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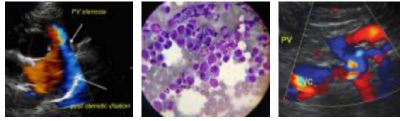

SonoPath
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DATE
1/11/22

PATIENT
Ritchie Martincheck

SPECIES
Feline

BREED
Domestic shorthair

SEX
Male, neutered

AGE
1/9/2015

WEIGHT
13 lbs.

INTERPRETED BY
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Roper

INVOICE
12842

PRESENTING CLINICAL SIGNS

History: Presenting Complaint: Vomiting Date: 01-09-2022 Notes: Since yesterday P started vomiting and not being able to hold any food down. O has tried to give P food and seems interested but is not able to keep it down. Today P is very lethargic. O has not observed P urinate because O is usually gone during most of the day. P is a rescue. O has had P for about 2 years. P does not usually eat foreign material. No other past medical history Assessment: Problems: Lethargy, Vomiting DDX: Gastroenteritis vs Pancreatitis vs FB.
Current Medications: Buprenex, gabapentin, metoclopramide, terbutaline.
Lab Results: CBC normal. BUN is normal but creatinine is 3.6. Globulins 6.3. USG 1.020, inactive sediment, trace proteinuria.
Radiographs: 2 View bronchiole pattern in the chest, dilated small and large intestines with air opacity.
Recheck: Still has uniform dilation of SI and bronchiolar changes in the chest.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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 size (4.20 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is variably thickened and hyperechoic and there is poor corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.04 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is variably thickened and hyperechoic and there is poor corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

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

The right adrenal gland is normal in size (0.50 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.73 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 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 gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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 disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas
The pancreas is diffusely prominent to enlarged with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. the pancreatic duct is visible but not overtly dilated (0.12 cm in diameter).

Free Abdomen
There is no evidence of free fluid. Several prominent mesenteric and colic lymph nodes are visualized, the largest measuring 1.02 cm in length. The nodes are normal in shape and echogenicity. Surrounding mesentery is slightly hyperechoic.

ULTRASONOGRAPHIC FINDINGS
Primary Findings:

- The pancreatic changes are suggestive of chronic pancreatitis.
- Bowel pattern most consistent with inflammatory bowel disease with the potential for emerging lymphoma, although neoplasia is considered less likely at this time.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

Secondary Findings:

