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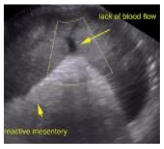

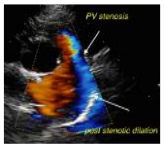

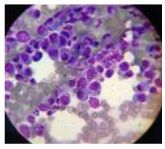
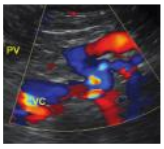

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1-800-838-4268 info@sonopath.com

PATIENT

Tiger Stoess

SPECIES

Feline

BREED

DSH

SEX

M/N

AGE

7

WEIGHT

2.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Belan

HOSPITAL NAME

Properties AH

REFERRING VET

Dr. Costa

INVOICE

14832

DATE

9/7/22

PRESENTING CLINICAL SIGNS

Emaciated lethargic with advanced dental disease
Abnormal PE/Chem/CBC/UA Results: Pending

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.

Both kidneys were enlarged in size with asymmetrical renal capsule contour exhibiting severe polycystic changes which disrupted or obliterated the majority of discernable corticomedullary parenchyma. Both kidneys exhibited bilateral mild pyelectasia. The left kidney measured 6.3 cm in length. The right kidney measured 6.6 cm in length.

Adrenal Glands

The bilateral adrenal glands were mildly prominent in size without overt evidence of neoplastic criteria. Patient variant with potential for mild stress hyperplasia is suspected. The left adrenal gland measured 0.54 cm. The right adrenal gland measured 0.55 cm.

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.

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. 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. Minor retained nonshadowing ingesta / chyme and minor luminal gas were present.

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.

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

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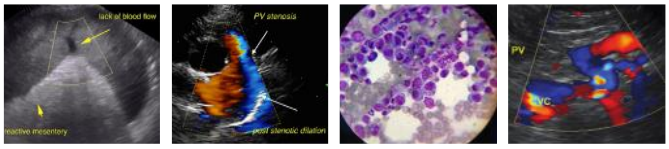

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Pancreas

The pancreas was normal in size with mild asymmetrical contour exhibiting mildly nonhomogeneous to hypoechoic parenchyma compared to adjacent mildly reactive peripancreatic omentum. Minor pancreatic duct dilation was present measuring 0.16 cm in diameter.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

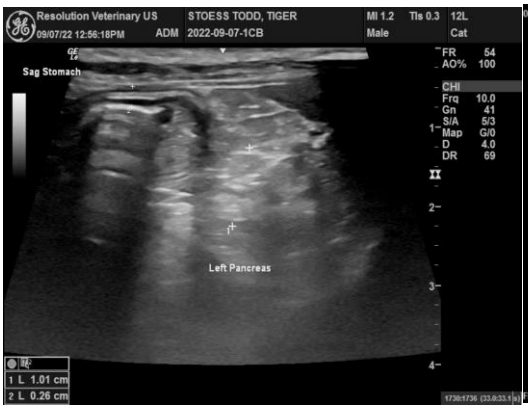
ULTRASONOGRAPHIC FINDINGS

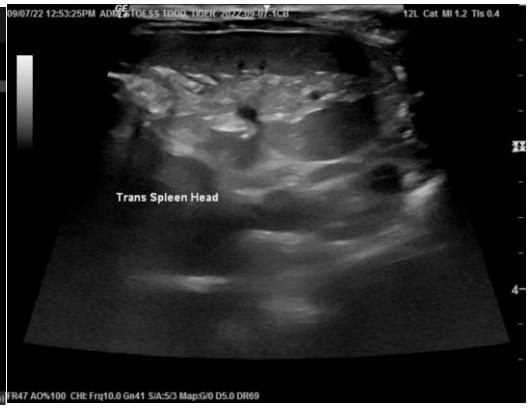
- Bilateral renomegaly exhibiting severe advanced polycystic kidney disease with loss of discernable corticomedullary parenchyma
- Potential concurrent low-grade chronic to chronic active pancreatitis
- Overtly normal gastrointestinal tract with minor retained gastric ingesta / chyme

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary finding of the kidneys is consistent with severe advanced polycystic kidney disease. Renal neoplasia is considered a less likely differential diagnosis. Given the degree of corticomedullary parenchymal loss, renal dysfunction is strongly suspected.

Correlation with a full CBC / Chemistry panel and full urinary workup including urinalysis, C/S, +/- UPC if evidence of proteinuria, is suggested. Assessment of systemic BP Is recommended. Pending full lab work and urinalysis, Spec fPL and/or full GI panel for further clarification of the pancreas, as well as assess for occult GI disease as a contributing factor could be considered. Three-view chest radiographs may be considered to rule out concurrent occult thoracic pathology as a contributing factor. A very guarded long-term prognosis, given the bilateral renal presentation and pending assessment of renal function, is warranted.





