



**PATIENT**

**PRESENTING CLINICAL SIGNS**

Comet Roe

Decreased energy and appetite, weight loss - started 6 wks ago - obsessively grooming, pruritic. June 8 rDVM sent home with prednisolone and flea treatment. Mild improvement. This week, however, symptoms continued. June 23 at rDVM: SQF, cerenia inj, clavaseptin PO, diet change to PVD NF early kidney. Labwork showed increased WBC and proteinuria. Has not been getting antibiotics as not eating.

**SPECIES**

Feline

**BREED**

DSH

June 25, admitted to hospital on 2M IVFT, Cerenia 1 mg/kg IV q24h, Mirtazapine 1.85 mg PO q24h, Pantoprazole 0.7 mg/kg IV q24h, Vetergesic 0.03 mg/kg IV q8h, Ampicillin 22 mg/kg IV q8h, Baytril 5 mg/kg IV q24h. Ate last night but was then NPO for AUS: >12 hour fast. Fever has broken. Sedated with Dexmedetomidine 3 mcg/kg IV and Alfaxan IV to effect. DDx: FIP vs. pyelonephritis vs. other.

**SEX**

FS

**Abnormal PE/Chem/CBC/UA Results**

June 25: T = 40.2C, mild skin tent, painful abd'l palpation (esp kidneys). Dull/depressed. CBC: Reticulocyte Hemoglobin = 11.4 pg (13.2-20.8), WBC = 27.43x10<sup>9</sup>/L (2.87-17.02), Neutrophils = 24.18x10<sup>9</sup>/L (2.3-10.29). CHEM: SDMA = 28 mcg/dL (0-14), Globulin = 61 g/L (28-51), GGT = 6 U/L (0-4). UA: cystocentesis, USG = 1.035, pH = 6.0, urine protein present, RBC = 1/HPF, WBC = 2/HPF, casts, likely bacteriuria (cocci).

**AGE**

13y

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**WEIGHT**

4.03kg

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

**INTERPRETED BY**

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

Both kidneys exhibited subjective subnormal size with asymmetrical cortical hypertrophy, subjective loss of medullary volume and mild asymmetrical renal margination. The left kidney measured 2.5 cm in length. The right kidney measured 2.8 cm in length.

**IMAGING PERFORMED BY**

Alejandro Lumbreras  
RVT

The area of the aortic trifurcation was free of pathology.

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Hospital

**Adrenal Glands**

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.31 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.43 cm width.

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Dr. Bell

**Spleen**

The spleen exhibited potential for mild subnormal size possibly owing to volume contraction with 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**

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

**Gastrointestinal**

**SPECIES**

Feline

The gastric fundus and body presented intact wall layering without evidence of mural thickening. The ventral fundus wall measured 0.23 cm in width. Regionally thickened gastric wall layering in the area of the antrum and pylorus exhibiting decreased mural echogenicity and loss of discernable wall layering to the level of the gastroduodenal junction was present. The pylorus wall measured 0.52 cm in width. The lumen of the stomach contained nonshadowing chyme with no signs of ileus, obstruction or foreign material.

**BREED**

DSH

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.

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

**Pancreas**

**AGE**

13y

The pancreas was normal in size and contour with a heterogeneous to mildly hyperechoic parenchyma and minor subjective pancreatic duct dilation.

**Free Abdomen**

**WEIGHT**

4.03kg

No peritoneal effusion was present.

Focal to intermittent mildly prominent to enlarged mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of a lymph node measured 1.0 cm x 0.42 cm.

