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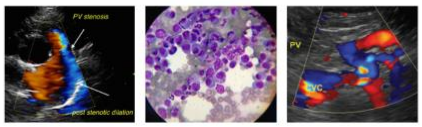


SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Prince Charming Haenni

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7 Years

WEIGHT

12 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Haenni

INVOICE

37546

DATE

5/9/22

PRESENTING CLINICAL SIGNS

Monday and Tuesday last week not eating well. Started fluids and pain meds Tuesday. Had sore under tongue so Wed got Convenia. Seemed better and eating. Yesterday was hiding and when found looked much worse. Not eating, did bloodwork and rads. Gave cerenia inj.
Abnormal PE/Chem/CBC/UA Results: 5/4/22 CBC/CHEM all values WNL 5/8/22 CREA 13.2, BUN >140, BIL 1.2, WBC 36 Rads: could not see right kidney, left kidney enlarged. This morning placed urinary catheter to be sure wasnt blocked. Urine pale yellow SpGr 1.016, rest was unremarkable.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild particulate pinpoint hyperechoic sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the aortic trifurcation was free of pathology.

The left kidney was moderately enlarged in size. Discernable corticomedullary architecture, yet loss of corticomedullary border distinction. Subtle evidence of mild cortical hypertrophy. Maintained primarily symmetrical renal margination. Moderate hydronephrosis with mild extension into lateral diverticuli. Mildly prominent renal sinus and proximal left ureter exiting the left kidney, yet could not be definitively passed the level of the left kidney. The left kidney measured 6.5 cm.

The right kidney was normal in size with mild asymmetrical regnal margination. Discernable corticomedullary architecture with mild loss of corticomedullary border distinction. Mild hydronephrosis, primarily in the area of the renal pelvis. Concurrent mildly prominent right renal sinus and proximal right ureter, which cannot be definitively visualized passed the level of the right kidney. The right kidney measured 3.5 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.40 cm. The right adrenal gland measured 0.43 cm.

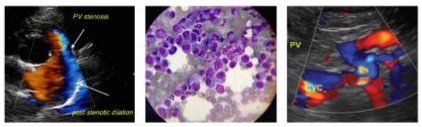
Spleen

The spleen exhibited potential for mild subnormal size owing to volume contraction, measuring 0.64 cm. The spleen presented 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 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.

Gastrointestinal



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The stomach presented intact wall layering with mildly prominent wall layering noted in the area of the antrum and pylorus with minor retained pyloric fluid. Pylorus wall measured 0.46 cm.

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. Jejunum wall measured 0.24 cm. Ileocolic wall measured 0.30 cm.

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 to mild volume anechoic peritoneal free fluid. Mild generalized reactive mesentery. No overt evidence of lymphadenopathy or omental masses.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sediment
- Left kidney moderate enlargement, exhibiting loss of corticomedullary distinction and moderate hydronephrosis
- Right kidney normal size with loss of corticomedullary distinction and mild hydronephrosis
- Mild pyloric gastritis – potential for mild uremic gastritis.
- Scant to mild volume anechoic peritoneal free fluid and minor generalized reactive mesentery

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although non-specific, the appearance of the bilateral kidneys is consistent with chronic versus acute on chronic nephropathy or unspecified nephritis (i.e., interstitial nephritis, pyelonephritis) or other nephropathy. Given discernable corticomedullary architecture with loss of corticomedullary border distinction, neoplastic criteria, specifically involving the left kidney, is thought less likely, with potential for left kidney compensatory hypertrophy.

Given the degree of renal azotemia, chronic to acute on chronic renal failure is likely. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Assessment of systemic blood pressure for evidence of hypertension recommended. Hospitalization with appropriate diuresis protocol, monitoring of body weight, urine output, systemic BP, and renal response, with possible sonographic reassessment of the left and right kidneys for evidence of progressive hydronephrosis or left or right ureter distention is recommended. Guarded prognosis.

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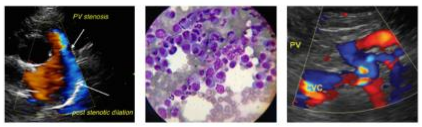

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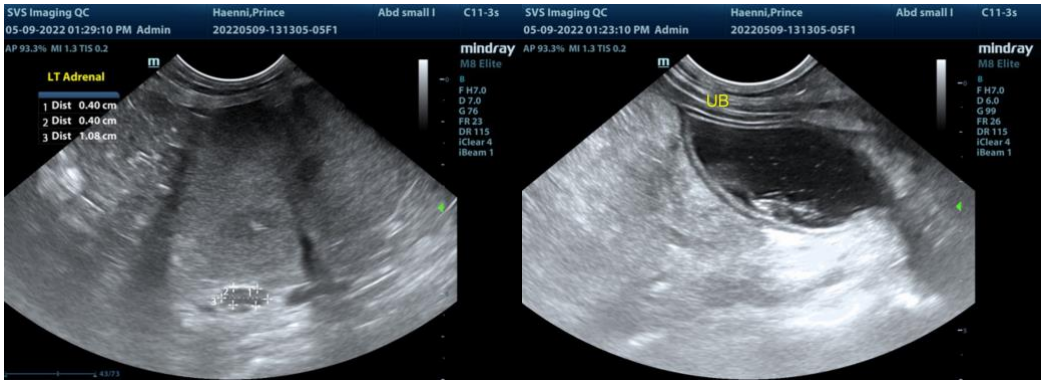

