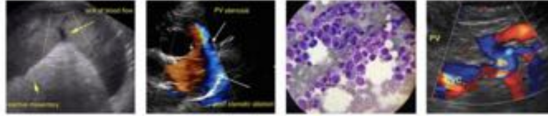

PATIENT

Cooney Wright

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

12/23/09

WEIGHT

8.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

River Oaks AH

REFERRING VET

Meg Smith

INVOICE

11923

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11.30.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Vomiting a lot over the last several months. O said he has been losing weight too. O changed his diet about 3-4 weeks ago to a higher fat diet. This new food has helped, as he went as long as 3 days without vomiting. O said he always vomits after he eats. Though the vomiting is not consistent, it is usually after food. O said sometimes he can vomit multiple times in one day. Appetite still same.

PE: Thin, mild cachexia, hair coat mildly unkempt.
~Stool palpable in colon.
~Radiographs revealed stool in colon.

Abnormal lab-work values: Will submit labs via email
TP: 6.2
Alb: 2.5
Creat Kinase: 546

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System
The urinary bladder is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small amount of suspended, 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 (3.45 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.

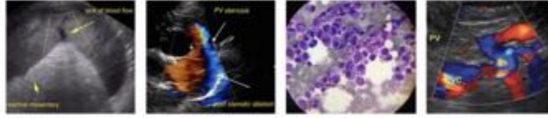
The right kidney is normal size (3.88 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands
The left adrenal gland is normal size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.30 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
The spleen is normal in size (0.86 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



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of congestion. No pathological hepatic lymphadenopathy observed. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder is mildly to moderately distended. The wall is borderline thickened (up to 0.15 cm). Luminal contents are anechoic. The cystic and common bile ducts are normal.

Gastrointestinal
The gastric lumen is moderately distended soft, shadowing material. 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 segmentally dilated with chyme. The small intestinal wall is normal to borderline thickened (up to 0.28 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 obvious evidence of an obstructive pattern.

Pancreas
The left limb is prominent with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic effusion.

Free Abdomen
There is no evidence of free fluid. A few prominent lymph nodes are observed in the cranial to midabdomen, the largest measuring 0.69 cm in length.

Other
A brief echocardiogram reveals no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

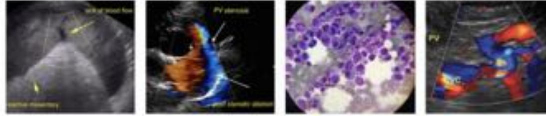
- The gastric luminal contents are most consistent with a moderate-sized trichobezoar.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- The mild small intestinal wall thickening may be secondary to inflammation or may be a normal variant for this patient. Emerging neoplasia is possible but considered unlikely at this time.

Secondary Findings

- Minor bilateral age-related renal changes
- The borderline gall bladder wall thickening may be artifactual due to lack of full repletion or may be secondary to benign age-related hyperplasia or cholecystitis. However, correlation with the patient's liver values is recommended.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- The following diagnostic/treatment recommendations can be considered:
    1. Serum cobalamin, folate, PLI and TLI



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2. A 6-week limited antigen diet trial to assess for food allergies along with initiation of a probiotic.

