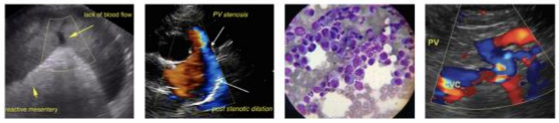


PATIENT

Tori Greer 53158

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

1/5/11

WEIGHT

6.0 Lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal*

HOSPITAL NAME

Charleston AS

REFERRING VET

Dr. Jamison

INVOICE

13304

DATE

1/7/22

PRESENTING CLINICAL SIGNS

History: Feral cat presented for 3-4 days of anorexia and weight loss.

TTDex 0.07 mL IM for sedation.

Evaluated teeth only one tooth and one partial tooth noted -- no need for a dental. Very dehydrated gave 100 mL SQ fluids. No microchip,microchipped and updated vaccines while under. Administered 0.3mL cerenia SQ, 0.2mL B12 SQ.

PE: Abnormals:

5-8% dehydrated noted by prolonged skin tent

underweight

GI: soft abdominal palpation (sedated), palpably thickened GI

missing all teeth but 204 (super erupted) and 304 (worn down, no pulp exposure). No inflammation noted that could be contributing to anorexia

ASA#: II

H and L WNL, HR and RR WNL, MM: pink CRT: less than 2 sec Attitude: QAR BCS: 3/9 Pain Scale: 0

EENT/oral: corneas clear, ears free of debris, no evidence of nasal discharge, throat palpates normally

Integument: no lesions noted

CVR: No cardiac murmurs or arrhythmias. Strong, synchronous femoral pulses. Normal lung sounds bilaterally.

MS: ambulatory x 4, thin musculature

CBC/Chem: mild leukocytosis 25.8 (3.9-19.0) characterized by mild neutrophilia and monocytosis.

slightly elevated SDMA 16 (0-14), low ALP 10 (12-59). Did not measure amylase, lipase or electrolytes.

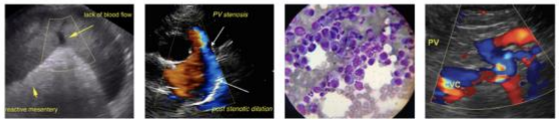
Radiographs: Lungs & heart unremarkable. Mineralization of distal ribs (old age changes). Round mineral opacity noted in the left mid abdomen, some view it looks like it is in the kidney, other views outside of the kidney. Possibly foreign material in GI overlying kidney in some views.

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 mildly to moderately distended. A small amount of suspended echogenic debris is observed within the lumen. 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 (3.62 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of



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corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.88 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate 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 (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and 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 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 normal in thickness. A small amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are visible/tortuous but not overtly dilated. The common bile duct can be followed to the level of the duodenal papilla. There is no evidence of intraluminal obstruction.

Gastrointestinal

The gastric lumen is distended with ingesta. 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 segmentally dilated with chyme. The small intestinal wall is normal to mildly thickened (up to 0.26 cm) with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely prominent in size with slightly irregular peripheral contours. The parenchyma is subtly 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 (0.20 cm in diameter).

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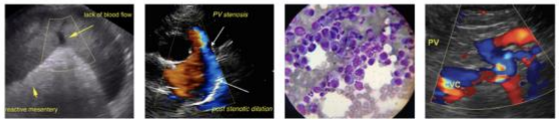

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Free Abdomen

Trace free fluid is observed. Several enlarged, irregular and hypoechoic mesenteric lymph nodes are visualized, the largest measuring 1.86 cm in length. A few cranial abdominal lymph nodes are also seen.

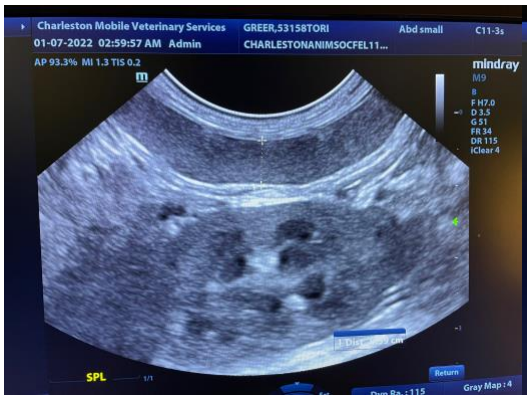
*Fine needle aspirates of the mesenteric lymph nodes were obtained without incident.

ULTRASONOGRAPHIC FINDINGS

- The pancreatic changes are consistent with chronic pancreatitis
- The abdominal lymphadenopathy could be consistent with infiltrative neoplasia (i.e., lymphoma), lymphoid hyperplasia or reactive lymphadenitis.
- The mild small intestinal wall thickening may be a normal variant for this patient or could be secondary to inflammatory bowel disease.
- Nonspecific bilateral age-related renal changes
- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If the lymph node cytology results are inconclusive, an abdominal exploratory with gastrointestinal and lymph node biopsies may be necessary to get a definitive diagnosis.
- A malabsorption panel, including serum cobalamin, folate, TLI and PLI as well as a fecal evaluation for ova and Giardia are recommended.