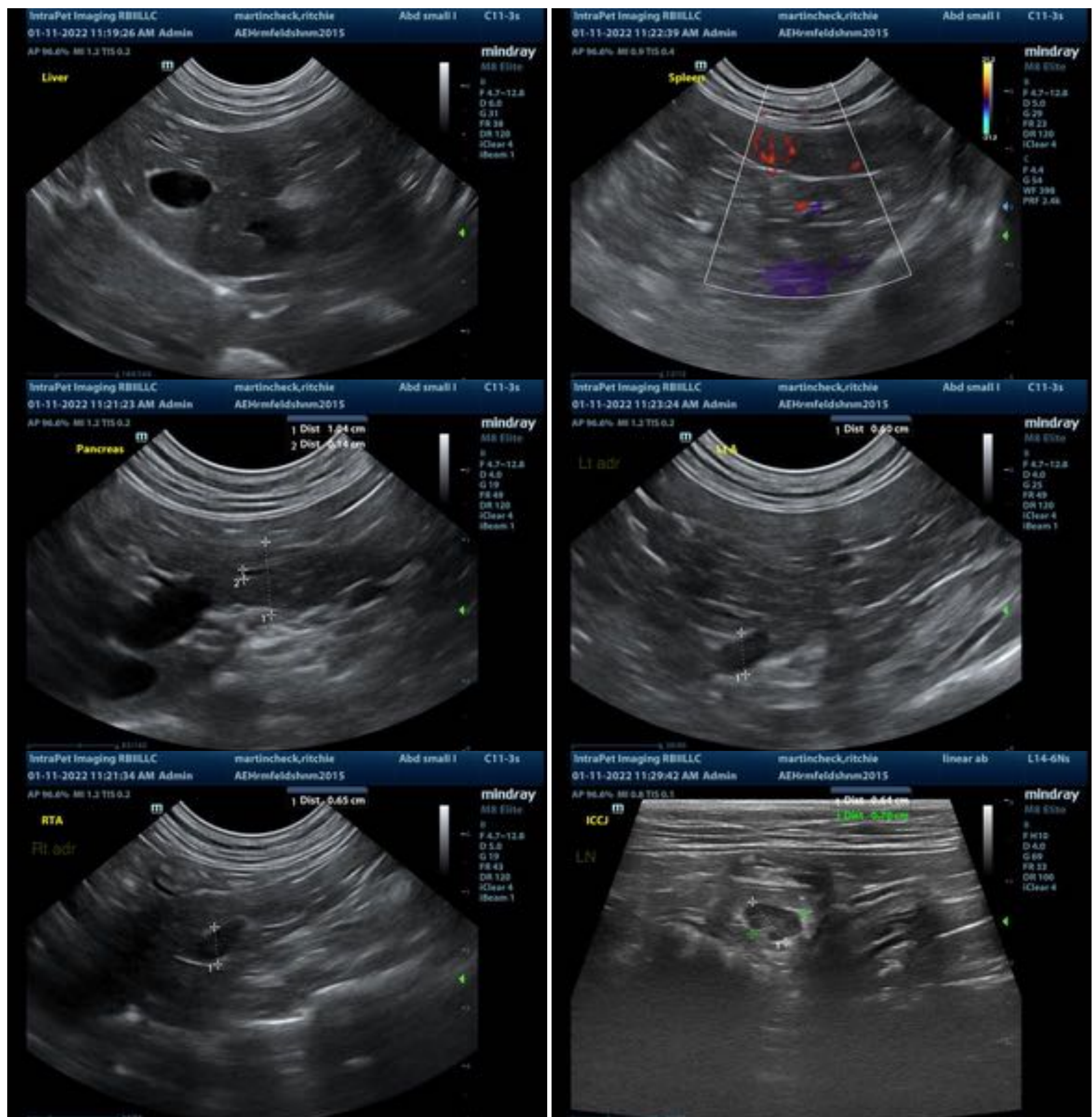
- Bilateral non-specific nephropathy.

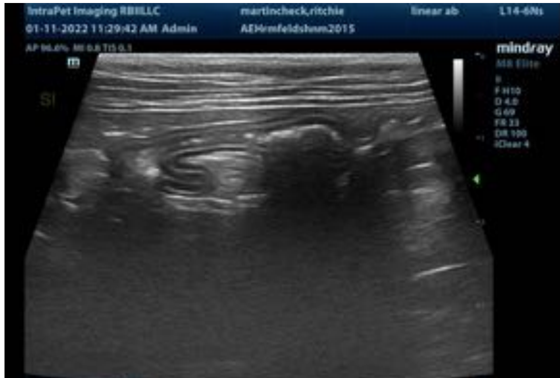
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS
- Given the GI signs, the following diagnostics are recommended:
    1. Malabsorption panel including serum cobalamin, folate, TLI and PLI.
    2. Fecal evaluation for ova and Giardia.
    3. Limited antigen diet trial (when patient is no longer vomiting).
    4. Ultimately, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.
- Regarding the azotemia and sonographic renal changes, consider the following:
    1. Urine culture and sensitivity.

2. UPC.

3. Baseline blood pressure measurement.

- While awaiting test results, supportive care for gastroenteritis/pancreatitis is recommended.

