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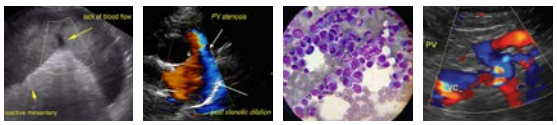

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT
Nyx Kelley

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
9 Years

WEIGHT
6.1

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

IMAGING PERFORMED BY
Jenna Walsh

HOSPITAL NAME
VCA Delta Oaks AH

REFERRING VET
Dr. Ashley Robinson

INVOICE
24826

DATE
8/19/21

PRESENTING CLINICAL SIGNS

ROUTINE OR STAT? ROUTINE Services Requested Abdominal Hospital Name VCA Delta Oaks Animal Hospital Overseeing Veterinarian Ashley Robinson Patient's First Name Nyx Patient's Last Name Kelley Species: Feline Breed: DSH Patient DOB or AGE: 9y 10m Patient Gender: Female Spayed Patient Weight: 6.1lb Clinical Exam Findings: Weight loss of 1.7lbs since April 2021 - cachexia Anemia reported from previous DVM visit at another clinic History or dermal lesions/over-grooming responsive to steroids Inappetent for past 3 days Ocular and nasal discharge for past 3 days Current Medications Clavamox suspension 62.5mg/ml - 1ml PO BID Primary Question/Differential to Be Answered in This Exam Cause of anemia and weight loss

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. Moderate particulate urinary bladder 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.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. The left kidney measured 3.3 cm. The right kidney measured 4.2 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease. The spleen was normal in size at 0.72 cm in width.

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 subnormal in size, potentially owing to the presence of gastric ingesta. The common bile duct was normal.

Gastrointestinal

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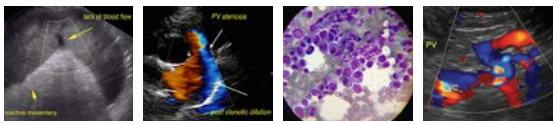

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate anechoic to echogenic fluid and retained ingesta/chyme. No overt evidence of mechanical pyloric outflow obstruction. Gastric body wall measured 0.26 cm. Pylorus wall measured 0.26 cm.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with intermittent jejunal mucosal speckling. Segmental intestinal digesta and retained fluid was present. Jejunum wall measured 0.20 cm. No evidence of loss of intestinal wall layering, intestinal masses, or mechanical obstruction.

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

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic inflammation. No overt evidence of neoplasia.

Free Abdomen

Subtle peripancreatic to generalized reactive mesentery noted. No overt lymphadenopathy. Small pockets of scant peritoneal free fluid present.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sediment
- Bilateral chronic nephropathy
- Subjective gastroenteropathy with gastric and segmental intestinal ileus/inefficient peristalsis
- Probable chronic active pancreatitis
- Small pockets of scant peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

The bilateral kidneys may indicate stable chronic renal changes with potential for non-specific interstitial nephritis.

The presence of gastric and segmental intestinal ingesta may potentially indicate recent meal ingestion or post-prandial presentation. However, potential for generalized gastrointestinal inefficient peristalsis or maldigestion pattern is suspected. IBD or other chronic inflammatory enteropathy combined with chronic active pancreatitis or possible Triaditis (if previous or current history of elevated hepatic enzymes are suspected). The anemia in this patient may be owing to chronic disease assuming no evidence of significant azotemia. Final diagnosis would require gastrointestinal +/- pancreatic or hepatic biopsies if clinically indicated. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. 3-view chest radiographs suggested if not done to rule out occult thoracic pathology as potential cause of weight loss.

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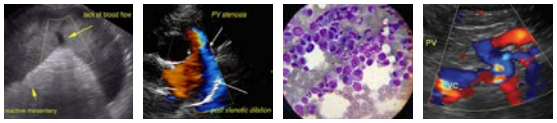

