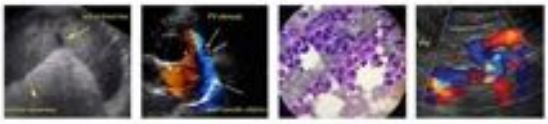


PATIENT

Zoe Schriber

SPECIES

Feline

BREED

Maine coon

SEX

Neutered Male

AGE

11 Years

WEIGHT

18 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Desert Hills AH

REFERRING VET

Dr. Caldwell

INVOICE

14067

DATE

2/4/22

PRESENTING CLINICAL SIGNS

History: : Intermittent diarrhea for a couple of years. Recently, elevated liver enzymes (AST, ALT) on labs. Historical sensitive stomach and has been on feline i/d for the last couple of years. Diarrhea will occur for 2 days, and then resolve. Seems to respond to metronidazole within 1-2 days when prescribed 1 year ago and recently last week. Indoor only and supervised in the yard and will sometimes eats the leaves. This may coincide with diarrhea episodes. Grade 2/6 murmur, lungs auscultate wnl. Abdominal palpation soft and non-painful. EENM clear. P has lost 0.7# in the last year, but does recently have a new kitten in the house and is more active. Sibling had HCM and passed. Current Therapy and Medications : Hill's i/d feline, metronidazole No sedation
Abnormal PE/Chem/CBC/UA Results: ALT minimally elevated 8/21 at 119. Labwork: cardiopet proBNP normal, fecal negative, CBC - lymphopenia 1178 (1200-8000), chem - albumin 4.0, ast 282 (10-100), alt 887 (10-100), cholesterol 333 (75-220) T4 2.8 (0.8-4.0), ft4ed wnl UA: usg 1.044, 1+ proteinuria, trace occult blood.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended. A scant amount of 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 (4.41 cm in length); normal shape and architecture with 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.

The right kidney is normal size (4.71 cm in length); normal shape and architecture with 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.

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.

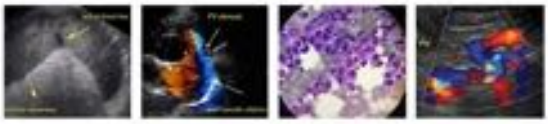
The right adrenal gland is normal in size (0.38 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.95 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. Luminal contents are anechoic. The cystic and common bile ducts are visible/tortuous but not overtly dilated.



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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. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The base and right limb of the pancreas are visible/prominent in size with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct was dilated (0.28 cm in diameter). Surrounding mesentery is hyperechoic.

Free Abdomen

There is no evidence of free fluid. At least 2 caudal abdominal lymph nodes are visualized at the aortic trifurcation, the largest measuring 1.56 cm in length. Both nodes are hyperechoic with a normal shape. A few prominent hypoechoic to slightly heterogeneous mesenteric lymph nodes are visualized, the largest measuring 1.12 cm in length. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

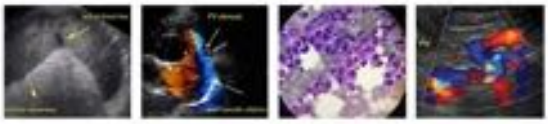
- The pancreatic changes are consistent with mild to moderate acute or chronic active pancreatitis.
- The abdominal lymphadenopathy could be consistent with lymphoid hyperplasia, reactive lymphadenitis or emerging neoplasia (i.e., lymphoma). Peritonitis is present adjacent to the mesenteric nodes.
- An obvious cause for the patient's elevated ALT is not identified in this study. Considerations include inflammatory disease (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis), hepatic lipidosis, reactive hepatopathy, infiltrative neoplasia (less likely), other.

Secondary Findings:

- Bilateral, non-specific age-related renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the patient's clinical history, consider the following:
  1. Prophylactic deworming with Fenbendazole, despite the negative fecal evaluation.
  2. Malabsorption panel including serum cobalamin, folate, TLI and PLI (send to Texas A&M).
  3. 6 week hydrolyzed protein or limited antigen diet trial.
  4. Supplementation with a probiotic with a high colony count (i.e., Proviable Forte).