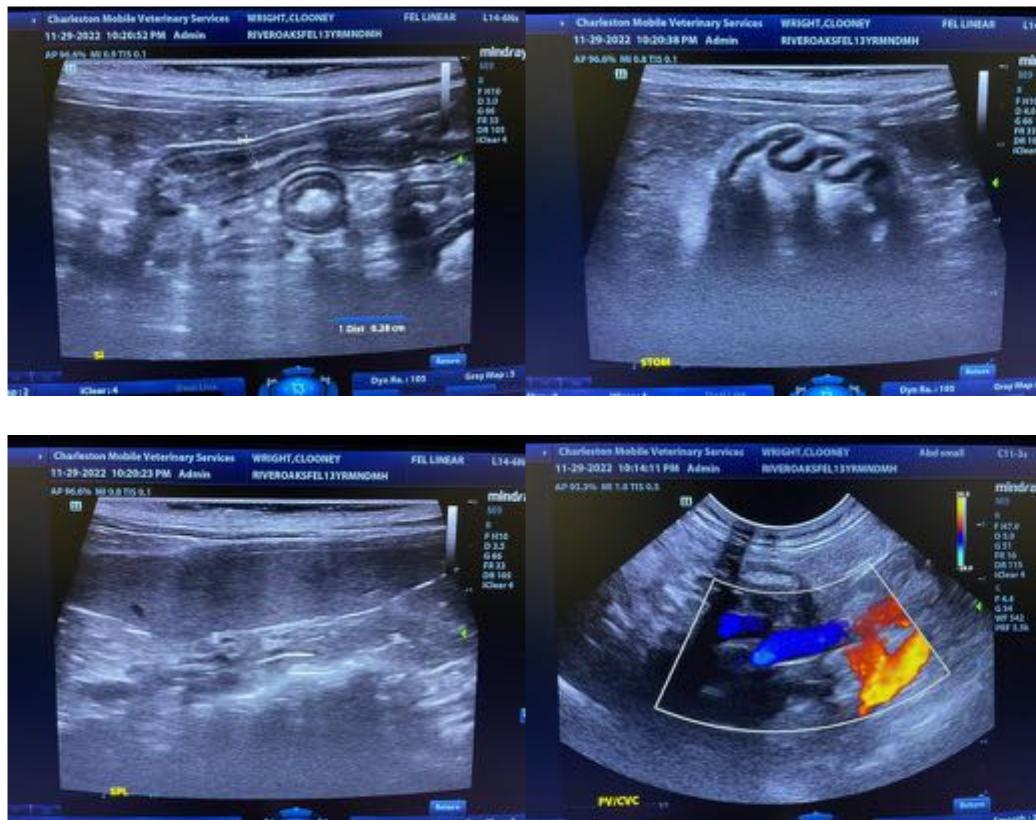
3. For patients where chronic vomiting is present but additional diagnostics are not to be performed, consider triple therapy as empirical treatment for Helicobacter gastritis:
    a. Amoxicillin: 10-22 mg/kg PO q 12 hours x 14-21 days
    b. Metronidazole: 10-15 mg/kg PO q 12 hours for 14-21 days
    c. Omeprazole: 0.7 mg/kg PO q 24 hours for 14-21 days
    d. (+/- the addition of Bismuth subsalicylate: 3.85 mg/kg PO q 6-8 hours x 14-21 days)

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

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

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

7. Serial monitoring of the patient's albumin is recommended to assess for worsening.



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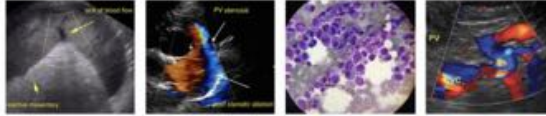

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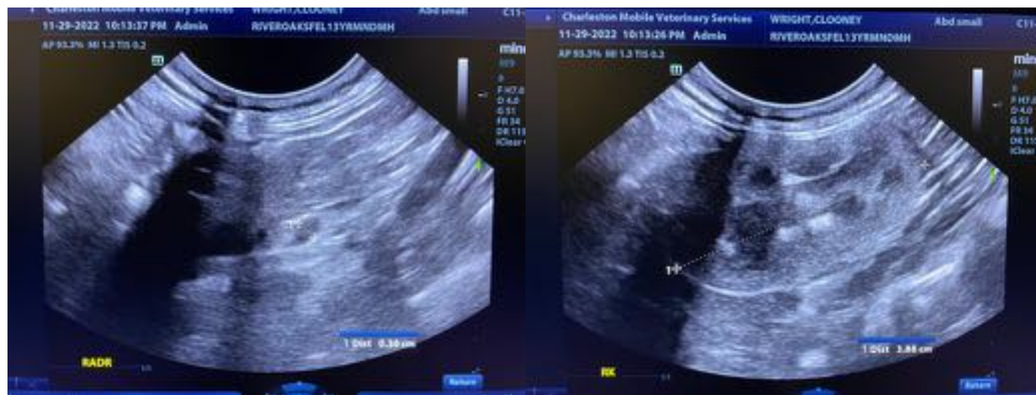

