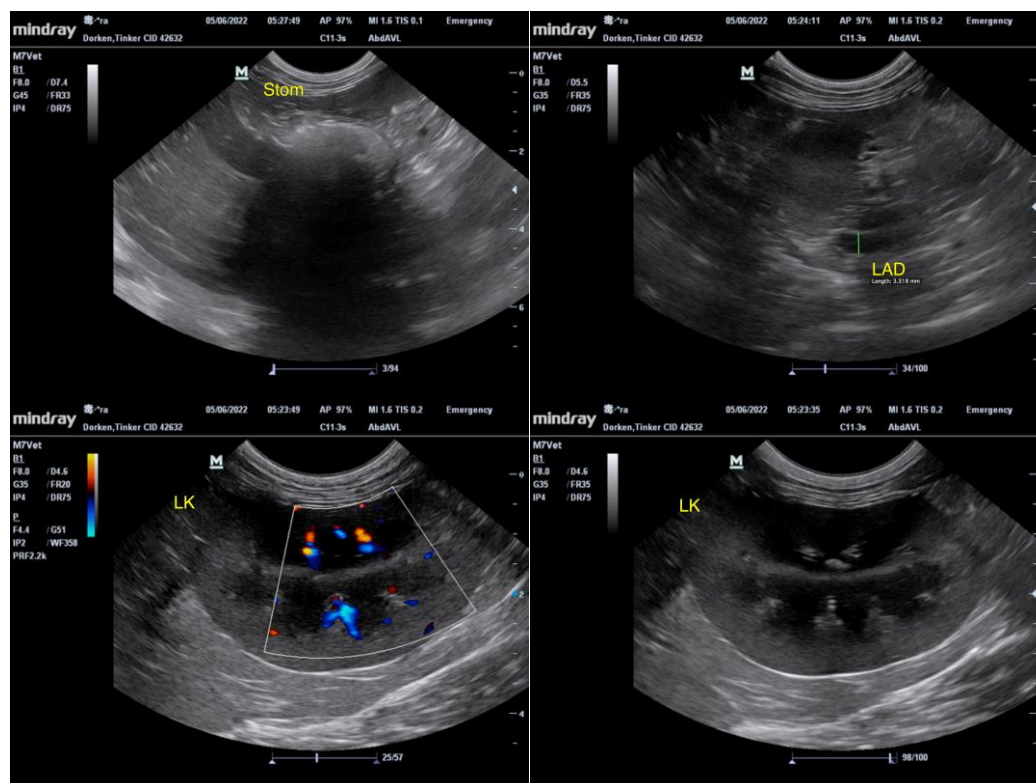
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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info@SonoPath.com