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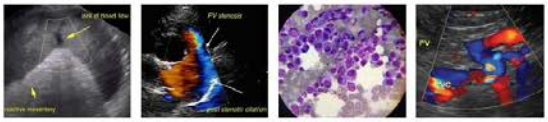

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Boonie Richardson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7 Years

WEIGHT

7

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Brighton Greens VH

REFERRING VET

Dr. Robin Janeway

INVOICE

25761

DATE

9/23/21

PRESENTING CLINICAL SIGNS

Sent lab work from 9/19 He has received 3 blood transfusions 9/17, 9/20, 9/22 His pcv prior to transfusion today was 10 Not eating well Lethargy Pale mmc Usually brighter and eating the day after transfusion then not doing well again. Lead levels owning- o lives near a junk yard and concern about lead. Radiology report: Radiographic Findings Whole body radiographs are supplied. There is the impression of mild cardiomegaly. Pulmonary vascular and parenchymal character is normal. Abdominal detail is satisfactory, but limited as the patient is emaciated. The stomach is moderately send with gas and small granular mineral material. The small bowel contains scattered gas with no abnormal distention. The colon contains moderate gas and scant formed feces. Partially visible renal margins suggest normal size and shape. There is mild hepatomegaly. Other visceral structures are without defined abnormalities. Conclusion Impression of mild cardiomegaly. If real, there is no evidence of decompensation. There is no evidence of bronchitis or bronchopneumonia. Emaciation. Evidence of dietary indiscretion with small mineral debris within the stomach. This could be associated with pica. Complicating G.I. abnormalities are not defined, although a degree of impaction of this material at the pylorus could cause gastric partial or intermittent outflow obstruction. Mild hepatomegaly. Other abdominal viscera are without defined abnormalities. Steve Harnagel, DVM, DACVR | - Currently on cerenia inj Prednisolone 1mg/kg bid Clopidrogrel developed a fever
Abnormal PE/Chem/CBC/UA Results: LABS attached

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 were noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint medullary mineralization was noted in both kidneys. Right kidney cortical infarcts were noted.

Adrenal Glands

The bilateral adrenal glands were normal in size and contour. Pinpoint areas of mineralization were present without capsular distortion or overt tumors. This is an age related finding and not pathological. The left adrenal gland measured 0.42 cm. The right adrenal gland measured 0.50 cm.

Spleen

The spleen exhibited subjective mild generalized enlargement with asymmetrical capsular contour. Reduced splenic parenchyma echogenicity noted with moderate coarse echotexture. The spleen measured 1.1 – 1.2 cm width at the level of the hilus. No distinct splenic masses or nodules.

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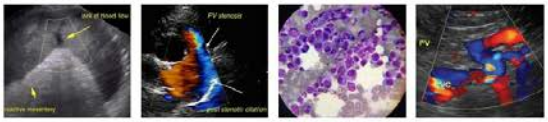

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Liver

The liver was mildly enlarged. 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. The gallbladder was non-distended in size with thin walls and very minor luminal debris. The proximal common bile duct was dilated (0.18 cm diameter) and tortuous without overt post hepatic obstruction.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild echogenic, nonshadowing ingesta/chyme, most consistent with post prandial presentation without signs of ileus, obstruction or foreign material.

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. Duodenum wall measured 0.25 cm. Jejunum wall measured 0.20 cm. Ileocolic junction 0.33 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 was evident.

Free Abdomen

No overt or significant lymphadenopathy. No evidence of peritoneal effusion. No omental masses.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic renal changes with medullary mineralization and right kidney cortical infarcts.
- Splenomegaly with hypoechoic to coarse parenchyma – hyperplasia, hematopoiesis, splenitis, with potential for neoplasia or less likely splenic torsion possible. Splenic torsion considered less likely given the lack of perisplenic free fluid.
- Hepatomegaly with generalized coarse parenchyma, non-specific
- Non-obstructive proximal common bile duct dilation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The proximal common bile duct dilation may suggest age related changes or secondary to underlying cholangitis / cholangiohepatitis especially if previous or current liver enzymes elevations have been noted.

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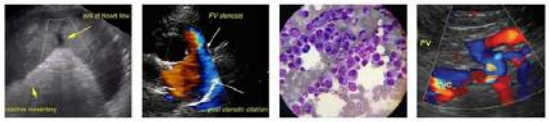

