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Clinical Sonography & Telecytology
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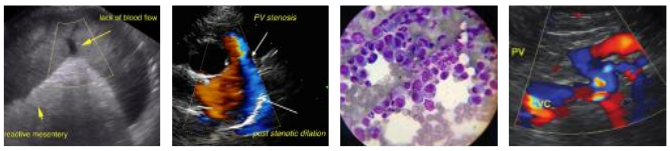

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1-800-838-4268 info@sonopath.com

PATIENT
Rollo Tinnelly

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
13 years

WEIGHT
3.23 kg

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

IMAGING PERFORMED BY
Dr. Jolee Stegemoller

HOSPITAL NAME
North Idaho Animal Hospital (VCA)

REFERRING VET
Dr. Jolee Stegemoller

INVOICE
10258

DATE
2/2/22

PRESENTING CLINICAL SIGNS

History: History: Presented 1/28 for evaluation of diabetes regulation. Owner is very concerned with weight loss, ravenous appetite, diarrhea, and inappropriate urination. Is on Prozinc insulin 2.5U q12h. Indoor only lifestyle. Sedated with butorphanol 0.2mg/kg, but patient still wanting to eat and walk around. Was not fasted. Meds: Prozinc 2.5 units Other diagnostics available (ie. Blood pressure, radiographs, etc): 1/28 hypertensive, but today, BP is WNL Primary reason for ultrasound referral: Looking for underlying disease causing weight loss concurrent with uncontrolled diabetes mellitus.

Abnormal PE/Chem/CBC/UA Results: Abnormal laboratory findings: 1/28: RBC 5.03, HCT 27.8%, HGB 8.4, MCV 55.3, Retic 50.8, WBC 36.63, Neu 27.05 with left shift, Mono 1.62, TT4 0.8, SDMA 12, Glu 534, Cre 1.3, Fructosamine 199, K 5.9, USG 1.030, pH 5, Glucosuria 1000mg/dL, quiet sediment, Cobalamin 150, Folate 24 Abnormal physical exam findings: BCS 1/9, very vocal and demanding for food, liquid brown diarrhea

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (4.92 cm in length); with a normal shape and smooth peripheral contours. The cortex is diffusely thickened. There is mild to moderate loss of corticomedullary distinction. Moderate pyelectasia is present (0.48 cm in the longitudinal plane). A cortical infarct is observed at the caudal pole. There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.45 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Moderate pyelectasia is present (0.46 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of the left adrenal gland is evaluated. No obvious pathology is observed.

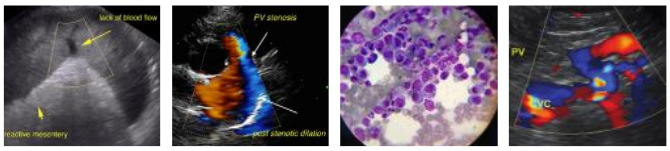
The right adrenal gland is mildly enlarged (0.48 cm cranial; 0.71 cm caudal; 1.33 cm length), with a normal shape and smooth peripheral contours. The parenchyma is homogenous with normal glandular detail. Surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.59 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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

Gastrointestinal

The gastric lumen is distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is diffusely distended with chyme. The small intestinal wall is normal to moderately thickened (up to 0.51 cm). In some segments, there is disruption in the normal 1:3 muscularis to mucosal ratio, with a greater than 1: 1 ratio in some regions. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The pancreas is largely obscured by the gastric and bowel distention. The visualized portion of the left limb appears enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. The pancreatic duct is borderline dilated (0.23 cm in diameter).

Free Abdomen

Trace free fluid is observed.

Lymph Nodes

At least one prominent lymph node (0.61 cm), is visualized. Larger nodes are suspected but are obscured by the chyme-distended bowel.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel changes consistent with severe inflammatory bowel disease or emerging lymphoma.
- Suspected abdominal lymphadenopathy.
- The pancreatic changes are suggestive of chronic pancreatitis with age-related remodeling +/- fibrosis.
- The trace ascites is likely secondary to bowel pathology.
- The hepatic parenchymal changes could be consistent with vacuolar hepatopathy (i.e., secondary to diabetes mellites), hepatic lipidosis, inflammatory disease or infiltrative neoplasia (i.e., lymphoma).

Secondary Findings

- The mild right adrenomegaly may be a normal variant for this patient, or may be secondary to stress, hyperplasia or emerging neoplasia.
- Bilateral age-related renal changes with pyelectasia and a left cortical infarct.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the pyelectasia, a urine culture and sensitivity is recommended.
- Given the bowel changes, endoscopic or surgical gastrointestinal biopsies would be necessary for further evaluation. Surgical biopsies are more likely to yield a definitive diagnosis, as all areas of bowel can be accessed with this approach.