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**ULTRASONOGRAPHIC FINDINGS**

- Regional thickened stomach / pylorus with loss of discernible wall layering and hypoechoic wall echogenicity, mild retained gastric chyme
- Possible mild chronic / chronic active pancreatitis
- Bilateral asymmetrical kidneys with subnormal kidney size - suggestive of chronic renal changes, possible nonspecific nephritis, neoplastic criteria considered less likely
- Intermittent subjective benign mesenteric lymph nodes

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RVT

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The gastric presentation may indicate moderate acute gastritis, however given the loss of gastric wall layering, primary concern is for infiltrative neoplasia i.e. gastric lymphoma. The visualized small bowel is overtly normal. If present, pancreatitis is either low grade or chronic and without obvious or significant pancreatic pathology. Assuming normal clotting status a FNA of the thickened gastric wall, if possible, could be considered for cytology. Biopsies likely needed for definitive diagnosis. Gastroprotectants and GI support warranted empirically. GI panel to include PLI/TLI/B12/Folate and three view chest radiographs (if not done) may be considered to rule out occult SI or thoracic disease as contributing factors to the clinical signs / weight loss aside from the stomach.

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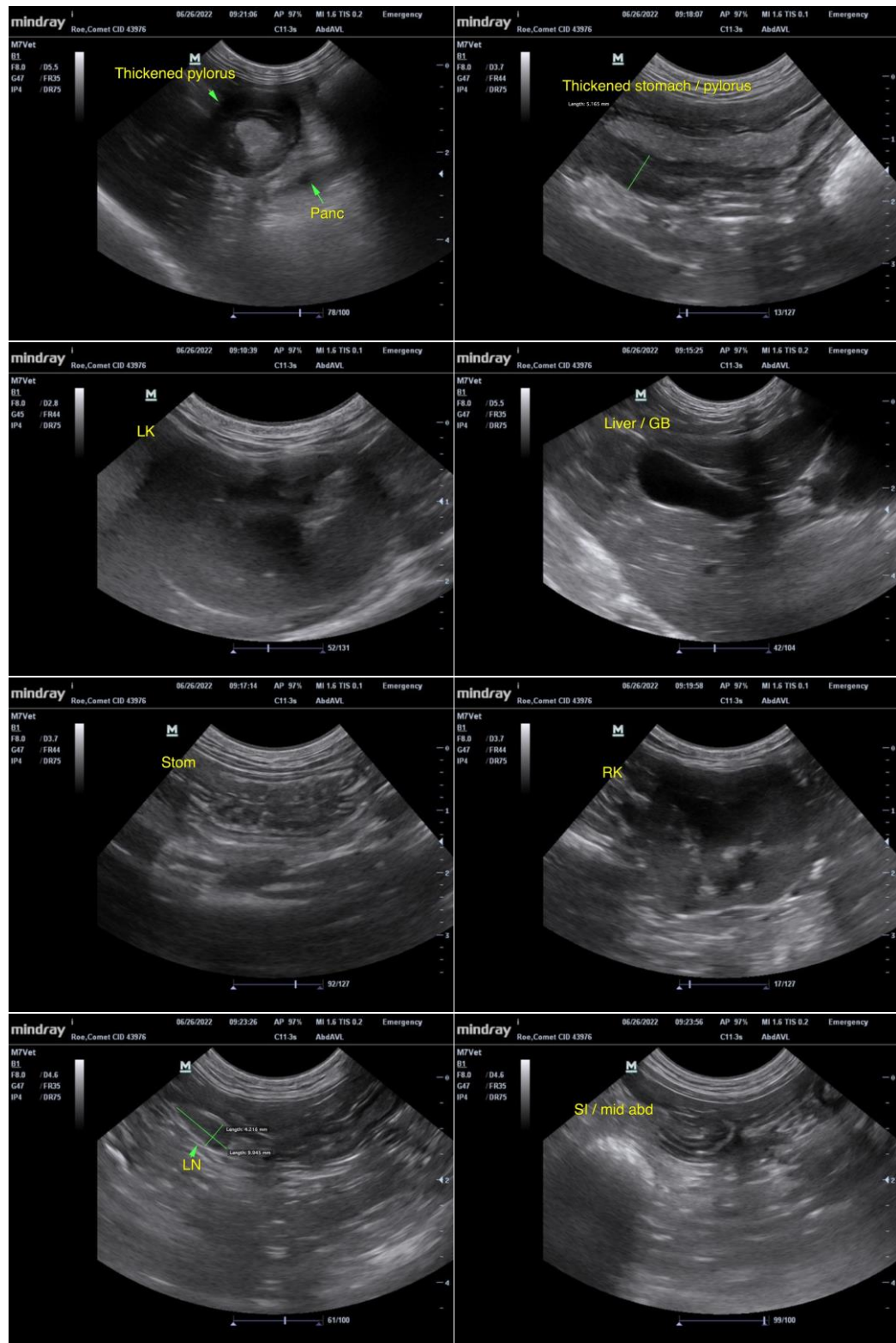
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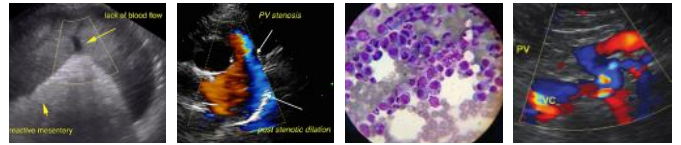
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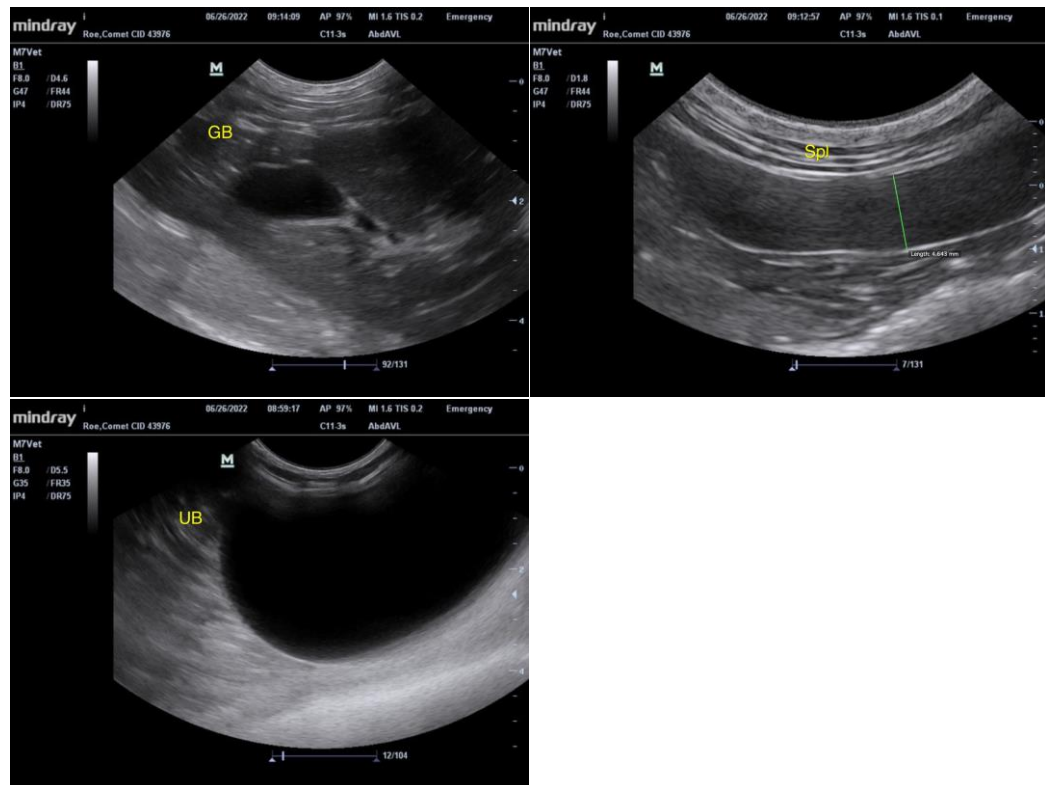
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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