



PATIENT PRESENTING CLINICAL SIGNS

Severus Gabrielson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 years

WEIGHT

14 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Neuhaus

HOSPITAL NAME

Willamette VH

REFERRING VET

Dr. Neuhaus

INVOICE

12013

DATE

1.4.23

History: Vomiting and lethargic the 12/31. Hyporexia. Yesterday when the O got home from the hospital pt ur once in the box and only ate about a tablespoon of the GI food that was sent home. Today O didn't notice any ur production from the pt and today also only ate about a tablespoon of the GI food again. O brought pt in once again today because of the pts change in behavior since being home. Doesn't want to be around the O like normal and just acting more "sick" per the O. O concerned with pt not eating. Pt didn't give the Cerenia she was sent home with today.

Abnormal PE/Chem/CBC/UA Results/PE: MM pnk/sl tacky, crt >2, heart and lungs wnl on auscultation, abd soft, urinary bladder small and soft, ambulatory x 4, Inn wnl
Diagnostics: catogram rads (nsf), PCV/TS (30%/4.0), CBC (33% lymph 0.4 K L, eosin 0.02 L) Chem 17 (glu 200 H, ALT 133 H), electrolytes (K 3.1 L), U/A (SPG 1.050, pH 6.5, urine protein 30 mg/dL, no bacteria, no crystals, WBC <1/hpf, RBC <1/hpf)

Diagnostics performed at Wilvet South- catogram rads (nsf), PCV/TS (30%/4.0), CBC (33% lymph 0.4 K L, eosin 0.02 L) Chem 17 (glu 200 H, ALT 133 H), electrolytes (K 3.1 L), U/A (SPG 1.050, pH 6.5, urine protein 30 mg/dL, no bacteria, no crystals, WBC <1/hpf, RBC <1/hpf). Soft abdominal palpation, small soft urinary bladder, Gums mildly tachy.

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. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal size (3.83 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.15 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

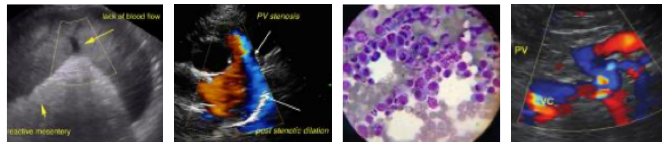
The region of the right adrenal gland is evaluated. No obvious pathology is observed.

Spleen

The spleen is normal in size (0.77 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.



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The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is minimally fluid-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 is normal to borderline thickened (up to 0.28 cm) 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 colonic wall is normal. There is no evidence of an obstructive pattern.

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Pancreas

The left of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

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Free Abdomen

There is no evidence of free fluid. A few prominent midabdominal lymph nodes are visualized (the largest measuring 0.68 cm in length). Surrounding mesentery is hyperechoic.

AGE

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ULTRASONOGRAPHIC FINDINGS

WEIGHT

14 lbs

Primary Findings

- The small intestinal wall changes are most consistent with inflammatory bowel disease. There is some potential for emerging lymphoma. However, 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.

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Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the patient's clinical signs and small intestinal wall changes, consider the following:
 1. Fecal evaluation for ova and Giardia
 2. GI panel including serum cobalamin and folate, TLI and PLI
 3. Consider initiation of a probiotic (when the patient is eating again).
 4. +/- GI biopsies (i.e., endoscopic or surgical). If biopsies are pursued, thoracic radiographs should be performed prior to anesthesia.

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- A T4/free T4 by equilibrium dialysis is also recommended (if not already performed).
- Given the proteinuria, a UPC is recommended

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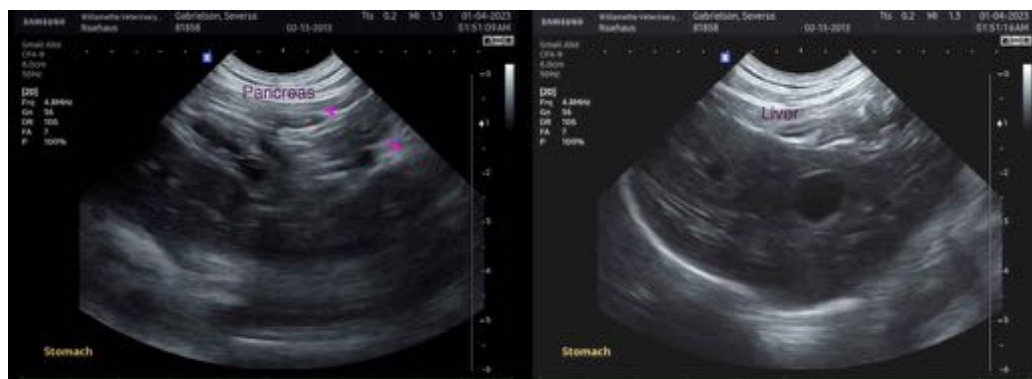
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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