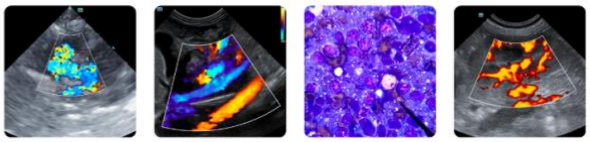

PATIENT

Princess Grace Winkelhaus

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

11

WEIGHT

8.6 lbs

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Desen Ertunc, DVM

HOSPITAL NAME

Humboldt VMG

REFERRING VET

Desen Ertunc, DVM

INVOICE

22712

DATE

3-18-26

PRESENTING CLINICAL SIGNS

- 2–3-week history of anorexia to hyporexia
- Initially was PU/PD, now resolved
- No improvement in appetite with Cerenia, SQF and Mirtazapine

Abnormal PE/Chem/CBC/UA Results: PE- mild progressive weight loss (2 Lbs in 1.5 years) CBC: WBC= 27.50 K/µL (2.87-17.02), Lymphocytes = 18.28 K/µL (0.92-6.88), Monocytes = 0.69 K/µL (0.05- 0.67), all other values WNL. Chem: DEXX SDMA= 21 µg/dL (0-14), Creatinine = 3.4 mg/dL (0.8-2.4), BUN= 47 mg/dL (16-36), Sodium = 172 mmol/L (150-165), ALT= 224 U/L (12-130), U/A: U.S.G.= 1.013, otherwise inactive sediment with no growth on culture Catalyst Pancreatic Lipase= 1.5 U/L (0-4.4)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Full urinary bladder with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident. Normal appearance of the trigone area, proximal urethra, and iliac blood vessels. Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Small left kidney (2.6 cm). Normal size of right kidney (3.1 cm). Both with increased echogenic appearance, loss of cortico-medullary differentiation, and normal pelvis and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern evident in both kidneys.

Adrenal Glands

Left adrenal gland is of normal shape, echogenic appearance, size (1.6 cm in length x 0.29 cm in width), position, and appearance of the visible peri-renal vasculature. Right adrenal gland not visualized.

Spleen

Enlarged (measuring 1.2 cm in width) but maintaining a normal echogenic appearance, a smooth homogenous parenchyma, but with a scalloped appearance of the capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.

Gallbladder

Small, containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen. Normal thickness of the small intestine (up to 0.3 cm) with no loss of layering, but a segmental increase in the muscularis: mucosa ratio, normal peristaltic activity, and no distension of the lumen.

Pancreas

Normal size and echogenic appearance. Regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas. Focal parenchymal, hypoechogenic nodule in the left lobe (measuring approximately 0.2 cm in size). Left pancreas measures 0.4 cm in width.

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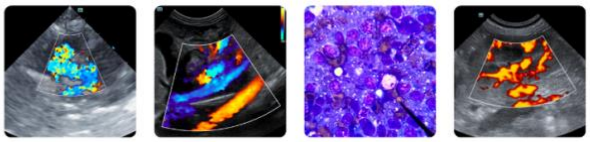

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Educational Teleconsultation Services™

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Free Abdomen

Enlarged mesenteric lymph nodes (measuring up to 0.6 x 1.5 cm in size) with a hypoechogenic appearance, but maintaining a normal shape. Hyperechoic appearance of the mesentery surrounding the lymph nodes. No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Renal disease
- Splenomegaly
- Mesenteric lymphadenomegaly
- Enteropathy
- Pancreatic nodule

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- The appearance of the kidneys is consistent with chronic kidney disease, and in line with laboratory abnormalities.
- Etiologies for both the splenomegaly and the mesenteric lymphadenomegaly would be reactive hyperplasia with inflammatory reaction, and infiltrative neoplasia possible differential diagnoses.
- Etiologies for the enteropathy would be parasitic enteritis, dietary indiscretion, and inflammatory bowel disease, with emerging lymphoma an important differential diagnosis.
- A less likely etiology for the pancreatic nodule would be an incidental nodular hyperplasia.
- Further assessment of the renal disease would be blood pressure and UPC. Initial further assessment would be fecal analysis, cobalamin and folate assay, and FNA cytology of the mesenteric lymph nodes, and spleen. Endoscopy of the upper GI tract could be considered if previous assessment fails to yield a specific diagnostic.
- Specific therapy would be dependent on an etiological diagnosis.