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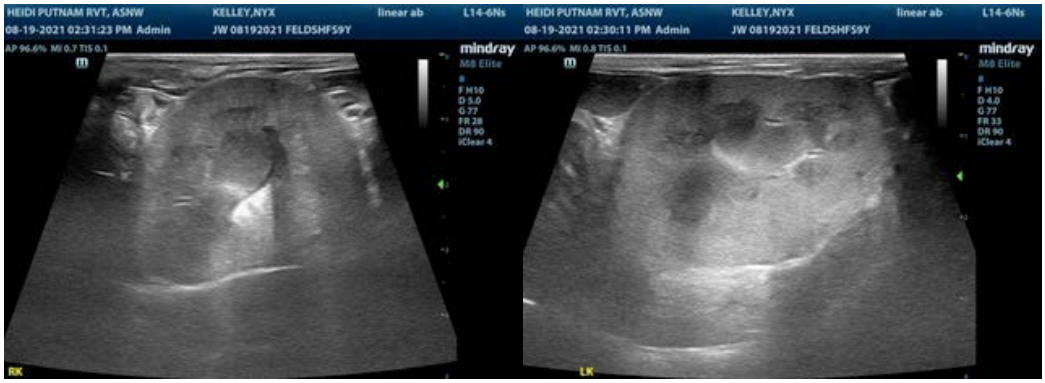

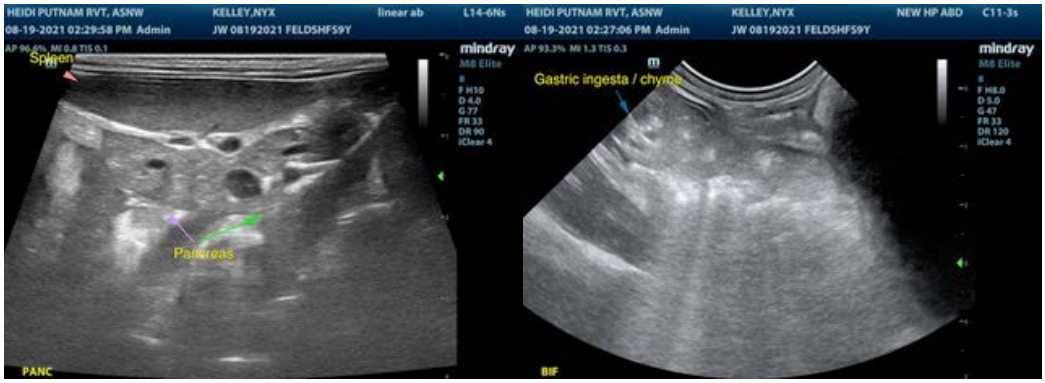

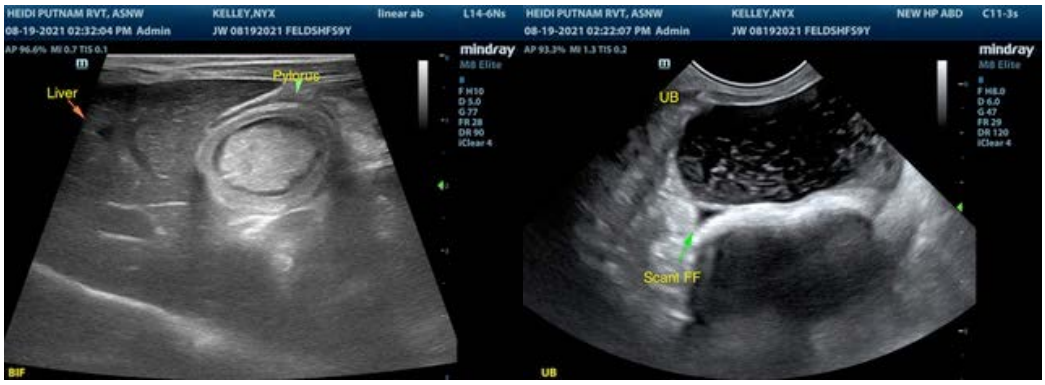

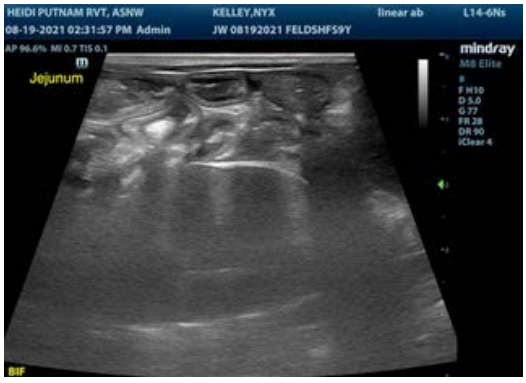

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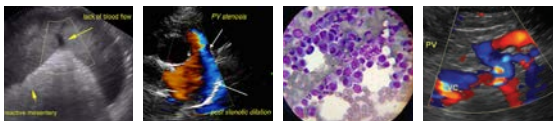

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com