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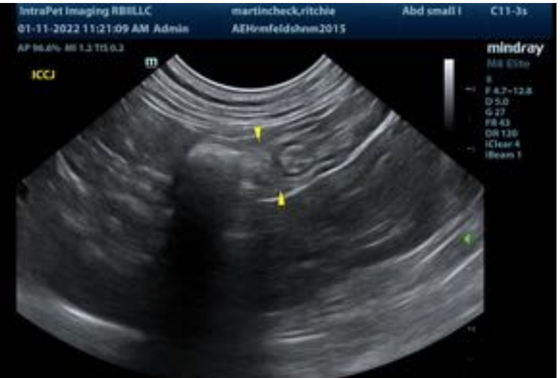
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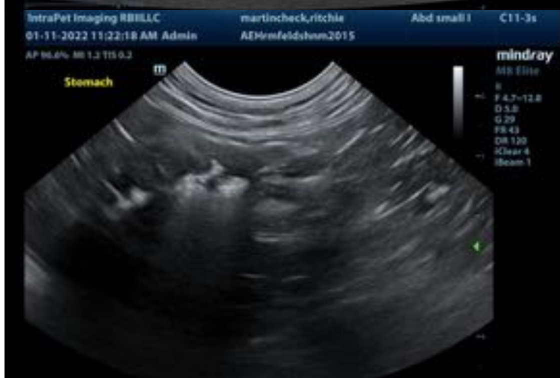
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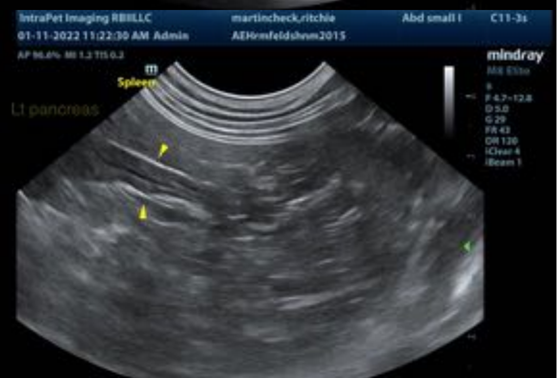
Stomach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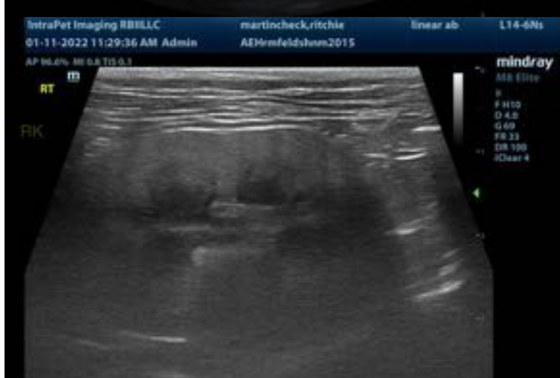
Spleen
Lt pancreas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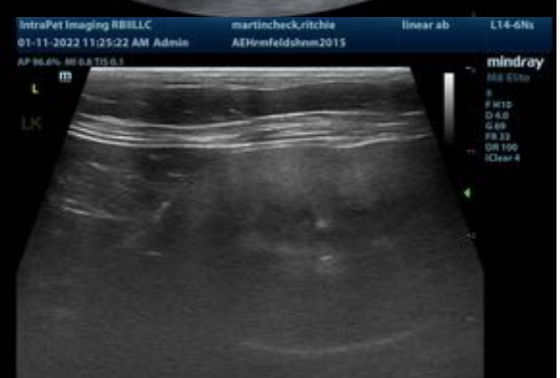
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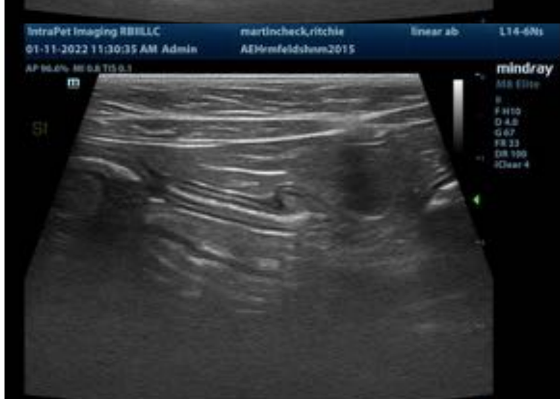
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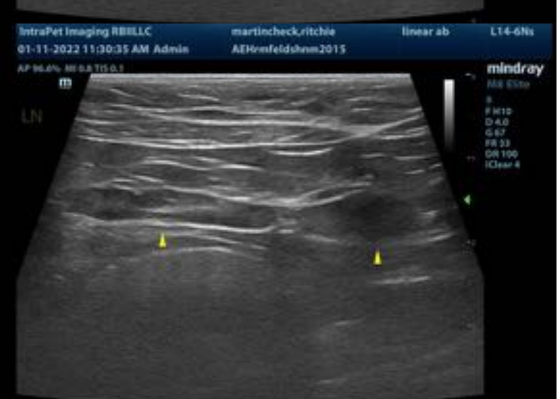
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)
Andrea.nicastro@sonopath.com