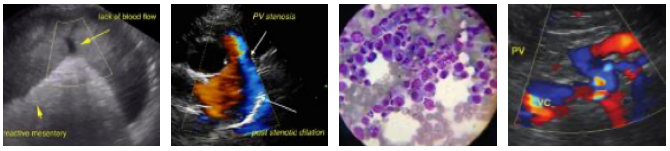

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1-800-838-4268 info@sonopath.com

PATIENT

Odin Conjerti

SPECIES

Feline

BREED

Domestic longhair

SEX

Male, neutered

AGE

11 Yrs.

WEIGHT

4.9 kg.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Patti Mayfield

HOSPITAL NAME

Highland VH

REFERRING VET

Dr. Rachel Poet

INVOICE

12558

DATE

11/17/21

PRESENTING CLINICAL SIGNS

History: Odin lives with another younger cat. He is 11 years old and ~ 2 years ago began receiving Zyrtec EOD to assist with herpes conjunctivitis/rhinitis. The Zyrtec has helped significantly, and in the last 2 years he has been more active and plays a lot with his feline housemate. Odin has lost ~ 9 # in 3 years, with 2# weight loss in the last 1 year. Client reports that he was overweight at the beginning of his weight loss, but with the unexplained change in weight, she has concerns. Odin remains playful and active. He doesn't groom as well as previously, and occasionally gets matted fur on his abdomen. No change in appetite, no vomiting, no diarrhea, no polyuria, polydipsia, or polyphagia reported. No behavioral changes noted. DIET: Iams dry and Iams canned or Rachel Ray canned
Abnormal PE/Chem/CBC/UA Results: Physical exam (11/17/21): Patient is a large cat. BCS 4/9. No severe muscle atrophy, however occasional crepitus with manipulation of the hips/elbows, especially when patient is mobile and kicking. Moderate dental tartar/gingivitis. Tachycardia, but no obvious murmur. Soft, supple abdomen with NSF. Unkempt and poorly groomed coat. 11-08-21 Senior Comprehensive Panel Feline FeLV - Negative FIV - Negative Heartworm - Negative CBC nsf Chem - - decreased ALP - T4 = 1.7 microg/dL, 1.8 previous result

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 cm, are normal.

The left kidney is normal in size (4.10 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.23 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

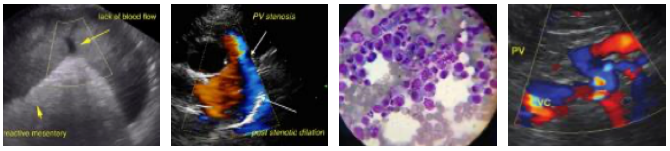
The right adrenal gland is normal in size (0.31 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.69 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



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congestion. No pathological hepatic lymphadenopathy observed. 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.

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 ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. Several prominent lymph nodes are observed at the ileocecal colic junction, the largest measuring 1.60 cm in length. Surrounding mesentery is mildly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Minor age-related degenerative renal changes with dystrophic mineralization.

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include microscopic gastrointestinal or pancreatic disease, occult neoplasia, non-metabolic disease (i.e., orthopedic and/or neurologic disease), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider the following diagnostics/therapeutics:

1. Three-view thoracic radiographs to assess for occult neoplasia.
2. GI panel (send to Texas A&M).
3. A fecal evaluation for ova/Giardia
4. Thorough orthopedic and neurologic evaluations. If orthopedic and/or neurologic pain is strongly suspected, consider empirical treatment with pain medication.
5. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.

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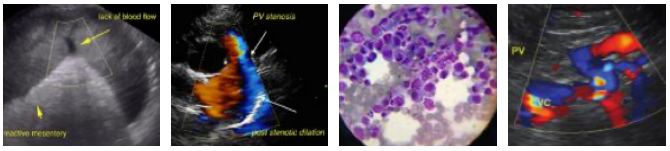

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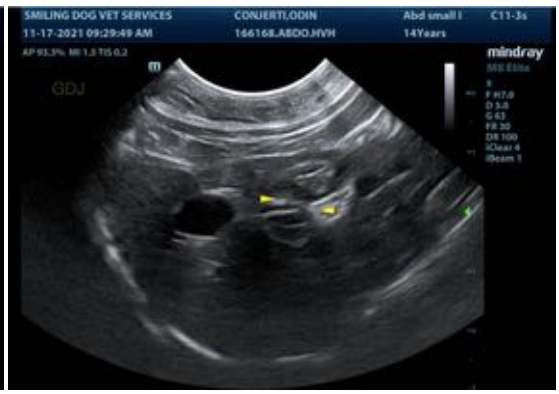

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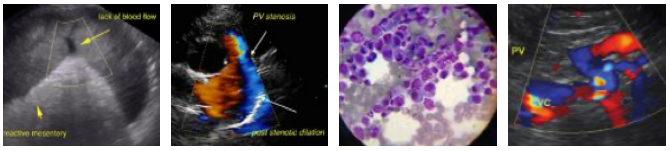

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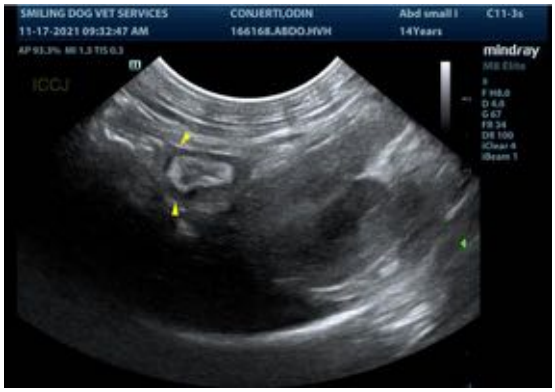

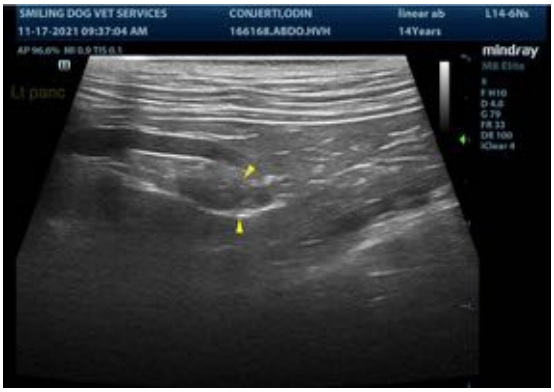

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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@sonopath.com