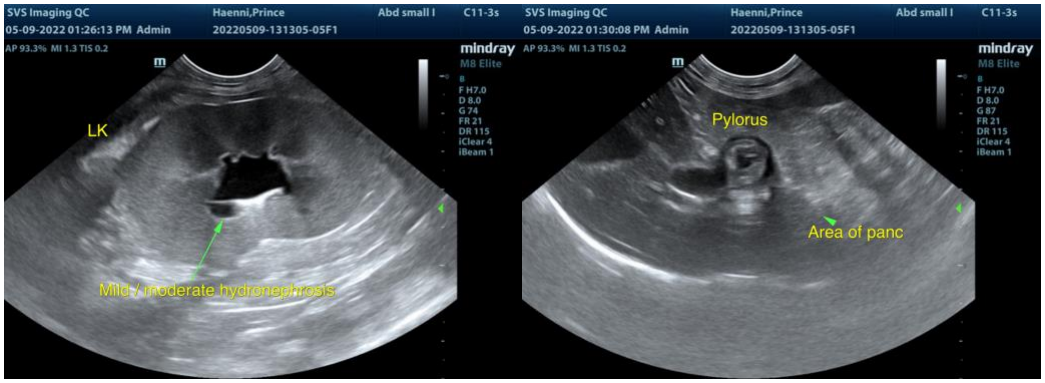

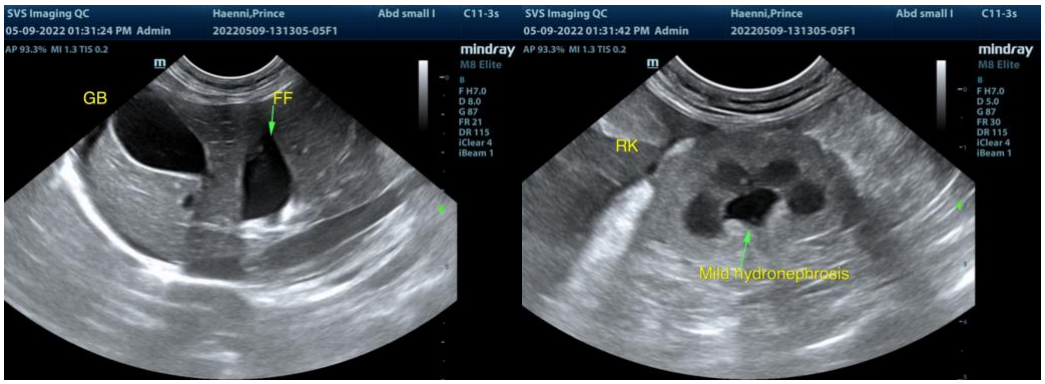

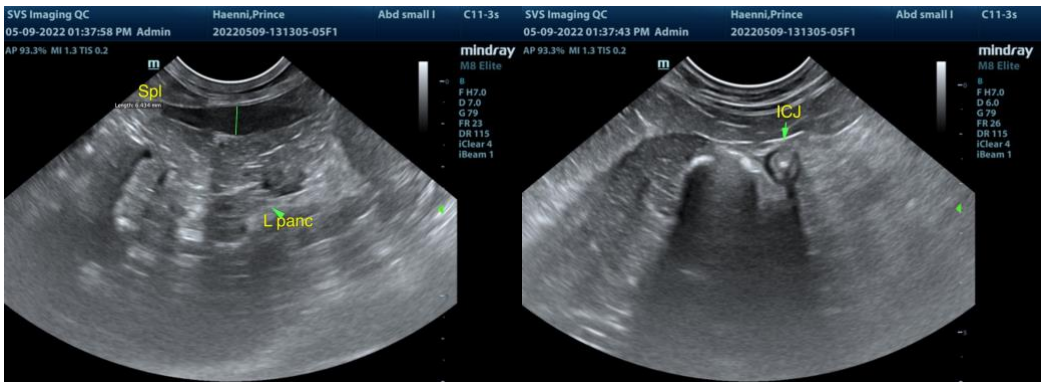

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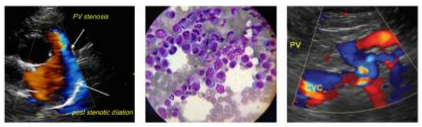

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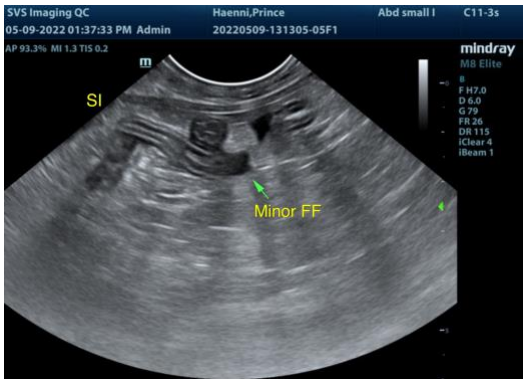

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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