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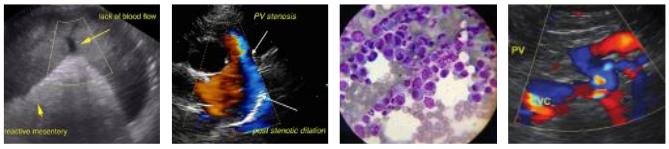

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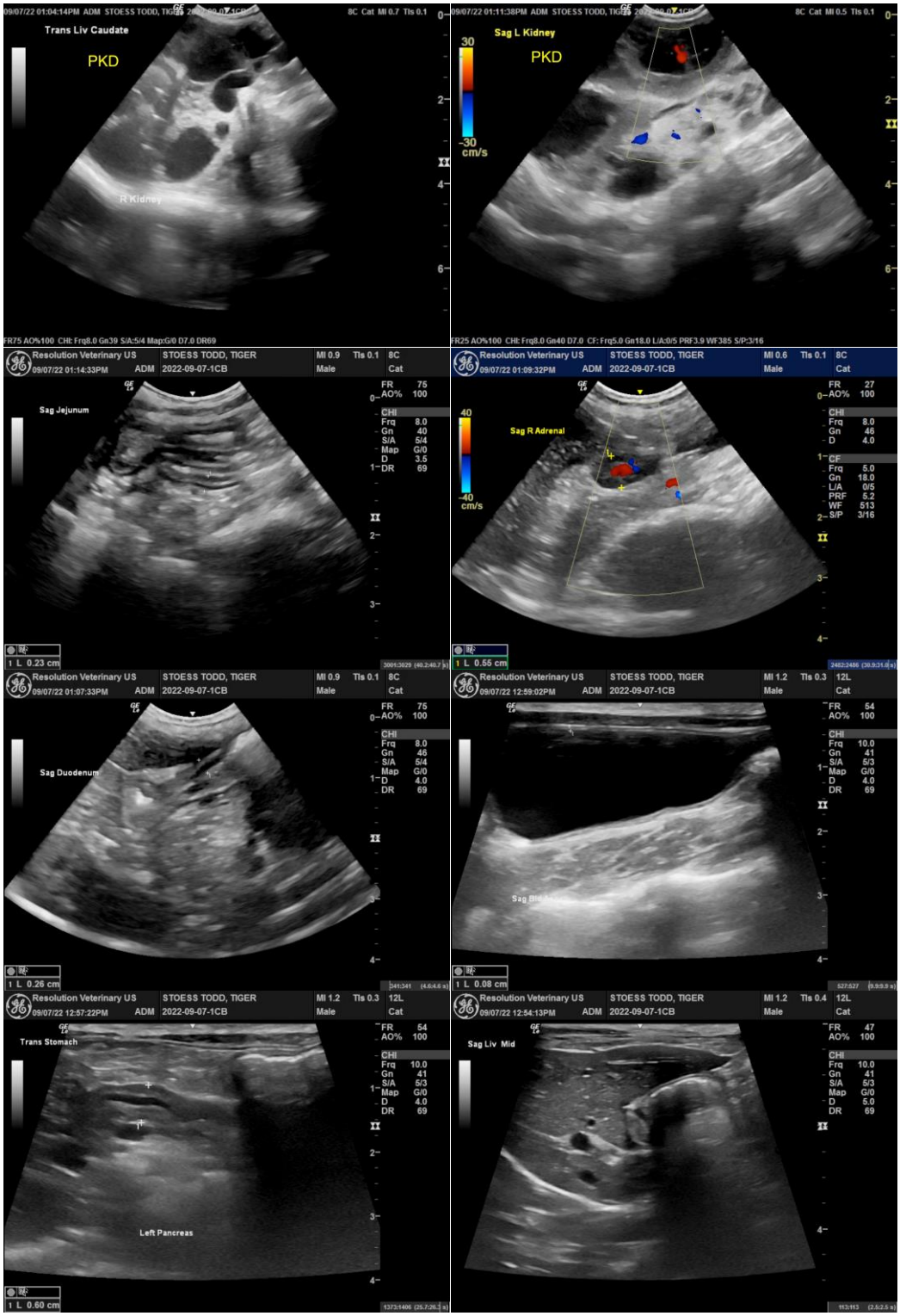

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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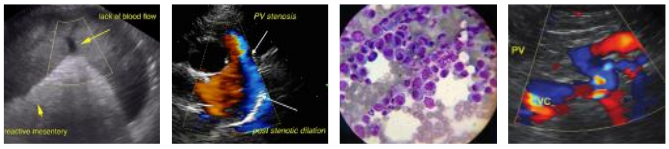

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com