



PATIENT

Spookie Werner

SPECIES

Feline

BREED

DSH

SEX

M

AGE

6yr

WEIGHT

4

INTERPRETED BY

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

IMAGING PERFORMED BY

Kathleen Massa

HOSPITAL NAME

Animal Emergency
Hospital Volusia

REFERRING VET

Kathleen Massa DVM

INVOICE

11342ag

DATE

08/14/2022

PRESENTING CLINICAL SIGNS

Spookie is a 6 Y MC DSH who presented for anorexia on and off for the last 2 months. O notes weight loss, diarrhea, V+ on and off. Indoor only. The differential diagnosis for the bilateral renomegaly includes bilateral hydronephrosis, polycystic kidney disease, neoplasia, perinephric pseudocyst formation, with hypertrophy being considered less likely. The minimal diffuse small intestinal distention is nonspecific and could be secondary to aerophagia or any cause of intestinal ileus/enteritis. The thickened appearance the small intestinal walls in the gas filled segment of small intestine and could be artifactual due to summation of fluid in the intestinal lumen with the wall or due to diffuse intestinal disease such as inflammatory bowel disease. The differential diagnosis for the mild diffuse bronchial lung pattern includes age related pulmonary changes in addition to feline asthma/airway disease. The suspect soft stool/diarrhea is nonspecific and a cause is not determined.

Mildly increased BUN of 35

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mildly distended with normal tone. The 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.

The left kidney was mildly enlarged in size exhibiting cortical hypertrophy, moderate to marked loss of corticomedullary definition and mild hydronephrosis with pelvic dilation containing anechoic fluid and minor medullary mineral. Subjective mild subcapsular fluid accumulation with potential for proliferative cortical tissue was present. No evidence of concurrent left ureter dilation or obstruction. The left kidney measured 4.7 cm in length.

The right kidney was enlarged in size exhibiting cortical hypertrophy, mild to moderate loss of corticomedullary definition and evidence of right retroperitoneal inflammation. The right kidney measured 4.3 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal glands were not 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. The spleen measured 1.0 cm in width at the level of the hilus.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a moderate coarse echotexture. A solitary non disruptive nonhomogeneous hyperechoic nodule in the deep mid liver was present measuring 1.9 cm in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion.



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The gallbladder was non-distended in size, divided into two compartments 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 a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.25 cm in width.

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The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. Small intestinal wall width 0.40 cm.

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

SEX

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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.

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Free Abdomen

Peri intestinal hyperechoic mesentery with pockets of peri intestinal to peritoneal fluid was present.

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ULTRASONOGRAPHIC FINDINGS

- Infiltrative enteropathy pattern - inflammatory (IBD / eosinophilic enteritis) or neoplastic (lymphoma etc) infiltrative enteropathy possible
- Intermittent minor mesenteric lymphadenopathy - sonographically suggestive of benign / reactive mesenteric LNs
- LK mild renomegaly exhibiting mild hydronephrosis with potential subcapsular fluid accumulation or mild proliferative cortex
- RK mild renomegaly with mild medullary mineral and pyelectasia
- Nonspecific liver nodule - benign biliary adenoma, hyperplasia, granuloma, neoplasia cannot be excluded yet considered less likely
- Secondary: Bilobed gallbladder - normal variant in a cat

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Full thickness SI biopsies are required for definitive diagnosis. The kidneys may indicate bilateral chronic nephropathy, potential for emerging neoplastic criteria in the left kidney possible. Concern for intestinal and emerging LK round cell neoplasia is warranted, although not definitive. If normal clotting status, FNA cytology of the left kidney cortex using 25 ga needle could be considered to assess for neoplastic round cells. The pyelectasia to mild hydronephrosis may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable) without obvious ureteral obstruction. Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.

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Empirically, IBD protocol with as needed GI and renal support would be reasonable. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

A guarded prognosis is indicated.

