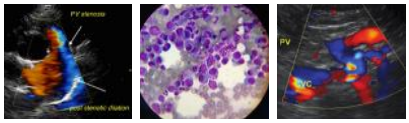
IMAGING PERFORMED BY

IntraPet.com



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DATE

10/28/21

PATIENT

King Taylor

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10/1/2020

WEIGHT

12.7 Pounds

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Eastern AH

REFERRING VET

Dr. Sole

INVOICE

14038

PRESENTING CLINICAL SIGNS

History: Chronic weekly vomiting 2-3 months with acute increase to hourly for 24 hours; Lethargy. Urine Specific Gravity 1.050

Current Medications: Cerenia Injection 10-26.
Lab Results: Mild SDMA elevation, mild glucose elevation. CBC wnl; RBCs on u/a- cysto, suspect sampling.
Radiographs: Unilateral renomegaly on radiographs with likely renal stones, possible changes to small intestine.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: IV sedative (domitore 0.1ml / torb 0.1ml) utilized for AUS
Stat Report: not requested

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. 2-3 small aggregates of mineralized sand (versus tiny calculi) are observed near the urinary bladder neck. The remaining luminal contents are anechoic. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (3.43 cm in length); with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A cortical infarct is suspected at the caudolateral aspect. A 0.34 cm cortical cyst is observed at the lateral aspect. Hyperechoic shadowing foci are visualized. Trace pyelectasia is present (0.17 cm in the longitudinal plane). There is no evidence of hydroureter.

The right kidney is normal size (4.29 cm in length); with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A few small foci mineralizations are present. Moderate to severe pyelectasia (0.78 cm in the longitudinal plane) is seen as well caliectasis. The proximal ureter is visualized for approximately for 0.5 cm to 1.0 cm, after which it tapers and is no longer seen. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively normal in size (1.02 cm in width at the level of the hilus) with a slightly undulating medial contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative

pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic mostly gravity dependent debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. There is mild thickening of the submucosal layer in most segments. Discreet masses are not identified. The ileocecalcolic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. There is no evidence of obstruction.

Pancreas

The right limb of the pancreas is visible/prominent with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. Several prominent lymph nodes are observed in the cranial and mid abdominal cavity, the largest measuring 1.00 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern consistent with inflammatory bowel disease
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral chronic renal changes with pyelectasia, more severe on the right. Non-obsructive nephrolithiasis. Left cortical infarct

Secondary Findings

- Urinary bladder sand versus tiny calculi

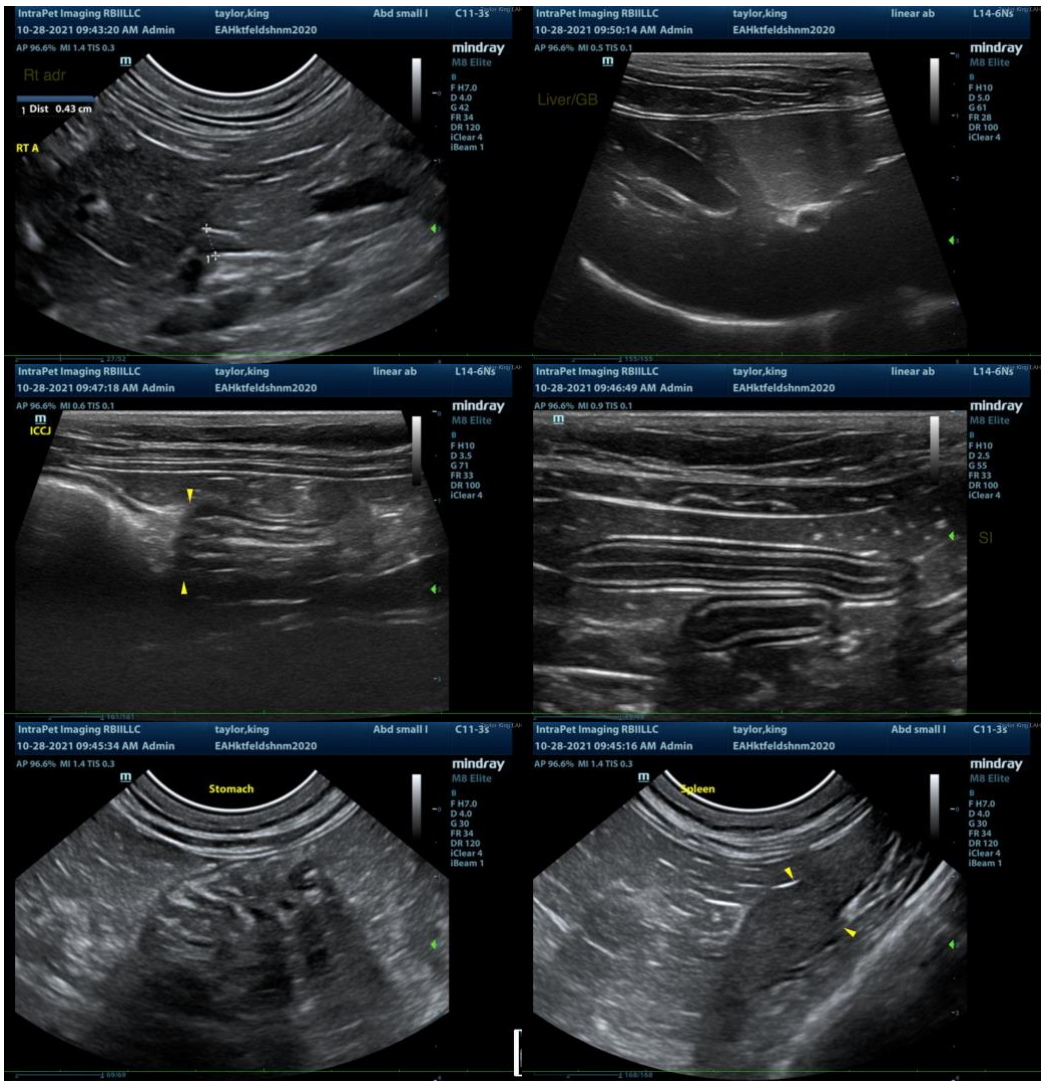
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

