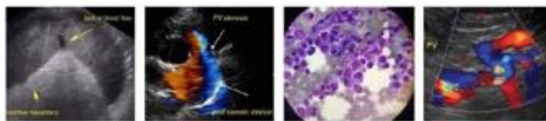


PATIENT

Lily Paul

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 years

WEIGHT

4.45 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Preston AC

REFERRING VET

Dr. Karafilov

INVOICE

11826

DATE

10.13.22

PRESENTING CLINICAL SIGNS

History: History of hematochezia/diarrhea at previous vet (~2 years ago) that responded positively to prednisolone - presumptive diagnosis of IBD -able to be gradually weaned off prednisolone in July 2022 - been managing on i/d stew & GI Biome stew since then -recently very picky with foods, 1 episode of vomiting & starting to vocalize when having bowel movements (similar to what was doing prior to prednisolone treatment) -owner noticed increased lethargy & head pressing in the last 1-2 weeks, also increased water intake but not increased urine output -on PE: has lost ~1kg since July 2022, mentation is QAR. m1 dehydration in spite of reported increased intake. abdomen palpates gassy/bloated. flinching on palpation of T-L spine meds: prednisolone 5mg q 24hr, restarted Oct 11

Abnormal PE/Chem/CBC/UA Results: -m1 normocytic normochromic non-regenerative anemia (Hct 28.5%; total RBCs are WNL) -m1 increased platelets: 620 K/uL -SDMA 17 (0-14) -potassium 7.7 (3.5-5.8)

ABDOMEN

Urinary System

The **urinary bladder** is 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 (3.76 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (3.79 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of the **adrenal glands** is evaluated. No obvious pathology is observed.

Spleen

The **spleen** is normal in size (0.85 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.

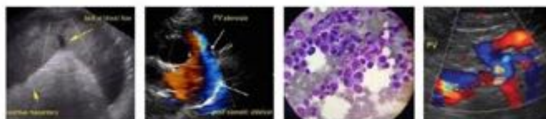
Liver

The **liver** is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic 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. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is not distended. The gastric wall is normal in thickness with a normal layering pattern. In one segment of small intestine, a small amount of soft, shadowing material is visualized. The small intestinal segments are otherwise empty. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal.



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Pancreas
The left limb of the **pancreas** is visible with normal curvilinear peripheral contours. The parenchyma is mildly hypoechoic 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.

Free Abdomen
The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The shadowing material within the small intestinal lumen likely represents transient foreign material (i.e., hair). There is no obvious evidence of an obstruction at the time of this study.

Secondary Findings

- Minor age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

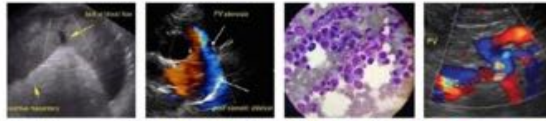
Given the neurologic signs, consider the following:

1. Baseline blood pressure measurement to assess for systemic hypertension.
2. T4/free T4 by equilibrium dialysis, if not already performed
3. Three-view thoracic radiographs to assess for occult neoplasia in the chest
4. Consultation with a board-certified neurologist for further evaluation (i.e., brain MRI +/- CFS tap)

Regarding the GI signs, consider the following:

1. A fecal evaluation for ova and Giardia
2. Malabsorption panel including serum cobalamin and folate, TLI and PLI
3. Hairball treatment (i.e., Laxatone)
4. Ultimately, GI biopsies, endoscopic or surgical may be necessary to get a definitive diagnosis. However, the patient's neurologic status should be assessed prior to performing GI biopsies.

Regarding the hyperkalemia, consider repeating the potassium level via jugular venipuncture and a vacutainer (if available) to reduce the risk of potential hemolysis artifact during sampling.