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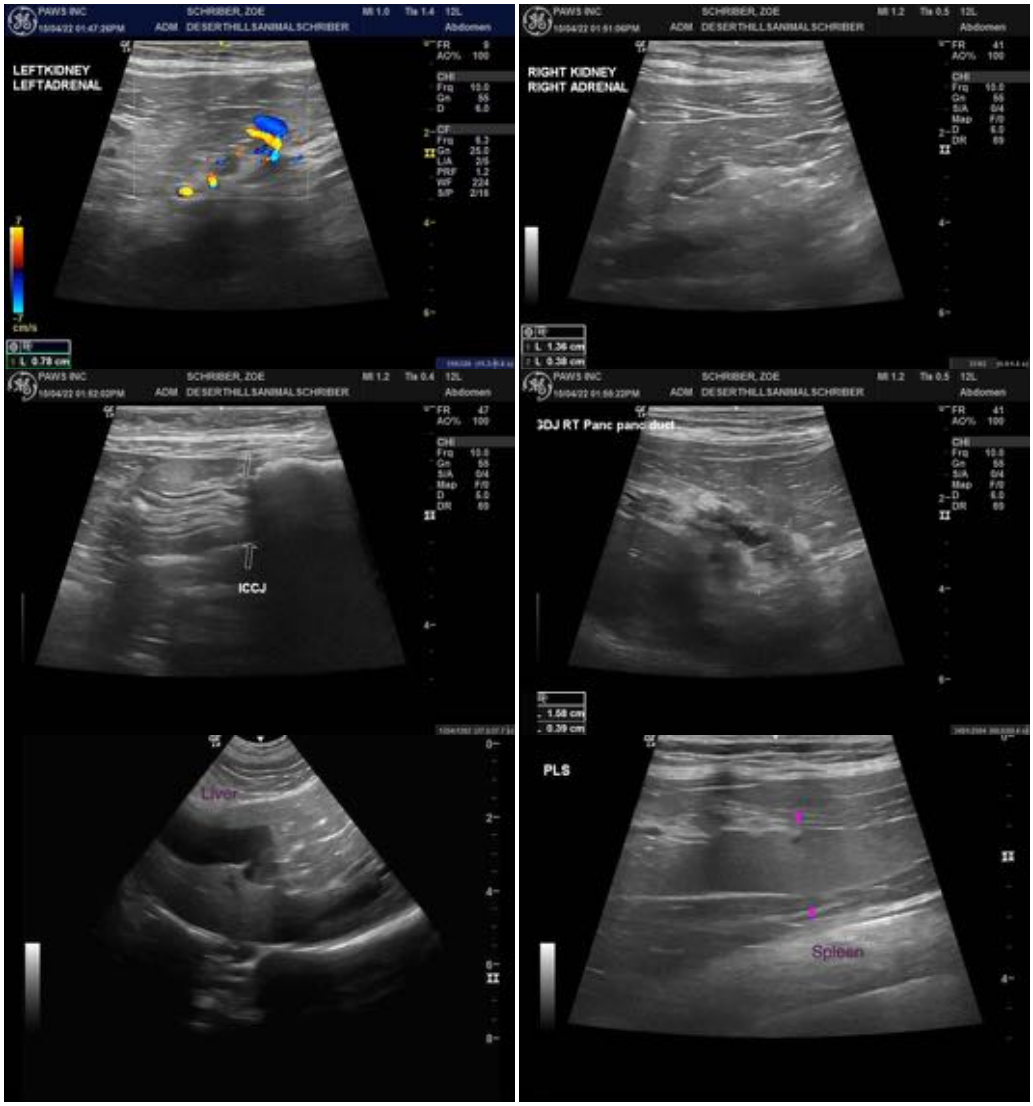
5. Consider empirical treatment for small intestinal bacterial overgrowth with 4 week course of Tylosin (in lieu of Metronidazole).
6. Ultimately, GI biopsies may be necessary to get a definitive diagnosis.

- Regarding the elevated ALT, consider hepatic tissue sampling (i.e., fine needle aspirate or surgical biopsy). If biopsies are pursued, bile cultures (aerobic and anaerobic) should also be obtained.
- If a more conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis with broad spectrum antibiotics (i.e., amoxicillin clavulanic acid) and hepatic antioxidants (i.e., Denamarin). If no improvement in the liver values is seen within 5-7 days of in initiating therapy, antibiotics should be discontinued and hepatic tissue sampling revisited.



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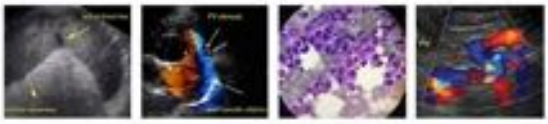

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pawsonography@gmail.com 530-786-8340

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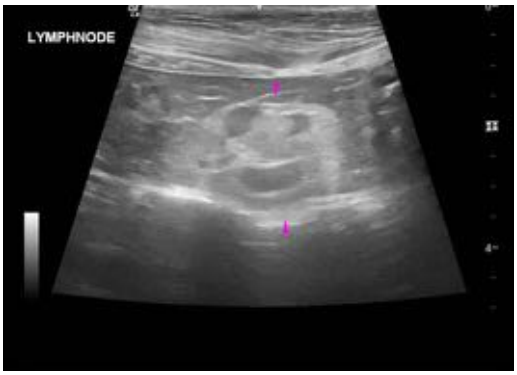

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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