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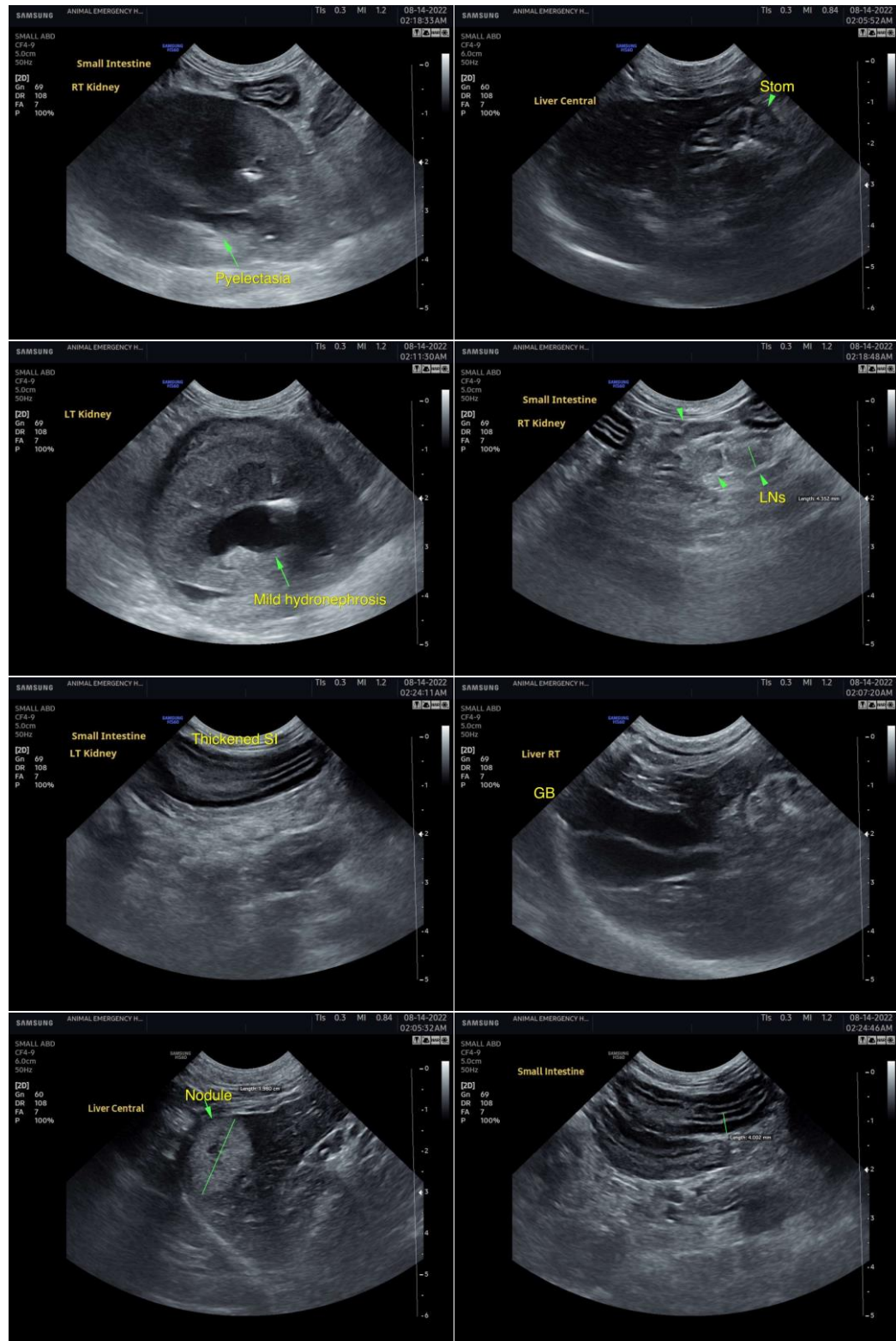
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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

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