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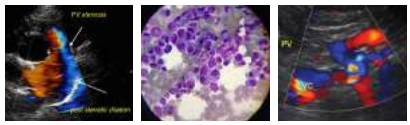

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DATE

10/6/21

PATIENT

Baxter Nesci

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Male Neutered

AGE

2007

WEIGHT

14.08 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Frederick Road VH

REFERRING VET

Dr. Beyer

INVOICE

11964kk

PRESENTING CLINICAL SIGNS

History: *weight loss, decreased appetite, vomiting, and diarrhea* Recently been vomiting past 4 consecutive days. Has been slowly losing weight since 2018. Lost 2.84 lbs from February to August. Extremely picky eater (per owner). Will not eat hypoallergenic diet-owner changes foods constantly. Was started on prednisolone after last u/s. Have tried to taper to lowest effective dose, but as tried to taper-pet would lose more weight or start to vomit again. Pet has now developed diarrhea as well. HCT has slowly been decreasing since 2016 (still wnl but lowering). Sometimes has: leukopenia, neutropenia, lymphopenia (other times these are wnl). Recently elevated TP +/- globulins. FeLV/FIV: N/N. Has had elevated spec fpl in past (mildly elevated). BP 130 mmHg. Grade I-II/VI systolic murmur (proBNP has been wnl in past).

Current Medications: Prednisolone 5 mg am 2.5 mg pm. Cerenia 4 mg PO PRN (owner has been using q 24-48 hrs recently). Mirtazapine 1.875 mg PO q 3 days (makes pet hyper/anxious). B12 0.25 mls SQ monthly (after once a week for 6 weeks).

Lab Results: Full senior panel is pending. Owner has declined GI panel in past but pending bloodwork and u/s results-owner open to adding on to FASTED blood at the lab. Borderline anemia at 27.5% hematocrit.

Date of Previous IntraPet Ultrasound: 09/20/2020

Sedation: Not needed.

Stat Report: Not requested.

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 is moderately distended. A small to moderate amount of aggregated, echogenic, suspended debris is observed within the lumen. No 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 (3.98 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 (3.49 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.

Adrenal Glands

The left adrenal gland is normal size (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.32 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.96 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 with no evidence of obstruction.

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 some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas
The body/right limb is visible/prominent with minimal deviation from the normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is mildly dilated (0.28 cm in diameter). There is no evidence of peripancreatic effusion.

Free Abdomen
No free fluid is observed. Several prominent hypoechoic lymph nodes are observed throughout the abdomen including those at the mesenteric root, adjacent to the descending colon, and 1-2 prominent cranial abdominal nodes. The mesentery surrounding all nodes is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The pancreatic changes are consistent with chronic pancreatitis.
- The hepatic parenchymal changes could be consistent with hepatic lipidosis, inflammatory disease, infiltrative neoplasia (less likely), normal variation, and other hepatopathy.

Secondary Findings:

- Urinary bladder debris.
- Minor, bilateral, age-related renal changes.

**Given the sonographic changes, “triaditis” is a consideration in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. If accessible, fine needle aspirates of the mesenteric lymph nodes are recommended (if clotting status is normal). 25-gauge needles should be used. However, it should be noted that corticosteroid

use may mask underlying pathology such as lymphoma.

2. A malabsorption panel including serum cobalamin, folate, PLI and TLI is also recommended.

3. Three-view thoracic radiographs should be considered to assess for lymphadenopathy in the chest.

4. Given the hyperglobulinemia, consider a serum protein electrophoresis to assess for a monoclonal gammopathy (which would be concerning for underlying neoplasia).

5. Ultimately, surgical gastrointestinal and lymph node biopsies may be necessary to get a definitive diagnosis in this patient.

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.

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