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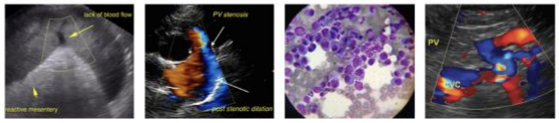

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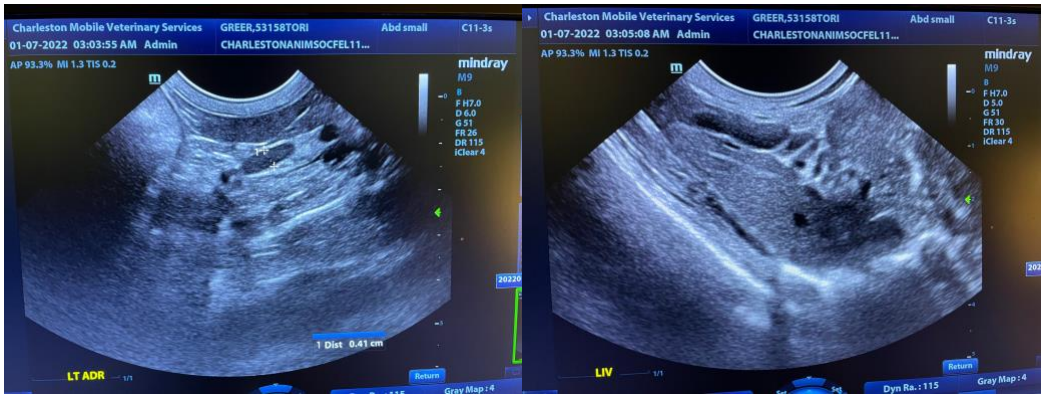

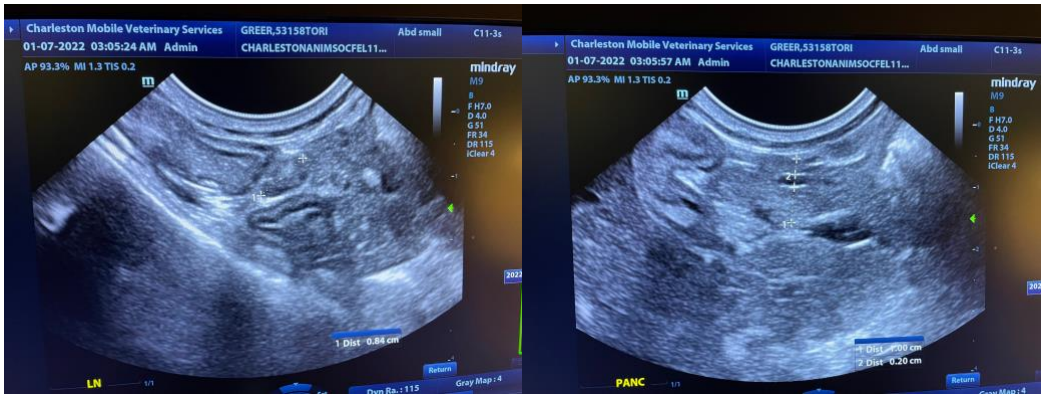

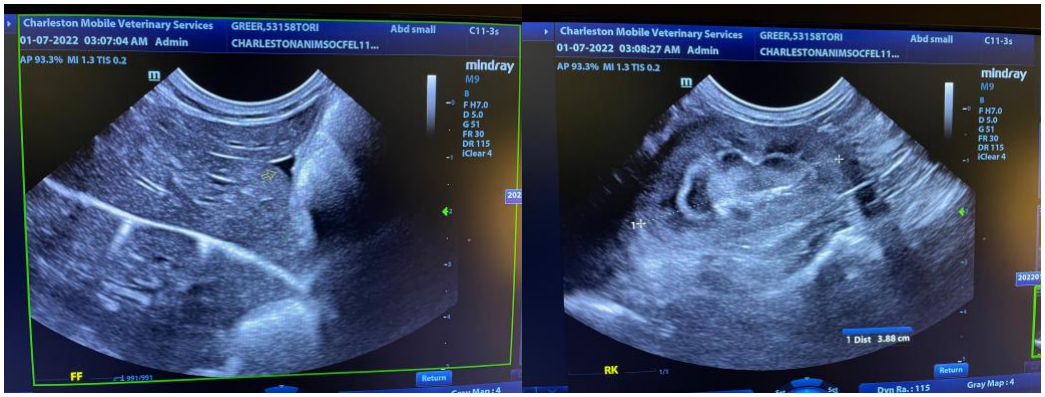

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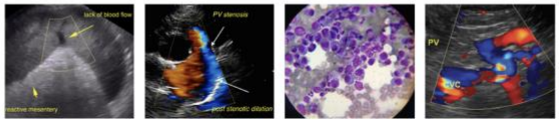

