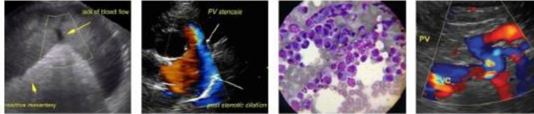


PATIENT

Carlie Geiser

SPECIES

Feline

BREED

Seal Point

SEX

Spayed Female

AGE

9 Years

WEIGHT

9.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Mountain View VH

REFERRING VET

Dr. Sarah Kalivoda

INVOICE

14273

DATE

11/11/21

PRESENTING CLINICAL SIGNS

History: chronic weight loss, intermittent vomiting Relevant Medica intermittent vomiting, decreased w/ recent diet change lost an average of 1.2 lbs per year the last 2 years without owner actively trying to get p. to lose weight, ~ poss. nodule palp. midabdomen in area of mesenteric root Recent Diagnostics: Relevant Labratory Results / Abnormalities: ~~ losing weight CBC: plt low, clumps on slide Chemistry: sdma 9 creat 1.2 bun 25 UA: 1.045 pH 6.0 uprot 3+ quiet sediment UPC: ~0.5 (>0.4) proteinuric T4: ~2.5 normal Pro-BNP: Normal ~46~ (0-100) FeLV / FIV: No indication of FeLV/ FIV disease based on results HW: No indication of HW disease

Abnormal PE/Chem/CBC/UA Results:

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 mostly anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2.0 cm, are normal.

The left kidney is normal size (3.84 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.

The right kidney is normal size (3.94 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.

Adrenal Glands

The left adrenal gland is normal size (0.25 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

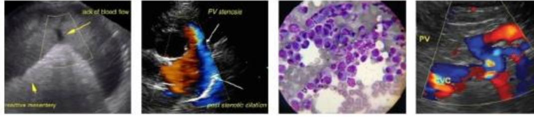
The right adrenal gland is normal size (0.33 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.97 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/not seen.

Gastrointestinal

The gastric lumen is mildly distended with fluid. 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 0.27 cm) with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. Several prominent to enlarged hypoechoic lymph nodes are observed at the mesenteric root, the largest measuring 2.41 cm in length.

Other

A brief echocardiogram (no charge) reveals no evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The abdominal lymphadenopathy could be consistent with lymphoid hyperplasia, reactive lymphadenitis or infiltrative neoplasia (i.e., lymphoma).
- The mild small intestinal wall thickening is suggestive of inflammatory bowel disease with minor potential for emerging lymphoma.

Secondary Findings

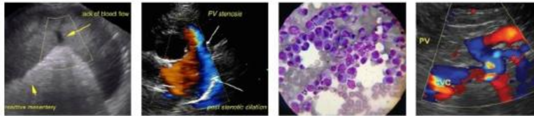
- Bilateral age-related renal pathology

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult esophageal disease.

The following diagnostic/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia
3. A 6-week limited antigen diet trial to assess for food allergies



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4. For patients where chronic vomiting is present but additional diagnostics are not to be performed, consider triple therapy as empirical treatment for Helicobacter gastritis:

    Amoxicillin: 10-22 mg/kg PO q 12 hours x 14-21 days

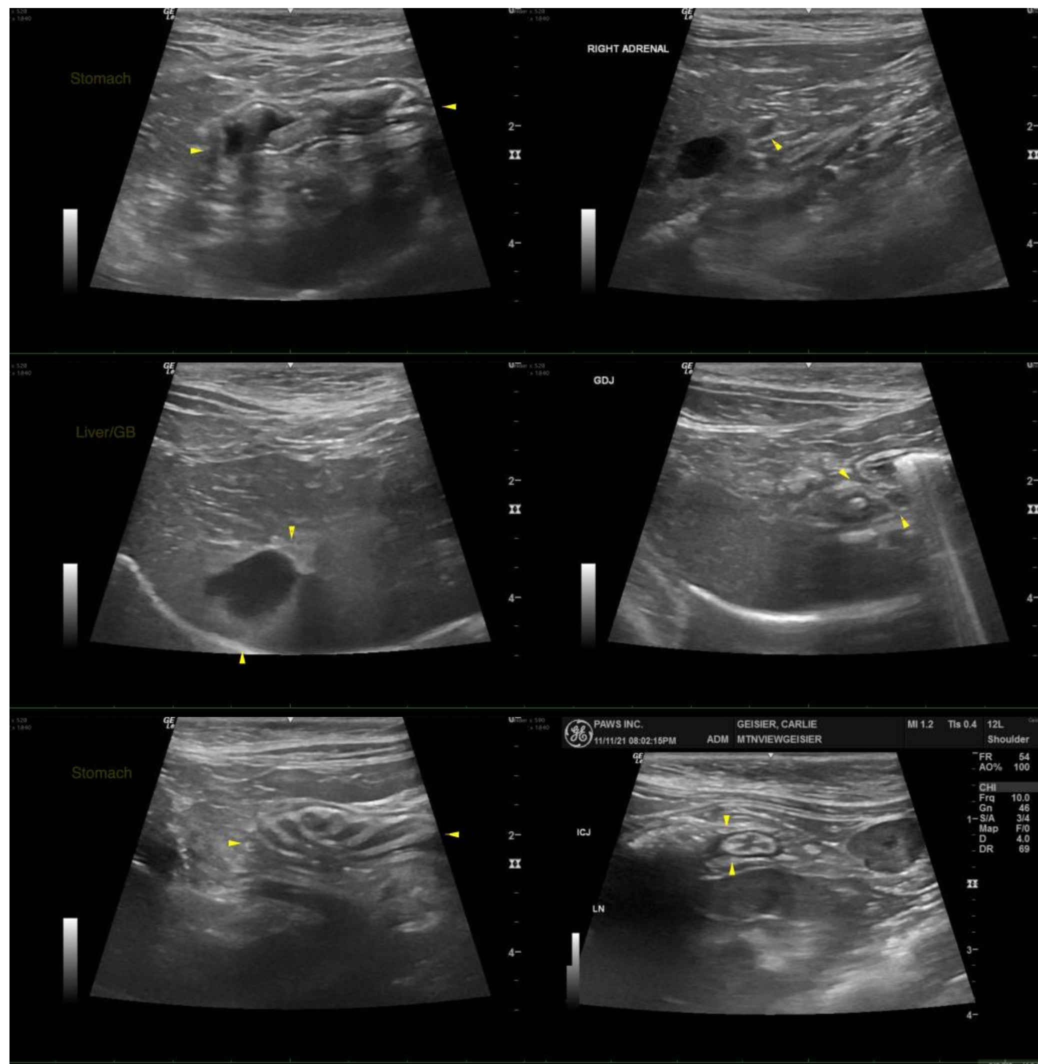
    Metronidazole: 10-15 mg/kg PO q 12 hours for 14-21 days