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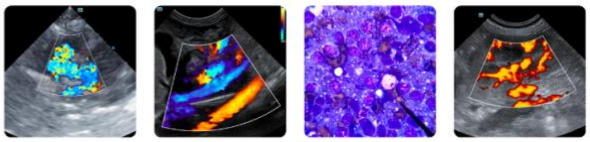

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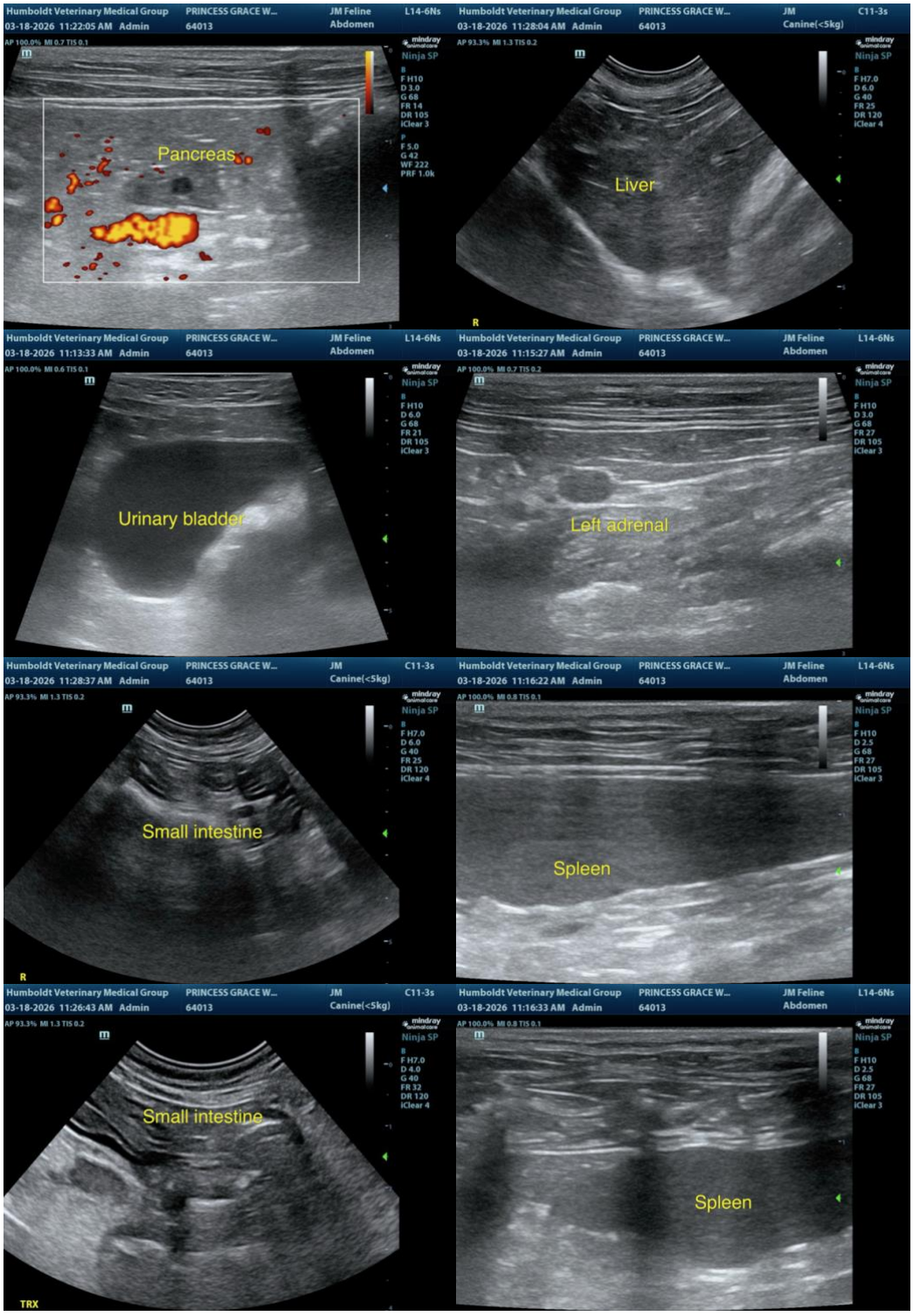

