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Clinical Sonography & Telecytology
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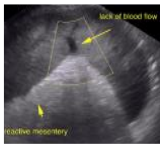

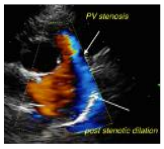

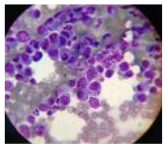
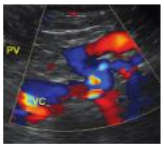

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1-800-838-4268 info@sonopath.com

PATIENT

Chloe Kronenberger

SPECIES

Feline

BREED

DSH

SEX

S/F

AGE

8 yr

WEIGHT

9 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ellen Puthoff

HOSPITAL NAME

Kings Veterinary Hospital

REFERRING VET

Dr. Ellen Puthoff

INVOICE

17403

DATE

9/21/22

PRESENTING CLINICAL SIGNS

Presented 9/20 for ear infection recheck, 0.5lb weight loss and palpated enlarged right kidney.

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. 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 was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured – cm in length. The right kidney measured – cm in length.

Adrenal Glands

Normal renal size was present in the left kidney. 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. Ill-defined hyperechoic band was noted just inside the corticomedullary border was present, this is a nonspecific finding seen in both normal and abnormal kidneys, and may be associated with interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma or FIP, however, it is a nonspecific finding. The left kidney measured 3.8 cm in length.

Normal renal size was present in the right kidney. Asymmetrical cranial margination noted with minor loss of associated cortical parenchyma, potentially indicative of cortical infarction. The right kidney appeared to be contained within a large anechoic cyst likely cavity, measuring approximately 6.8 cm in diameter. 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 right kidney itself measured 3.2 cm in length.

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 0.9 cm in width at the level of the hilus.

Liver/ Gallbladder

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.

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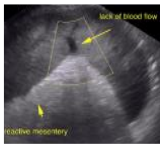
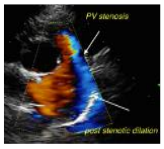
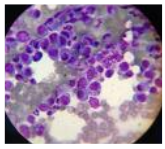
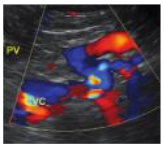

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The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

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 0.24 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. The small intestine measured 0.25 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 were evident.

Free Abdomen

No omental masses, lymphadenopathy or evidence of peritoneal free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Right kidney perinephric pseudocyst with concurrent interstitial nephritis pattern
- Left kidney concurrent interstitial nephritis pattern with ill-defined nonspecific medullary rim sign
- Sonographically unremarkable GI tract

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The palpable enlarged right kidney is consistent with perinephric pseudocyst and concurrent probable interstitial nephritis. No overt evidence of right kidney neoplastic criteria. Percutaneous drainage of the right kidney perinephric pseudocyst, initially, could be considered; however, the pseudocyst will likely recur. Consultation for potential surgical options regarding the perinephric pseudocyst may be considered. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Assessment and monitoring of systemic blood pressure, as well as renal parameters and urinalysis is recommended. A GI panel to include PLI/TLI/Cobalamin/Folate may be considered to assess for occult intestinal or pancreatic disease as a contributing factor to the weight loss.

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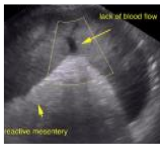
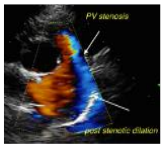
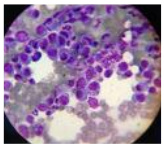
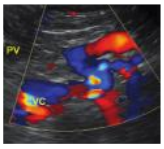

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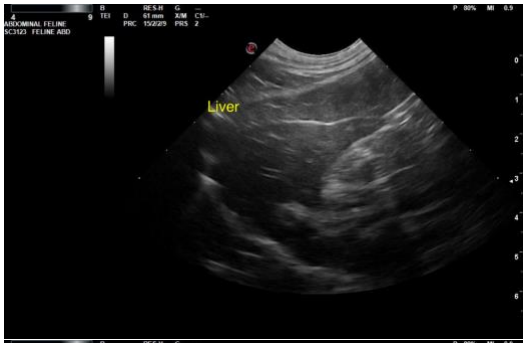

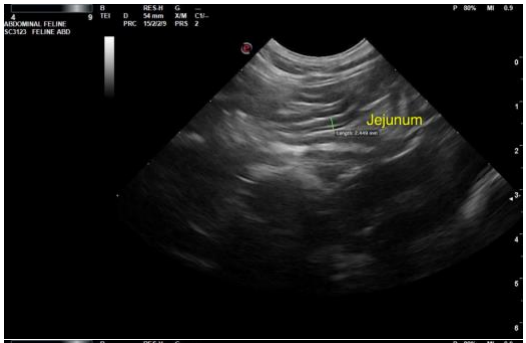

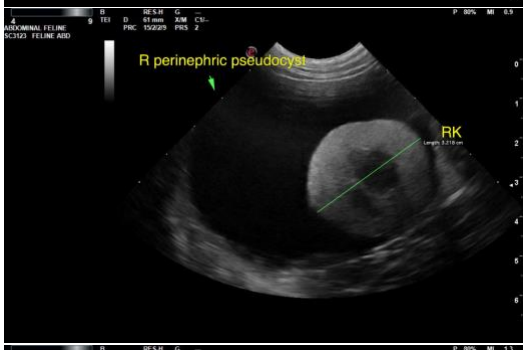


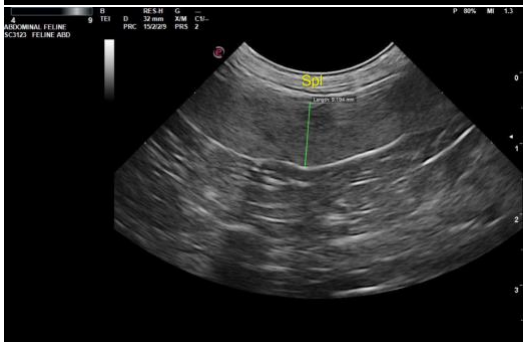

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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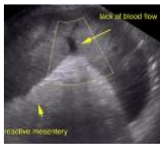

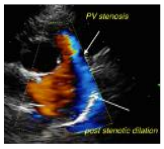

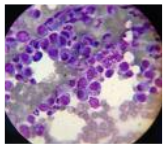
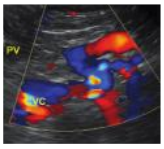

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