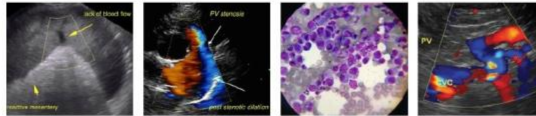
    Omeprazole: 0.7 mg/kg PO q 24 hours for 14-21 days

    (+/- the addition of Bismuth subsalicylate: 3.85 mg/kg PO q 6-8 hours x 14-21 days)

5. Also consider heartworm antigen and antibody testing as heartworm disease can be a cause of chronic vomiting in cats.

6. If the above diagnostics/therapeutics are inconclusive, endoscopic or surgical gastrointestinal biopsies may be warranted.





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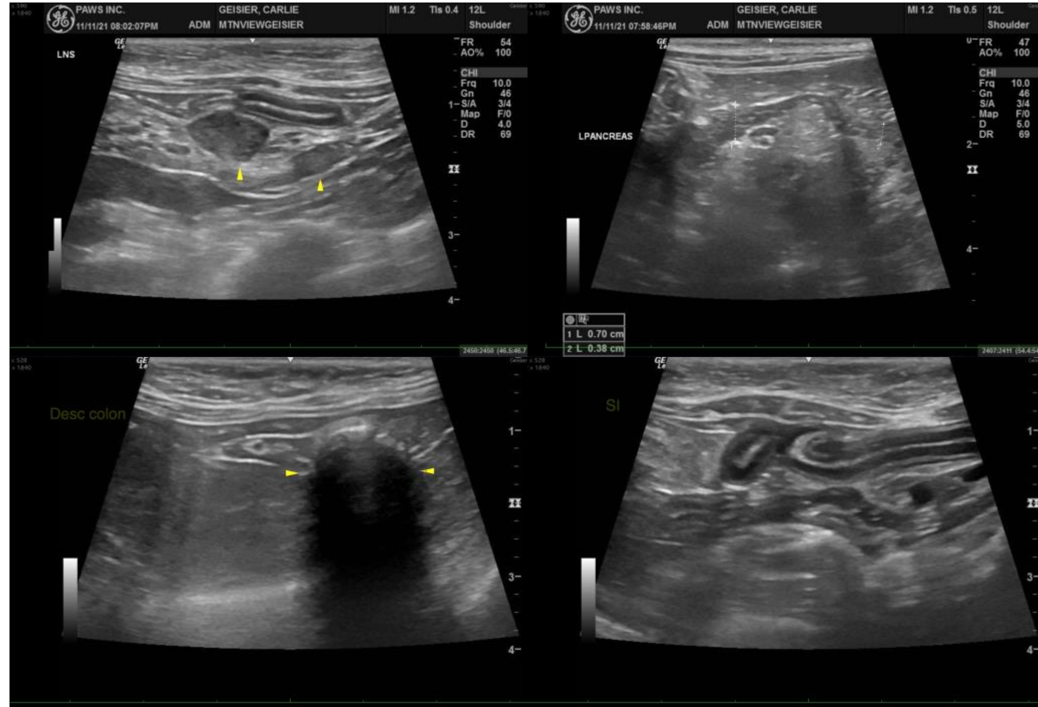

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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_nicastro2@hotmail.com