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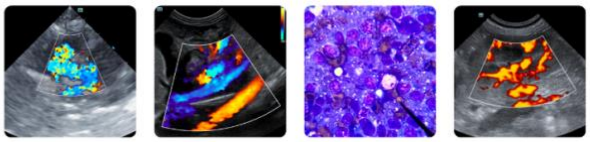

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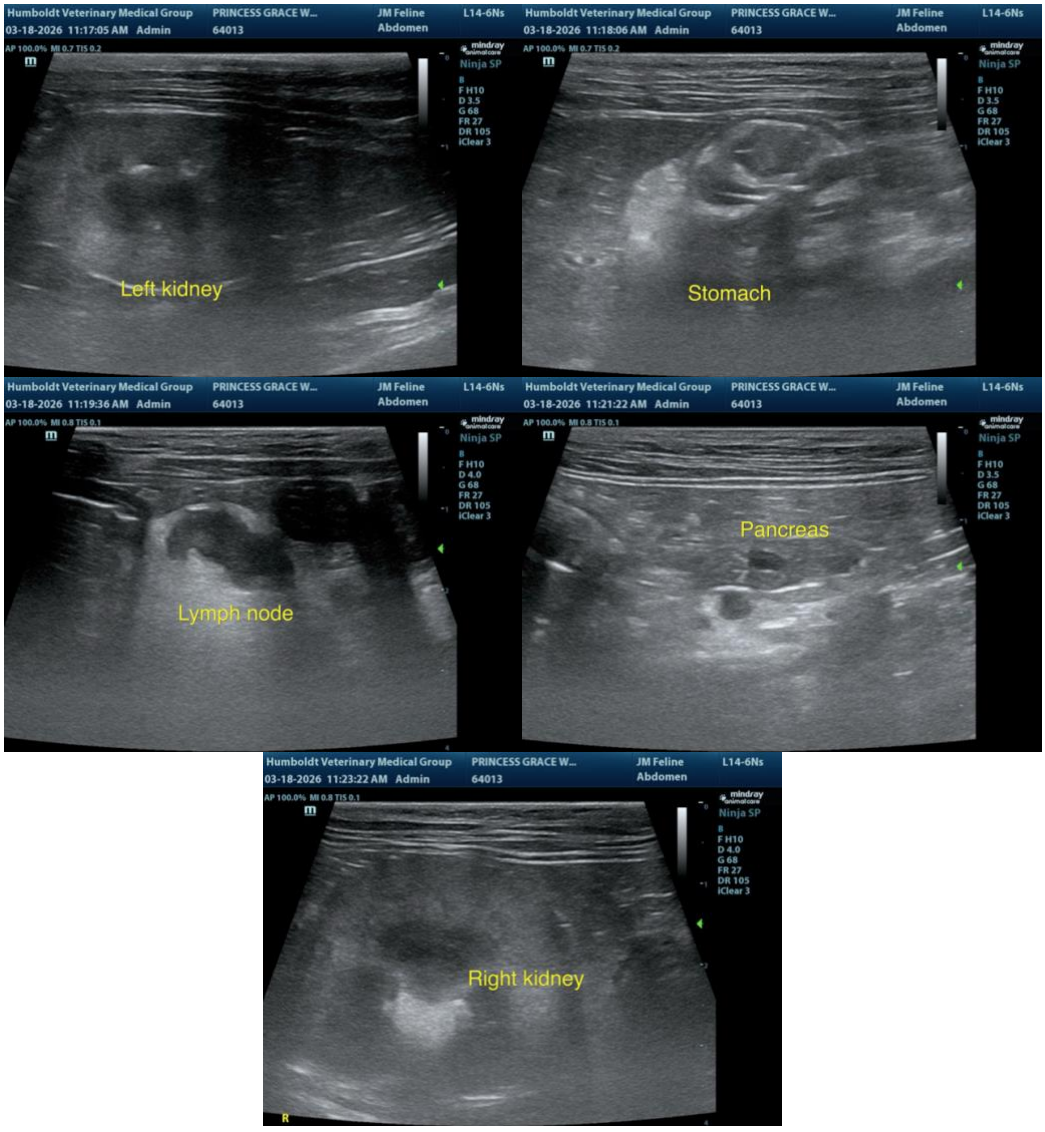

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)
info@sonopath.com