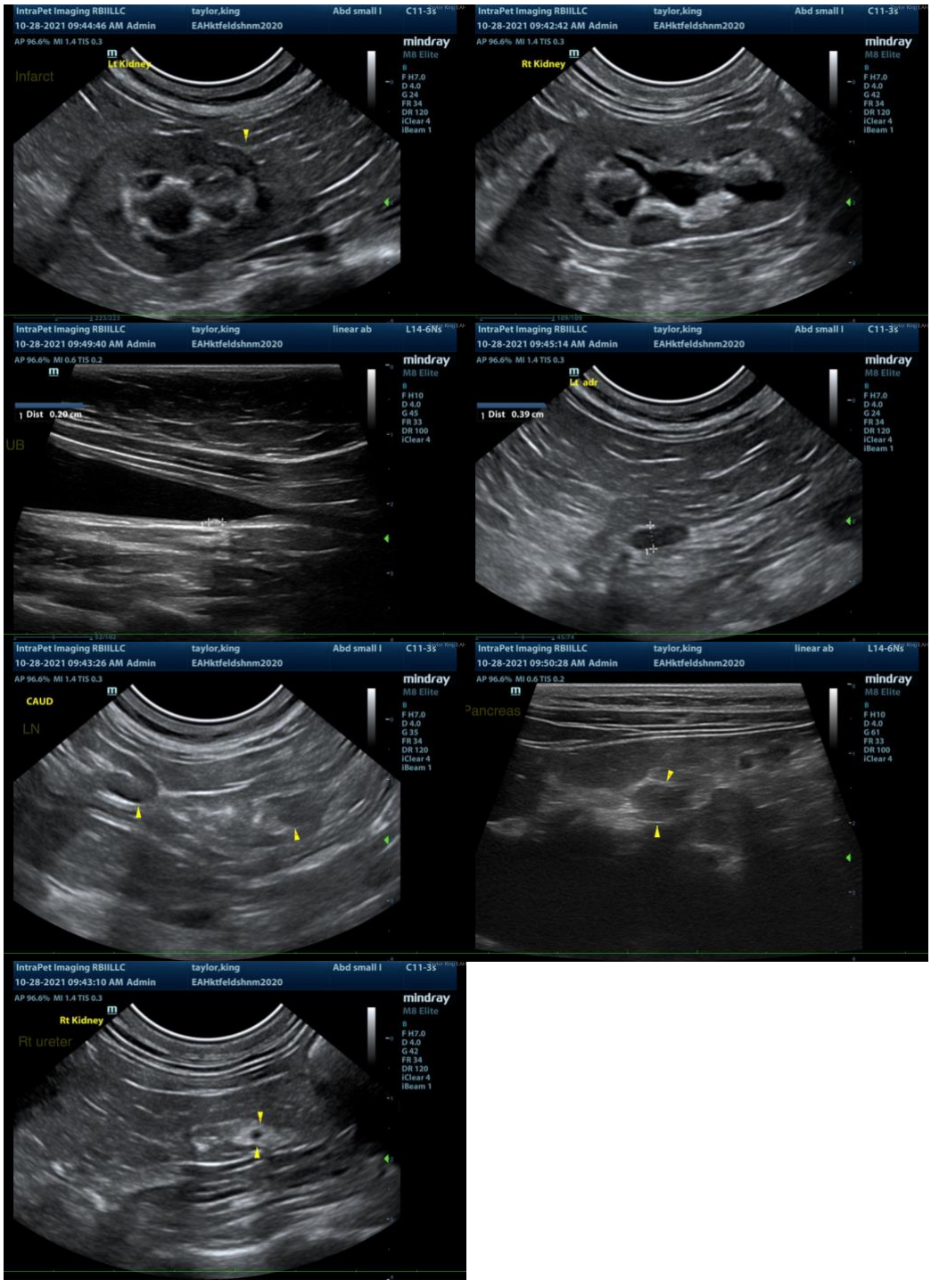
The following diagnostic/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia
3. A 6-week limited antigen diet trial to assess for food allergies

4. Also consider heartworm antigen and antibody testing as heartworm disease can be a cause of chronic vomiting in cats.
5. Three-view thoracic radiographs are recommended to assess for occult esophageal disease.
6. If the above diagnostics/therapeutics are inconclusive, endoscopic or surgical gastrointestinal biopsies may be warranted.

- Given the renal changes, a urine culture and sensitivity is recommended.
- Regarding the mineralized urinary bladder debris, a recheck ultrasound is recommended in 2-3 months to assess for progression. In the meantime, consider increasing the patients' water consumption to reduce the risk of stone formation.





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.

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