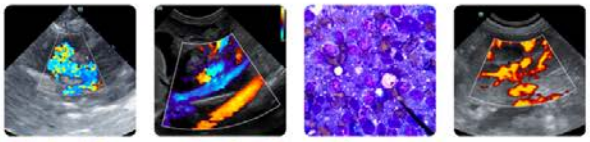

PATIENT

Frank Cameron

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

11

WEIGHT

5.38

INTERPRETED BY

Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY

Dr. Axenoff

HOSPITAL NAME

Wilvet South

REFERRING VET

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INVOICE

71506

DATE

11/2/25

PRESENTING CLINICAL SIGNS

10/31, Patient presented for 24 hour history of hiding, lethargy, and anorexia. A comprehensive diagnostic workup was performed and AFAST revealed free abdominal fluid surrounding left kidney and mid-abdomen, which prompted intake DVM to recommend first Sonopath AUS. Urinary bladder was firm, but expressible; intake DVM opted to perform decompressive cystocentesis after AUS. P was being med boarded over night (10/31 leading into 11/01) pending AUS report to see if FNA sampling of fluid or suspect mass was recommended. Overnight P did eat with appetite stimulation and had a bout of diarrhea. AM nurse noted that P had firm, unexpressible bladder and P was promptly hospitalized for urinary obstruction. 11/01 Day shift DVM placed indwelling urinary catheter with collections system. Recheck labs showed worsening azotemia. Urine removed after obstruction was golden yellow and concentrated, but not grossly hemorrhagic. When evaluating the placement radiographs during PM rounds, concerns for sublumbar mass arose due to ST opacity just ventral to the lumbar spine; rectal exam was unremarkable and no mass or lymphadenopathy was appreciated. New concerns are for left ureteral obstruction or sublumbar mass being underlying etiology for azotemia with left perirenal FAF and adequately concentrated urine. O elected to submit targeted ultrasound for additional answers.

Abnormal PE/Chem/CBC/UA Results: See below diagnostics: CHEM17: Glucose 167, Creatinine 3.5, BUN 37, all other wnl CBC: Neutrophils 11.27 (elevated), Monocytes 1.66 (elevated), Platelets 149 (low) Ultrasound (FASTSCAN): Scant amount of free abdominal fluid in mid-abdominal region caudal to left kidney, full anechoic urinary bladder with hyperechoic suspended debris, abnormal mass caudal to left kidney suspect LN. Patient very tense during FAST scan- rec sedation and complete diagnostic US.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. A small amount of mineralized luminal sediment is present. There is also a small amount of free air noted within the bladder. The ureteral papillae, trigone and pelvic urethra (visible to 3.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. There is a linear hollow structure noted in the region of the trigone, consistent with a urinary catheter.

The left kidney is of normal size with an increased cortex to medulla ratio and mildly decreased corticomedullary differentiation. There is nephrolithiasis noted within the pelvis. The proximal ureter is dilated to 2.6 mm and can be traced 1.0 cm from the kidney. An obstruction is not observed within the ureter. The right kidney measures 4.7 cm in length.

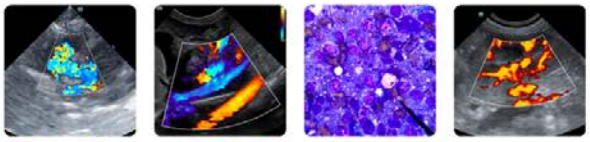
The right kidney exhibits an increased cortex to medulla ratio with mildly decreased corticomedullary differentiation. There is trace pyelectasia present as well as nephrolithiasis, unchanged form the images on October 31st. The left kidney measures 4.2 cm in length.

Adrenal Glands

The adrenal glands are not distinctly visualized, but the regions appear unremarkable.

Spleen

The spleen is of appropriate size (9.6 mm) and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. Thickness at the splenic hilus is normal.



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Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is moderately distended with ingesta. The gastric wall has normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness with intact wall layering. The ileocecal junction.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is focal free fluid present within the retroperitoneal space. The associated omentum and intra-abdominal fat are hyperechoic. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

There are 32 cine loops included of the sublumbar region, which include images of the hyperechoic hazy perinephric fat and effusion. There are no masses or other lesions noted within the sublumbar space.

PRIMARY FINDINGS

- Progression to left hydronephrosis with dilated proximal ureter, along with steatitis and retroperitoneal effusion (see attached photo), stable chronic changes and nephrolithiasis
- Unchanged right kidney, with chronic changes, nephrolithiasis, and trace pyelectasia
- Moderately distended bladder with some mineralized sediment / sand. There is also free air within the bladder, likely secondary to catheterization.
- No mass observed within the clips of the sub-lumbar space, however there is inflamed retroperitoneal fat and effusion (which may have created a radiographic abnormality)
- Otherwise unremarkable abdomen

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I was not able to visualize a nephrolith or other obstructive lesion within the ureter - based on the history, I suspect that there is one present more distally, or possibly a nephrolith or clot was recently flushed via the current fluid therapy. Tracing the ureter to the bladder, using color Doppler to

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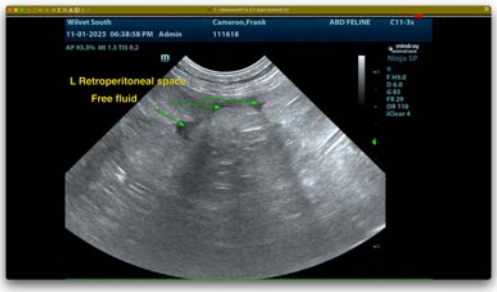
differentiate it from blood vessels, could be attempted but would likely require heavy sedation. Continuing with aggressive diuresis along with supportive care such as analgesia and appetite stimulants could be attempted. If there is not clinical improvement within 24-48 hours of diuresis, then stenting or subcutaneous ureteral bypass (SUB) is recommended. Alternately a nephrectomy could be considered.



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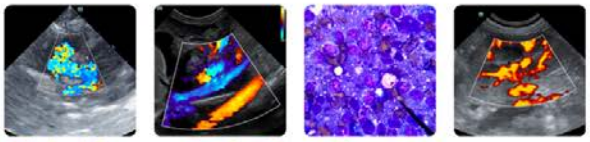

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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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.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com