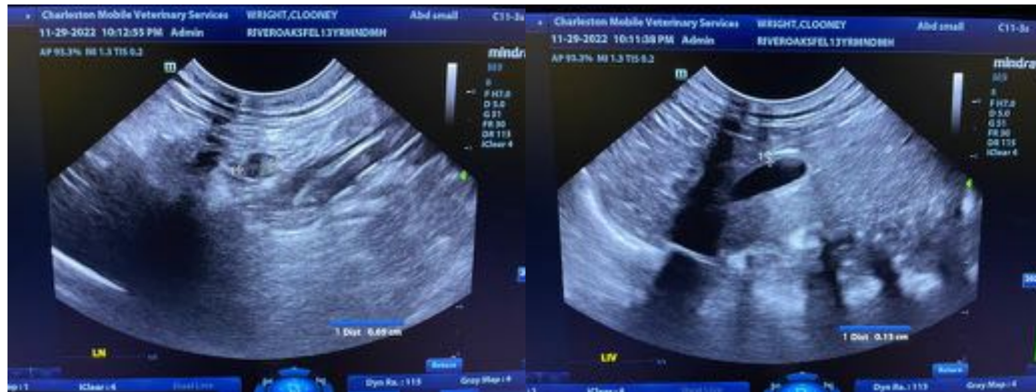

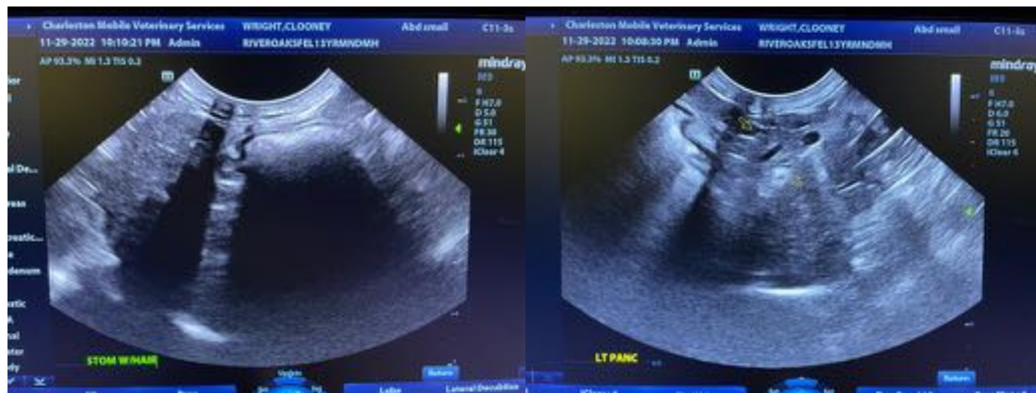

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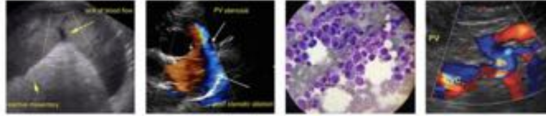

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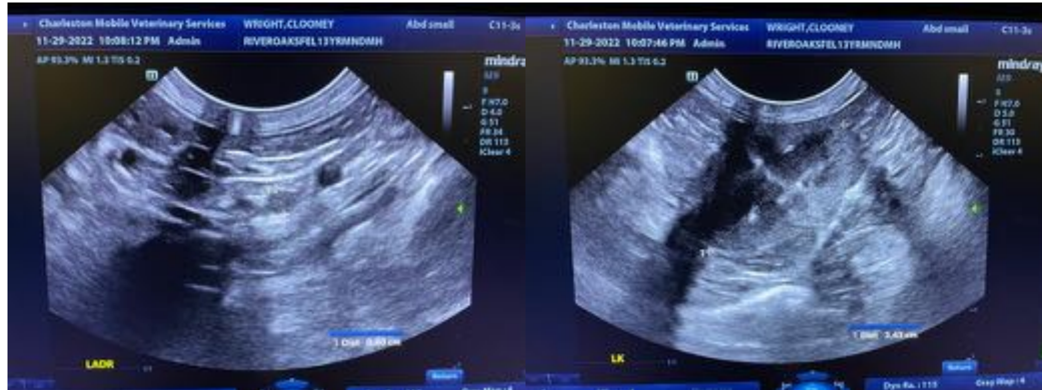

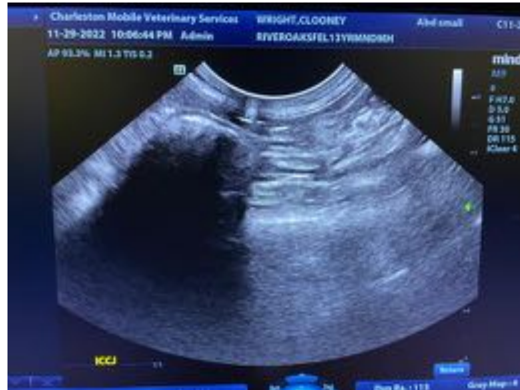

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com