



**PATIENT**

Shadow McBride

**SPECIES**

Feline

**BREED**

DSH Mix

**SEX**

Neutered Male

**AGE**

8 Years

**WEIGHT**

6.17 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

JSS

**HOSPITAL NAME**

King Hopkins PH

**REFERRING VET**

Dr. Latoya Brown

**INVOICE**

16074

**DATE**

6/13/22

**PRESENTING CLINICAL SIGNS**

History: Patient History: Shadow is an 8 yr old neutered cat with the chief complaint of anorexia. He is a newly adopted cat, rehomed about 2 months. The previous O is in a long term care home that the family knows (O's brother work colleague). He was doing fine for the first 2 months up until about a week ago, now he has stopped eating. The O is concerned of his general health, which the new O has no previous health hx, or rDVM. The O believes he is under weight/has lost some weight. No BM observed, no vomiting seen. Hx of indoor only, vx status unknown. Diet: originally fed whiskas/friskies, transitioned to blue buffalo PE findings: Mentation: BAR BCS: 5/9 ideal Mucous membranes: pink, slightly tacky Hydration Status: hydrated Oral cavity: Clean teeth, normal gum. Eyes: No obvious discharges, white sclera Ears: No evidence of debris or discharges Cardiac: No audible murmurs/arrhythmias heard; pulses strong and synchronous Respiratory: No abnormal sounds, No crackles or wheezes Integument: hair coat in good condition, no evidence of external parasites Musculoskeletal: ambulatory on all 4 limbs, no limping or lameness noted, no pain noted Digestive: No organomegaly, No pain elicited on palpation. Genito-urinary: unremarkable Neurological: unremarkable

Abnormal PE/Chem/CBC/UA Results: CBC: mild neutrophilia, remaining parameters WNL WBC 17.50 x10<sup>9</sup>/L 2.87 - 17.02 HIGH NEU 15.33 x10<sup>9</sup>/L 2.30 - 10.29 HIGH CHEM: increased ALB, mildly elevated ALT, ALKP, TBIL, hyponatremia ALB 42 g/L 23 - 39 HIGH ALT 177 U/L 12 - 130 HIGH ALKP 206 U/L 14 - 111 HIGH TBIL 17 μmol/L 0 - 15 HIGH Na 166 mmol/L 150 - 165 HIGH fPL: Normal

\*\*This study contained 17 still images and 1 video for review. Please include multiple and comprehensive videos for interpretation.

**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 nondependent particulate 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.

A single still image of transverse left kidney revealed subjective mild loss of corticomedullary border demarcation. No overt evidence of pyelectasia was noted.

The right kidney was not definitively visualized.

**Adrenal Glands**

The labeled left adrenal gland appeared to be overtly normal in size, position and shape, measuring 0.31 cm in width.

The right adrenal gland was not definitively visualized.

**Spleen**

The spleen was not definitively visualized.