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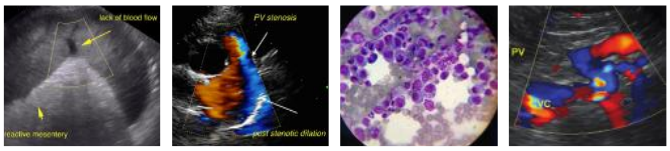

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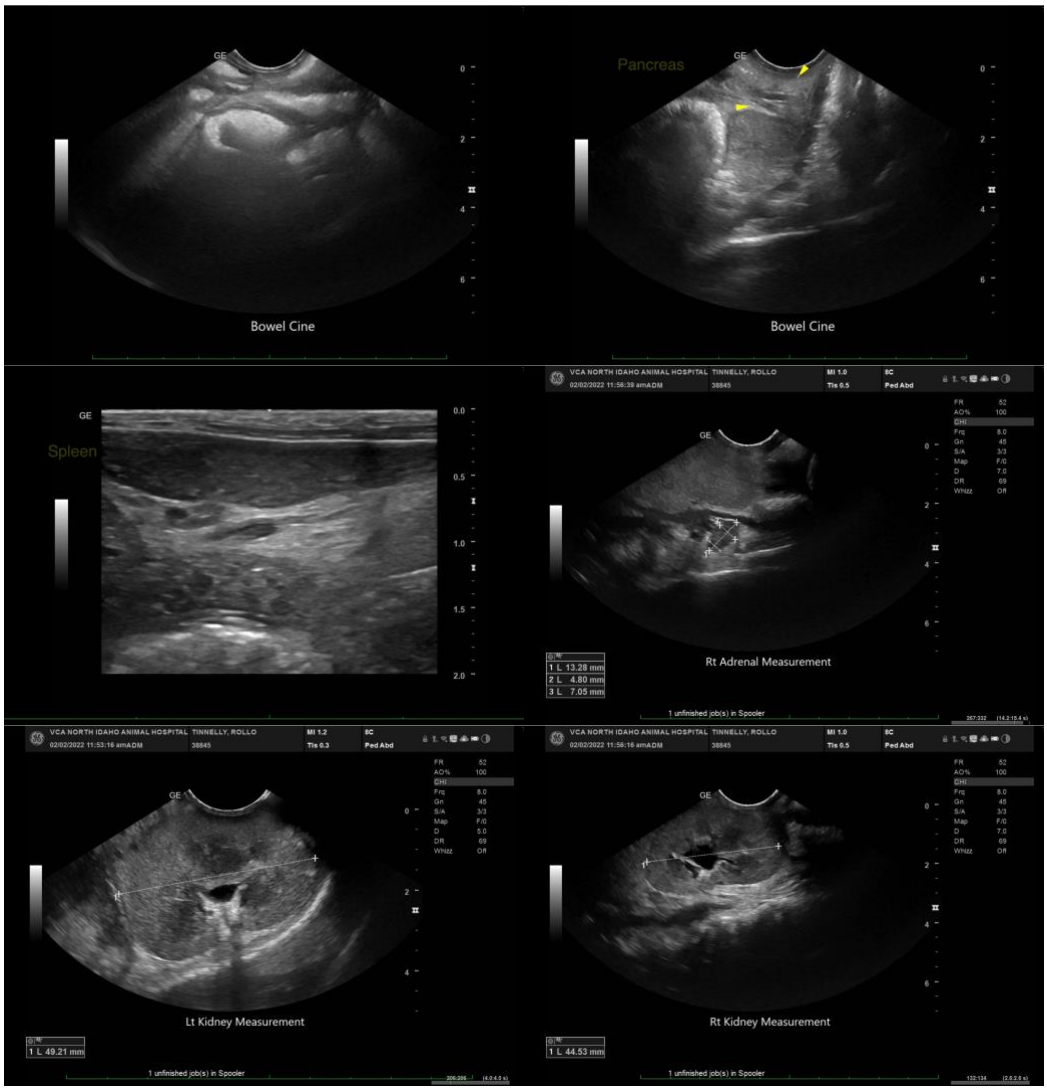
- Three-view thoracic radiographs should be performed prior to anesthesia, particularly given the patient's age and metabolic status.
- Given the presence of hypocobalaminemia, B^{12} supplementation is recommended.
- Also consider empirical treatment for small intestinal bacterial overgrowth with a 4-week course of Tylosin or metronidazole.
- Consider a fine-needle aspirate of the liver if clotting status is appropriate



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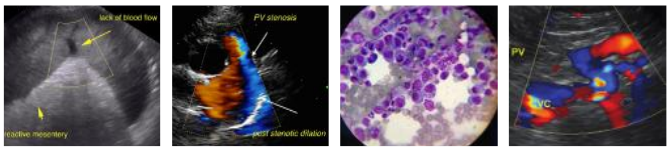