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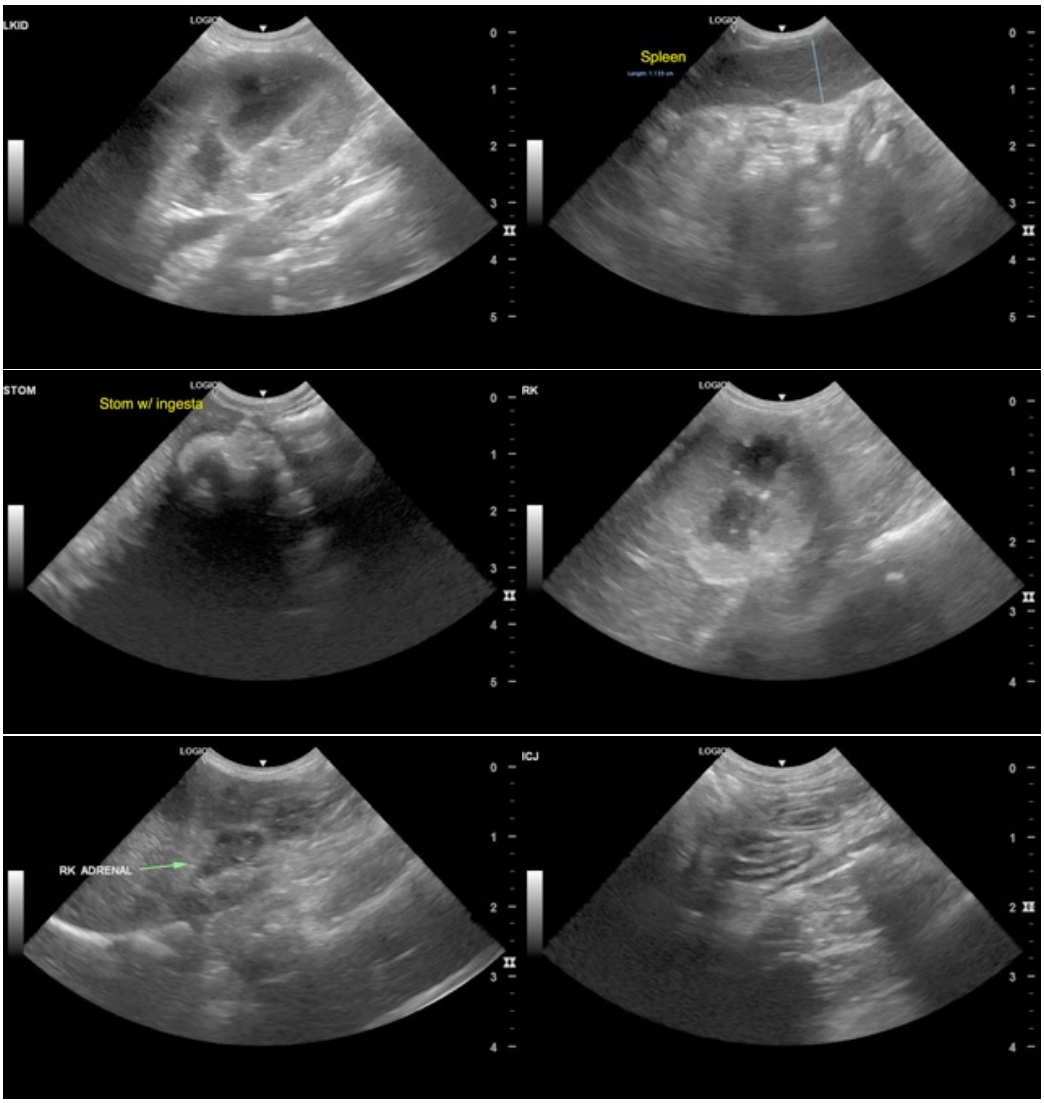
Given the lack of hepatic enzyme elevations, the liver was non-specific. Considerations may include patient variant, reactive hepatopathy, inflammatory hepatobiliary process (given the minor common bile duct dilation), vacuolar hepatopathy, while the possibility of neoplasia cannot be definitively excluded. Assuming normal clotting status, hepatosplenic FNA for screening cytology using 25-gauge needle is recommended. Otherwise, no overt evidence of intraabdominal pathology as an obvious cause of the CBC abnormalities. Pending additional diagnostics (i.e., hepatosplenic sampling, FELV/FIV test, infectious disease serology, etc.), bone marrow assessment may be indicated.



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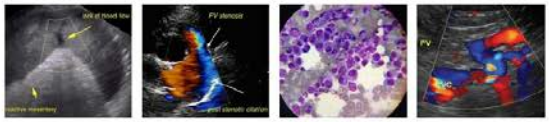

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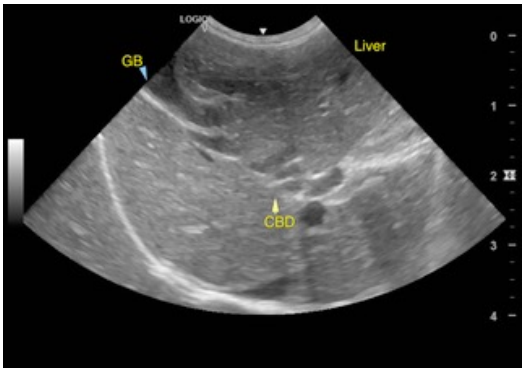

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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