**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.



<b>PATIENT</b>	The gallbladder was non-distended with primarily anechoic content with mild nonmineralized luminal debris. The gallbladder walls were sonographically normal without evidence of inflammatory criteria. No overt evidence of common bile duct dilation.
Shadow McBride	
<b>SPECIES</b>	<b><i>Gastrointestinal</i></b>
Feline	The stomach was indistinctly visualized. In one single still image, potential for shadowing gastric ingesta versus luminal gas artifact possible.
<b>BREED</b>	The small intestine was not definitively visualized.
DSH Mix	Normal visible colon wall layers were present with apparent formed feces in lumen.
<b>SEX</b>	<b><i>Pancreas</i></b>
Neutered Male	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.
<b>AGE</b>	<b><i>Free Abdomen</i></b>
8 Years	No overt omental masses, lymphadenopathy or evidence of peritoneal effusion was present.
<b>WEIGHT</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
6.17 kg	<ul style="list-style-type: none"> <li>• Hepatopathy- subjectively benign</li> <li>• Mild gallbladder debris</li> <li>• Possible shadowing gastric ingesta</li> <li>• Left kidney, subjective minor to mild chronic changes</li> <li>• Mild urinary bladder sediment</li> </ul>
<b>INTERPRETED BY</b>	<b><u>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</u></b>
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	The overall hepatic presentation is nonspecific yet suggestive of benign hepatopathy. Although sampling is required for further assessment cholangiohepatitis pattern is suspected, given the concurrent presence of gallbladder debris. Vacuolar to reactive or metabolic hepatic changes re also possible. Further assessment may include , assuming normal clotting status, ultrasound guided hepatic FNA, for screening cytology.
<b>IMAGING PERFORMED BY</b>	Sonographic monitoring for evidence of gastric emptying is suggested. Structurally insignificant inflammatory gastroenteropathy or low-grade to chronic pancreatitis, both of which may present as sonographically normal, could be present, although potential for low-grade pancreatitis may be considered less likely given the normal fPL level. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. As needed gastrointestinal support +/- hair ball therapy, if previous history of hair balls would be reasonable.
JSS	
<b>HOSPITAL NAME</b>	The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.
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<b>REFERRING VET</b>	If not done, three-view chest radiographs suggested to rule out occult thoracic or esophageal pathology as a contributing factor.
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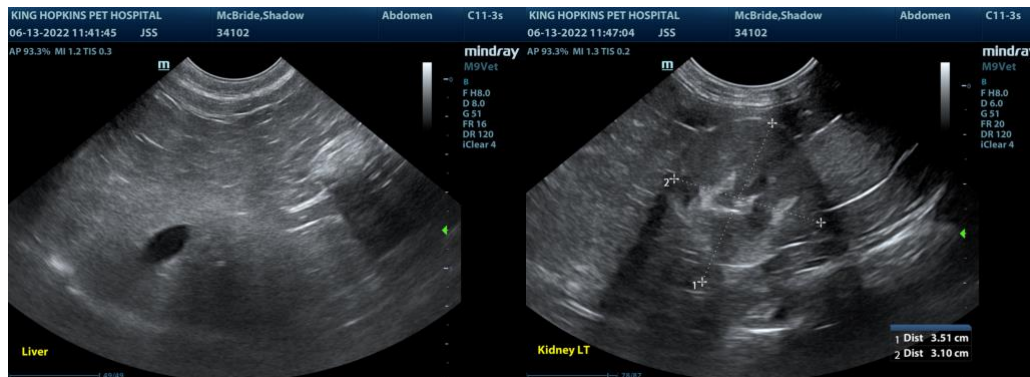
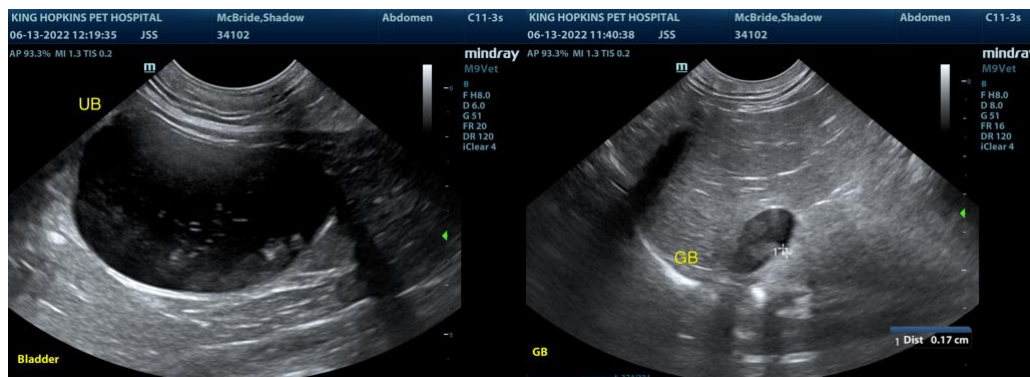
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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