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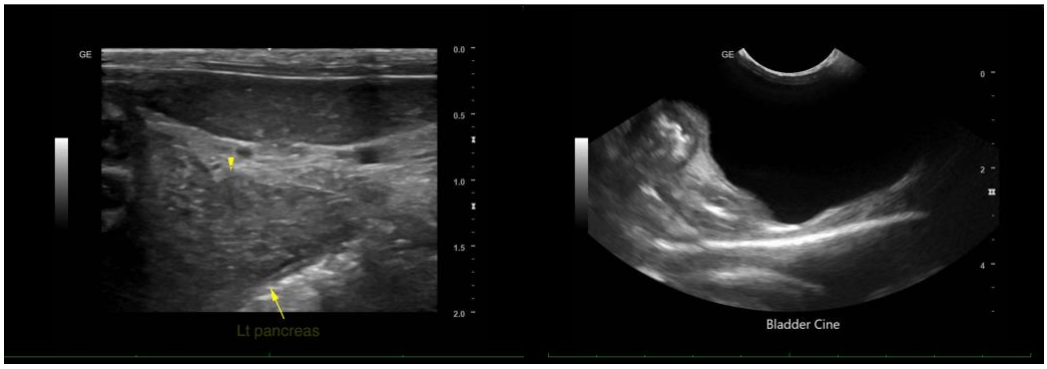

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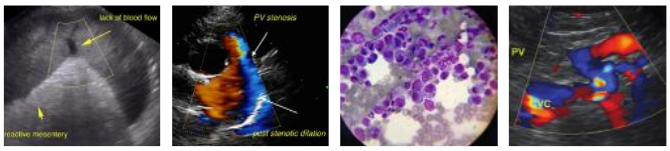

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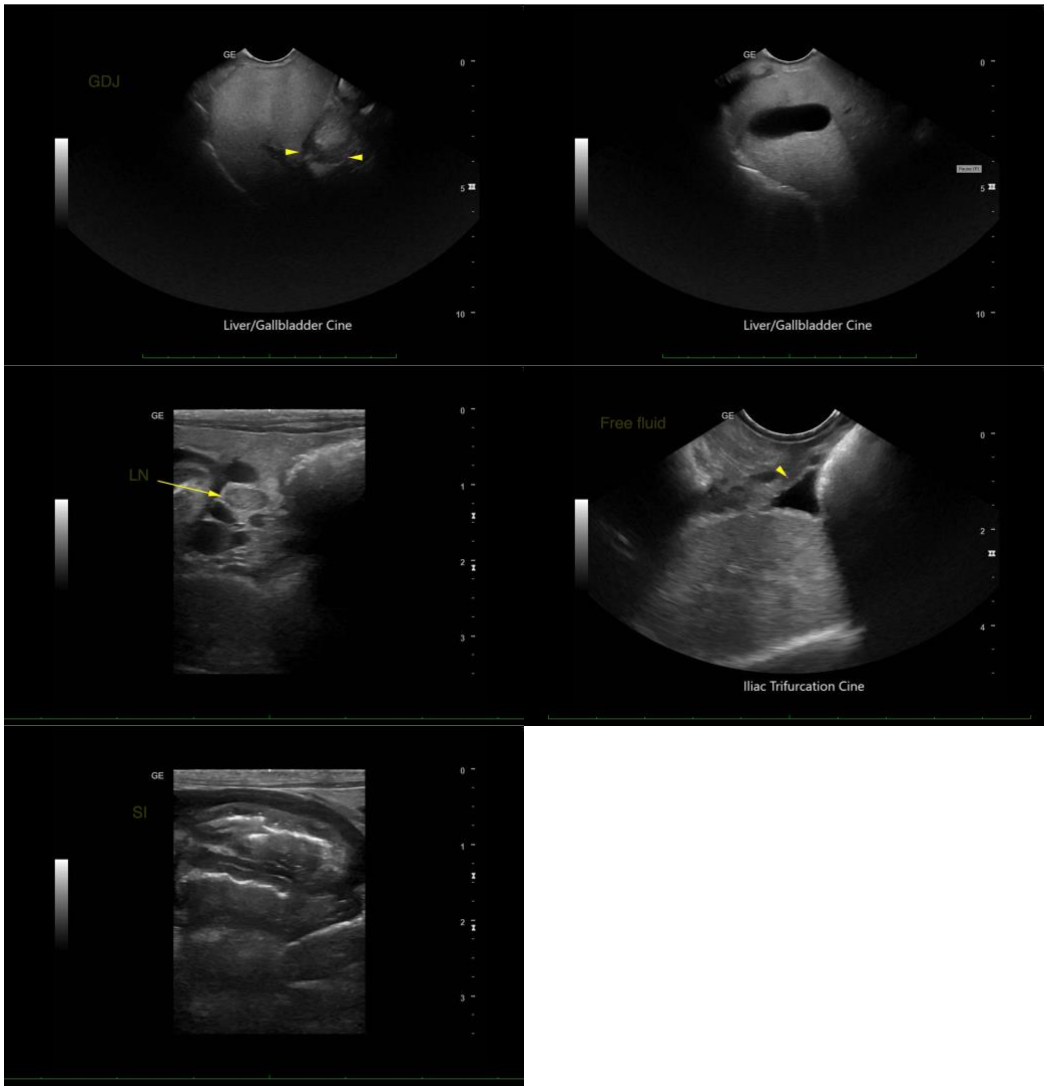

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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