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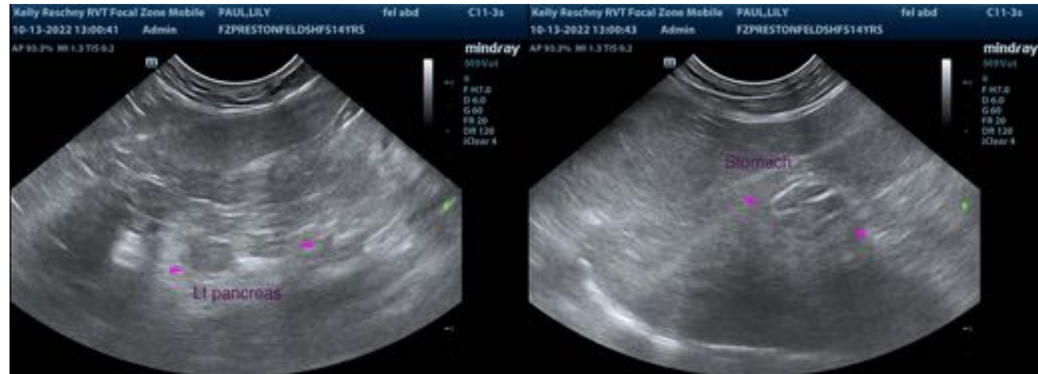
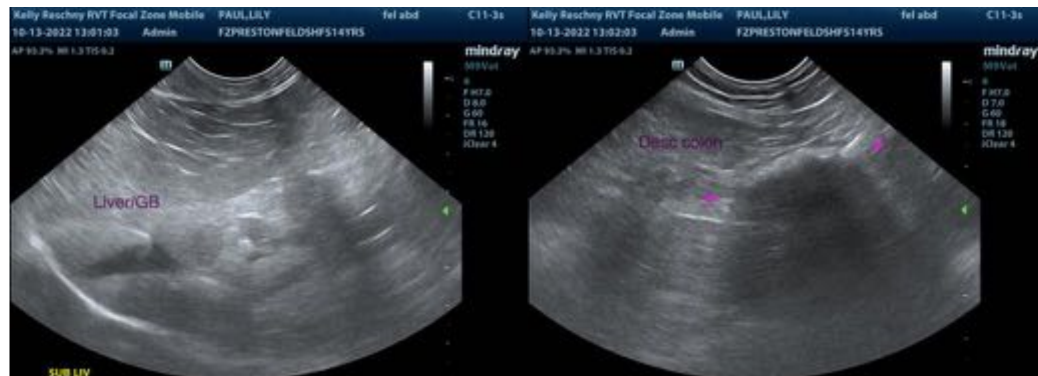
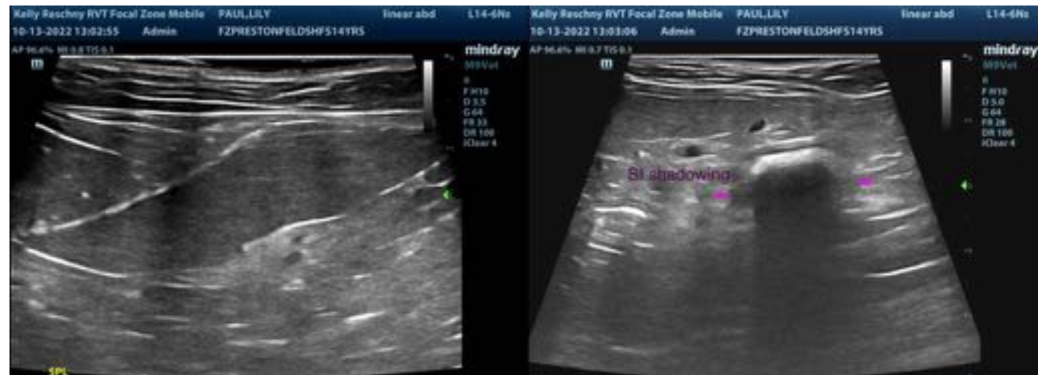
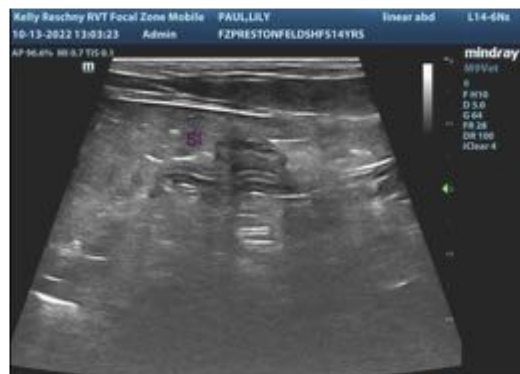
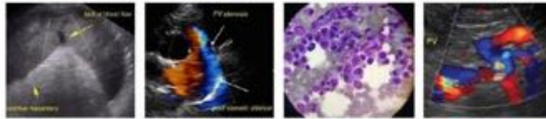








The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not



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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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com