



PATIENT

Lovey Sherburne

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7 years

WEIGHT

5.42 lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Charlie Rodriguez

HOSPITAL NAME

Bethany Family PC

REFERRING VET

Tiffany Pow

INVOICE

11959

DATE

11.2.22

PRESENTING CLINICAL SIGNS

History: Dr. Pow has been treating low albumin and gastrointestinal issues since January 2022. Has been on Feline hypoallergenic HP since Sept (switched from Gastro HE due to not doing well/vomiting increase) and Prednisolone 50 mg/mL transdermal 0.05 ml applied to inner ear every 24 hours. Has been getting weekly Vit B12, Cerenia injections PRN and weekly SQF. Recently has now been vomiting every day.

Abnormal PE/Chem/CBC/UA Results: September albumin 2.7 October 27th: albumin 1.9 (increased pred to 0.08 ml) Rechecked albumin today: still 1.9, HCT 29%, TP 5.6 g/dL

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 mildly distended. A scant amount of suspended, echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The **left kidney** is normal size (3.21 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 (3.26 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. 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 (0.59 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. The liver is isoechoic relative to the spleen. 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 mildly distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **stomach and intestine** are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. 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 ileocecolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

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



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slightly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

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Free Abdomen

There is no evidence of free fluid. A few mesenteric lymph nodes are visible, the largest measuring 0.83 cm in length. Surrounding mesentery is mildly hyperechoic.

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ULTRASONOGRAPHIC FINDINGS

Findings

- Bilateral chronic age-related renal changes
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

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*An obvious cause for the patient's worsening gastrointestinal signs is not identified in this study. Considerations include unregulated inflammatory bowel disease, infectious/parasitic disease, occult hepatic disease, occult neoplasia, other.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider three-view thoracic radiographs to assess for occult neoplasia in the thorax.

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A malabsorption panel, including serum cobalamin and folate, TLI and PLI, should also be considered, along with a fecal evaluation for ova and Giardia.

Ultimately endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis. If biopsies are not pursued, consider adjustment in the corticosteroid dose.

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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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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