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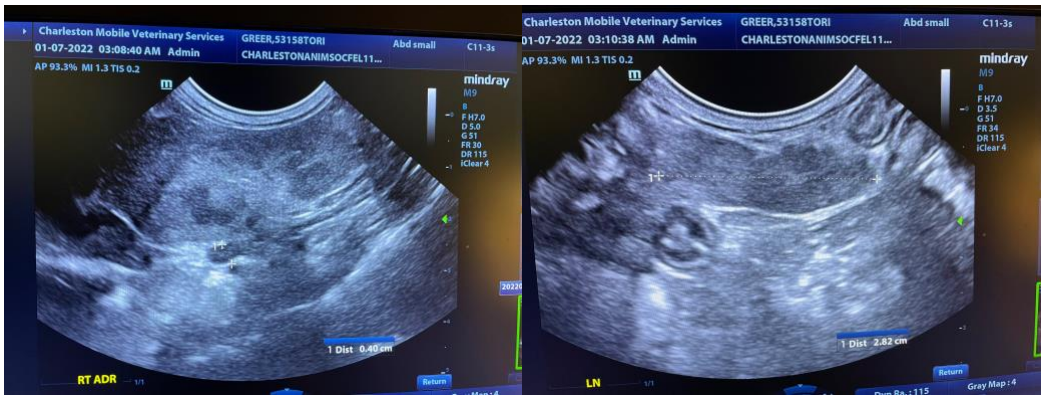

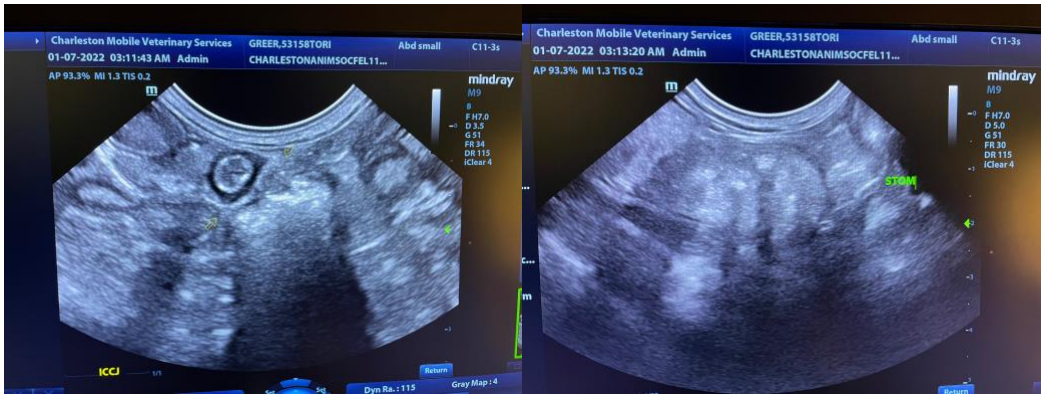

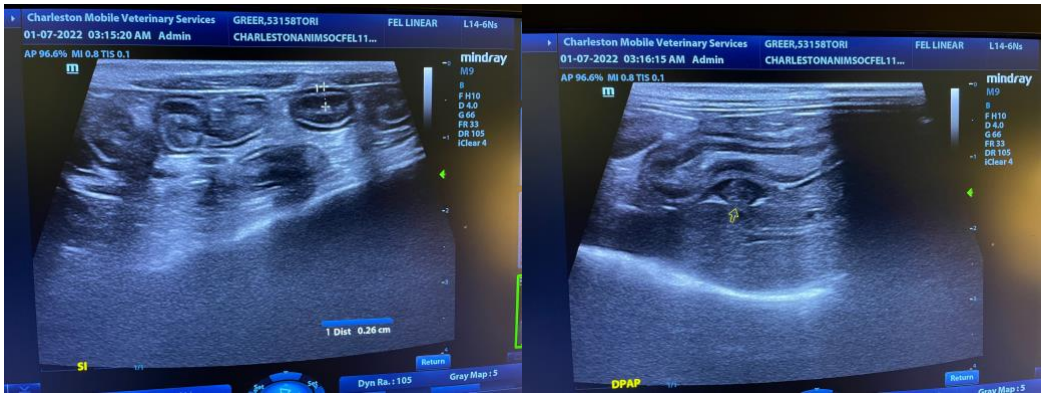

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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@CharlestonMobile.net