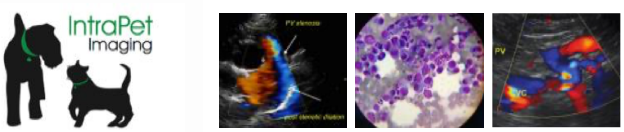
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

11.6.2022

PATIENT

Boaty Dorsey

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2018

WEIGHT

4.8 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal EH

REFERRING VET

Dr. King

INVOICE

11982

PRESENTING CLINICAL SIGNS

Presenting Complaint: Foreign Body. Vomiting. Dehydrated.

History: Date: 11-05-2022 Notes: 11/4 -- RDVM P presents for check ears- tips of ears starting to flop over P has gone from 6.623 lbs. to 4 lbs. 14 oz in 2 months. gave P a treat in room and P really wanted it but vocalized when eating it, then vomited. Labwork Triple neg. Na = 169, K = 3.3, fecal neg in sept. Rads: a little bunching, some material in stomach Sent for continued care, +/- US/explore as indicated

Assessment: Discussed -- weight loss, very concerned about chronic disease IBD, neoplasia vs other, parasites, chronic fb, other.

For now, recommend IVF, GI support, and repeat films-- if not obvious fb, would wait to get US first - owner agrees. Also consider prophylactic deworm.

Current Medications: Gabapentin, Potassium Chloride 2mEq/mL Injection, Oral Buprenorphine 0.3mg/ml, Pantoprazole (Protonix) 40mg/vial Injection (Per mL), and Vitamin B12 1000mcg/mL Injection.
Lab Results: Attached.

Radiographs: Xray
colon is very large/gassy, but SI and stomach are small - recommend US.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with 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 size (3.47 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (4.03 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal 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 (0.44 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.49 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
The **spleen** is normal in size (0.73 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. The portal vein to caudal vena cava ratio is approximately 1: 1.

The **gall bladder** lumen is moderately distended. The wall is thin and smooth. A scant amount of aggregated, echogenic debris is observed within the lumen. The cystic and common bile ducts are visible but not overtly dilated.

Gastrointestinal
The **gastric lumen** is moderately distended with ingesta and some 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 not dilated. The small intestinal is normal in thickness with retention of the normal layering pattern. There is evidence of mucosal speckling in some segments. Discreet masses are not identified. The colonic wall is normal.

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
Trace free fluid is observed fluid is observed. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes are suggestive of an inflammatory process (i.e., inflammatory bowel disease). The gastric luminal contents may represent normal ingesta and/or foreign material (i.e., hair).

- Trace ascites. This may be secondary to increased vascular permeability (i.e., vasculitis), increased hydrostatic pressure, or less likely, low oncotic pressure.

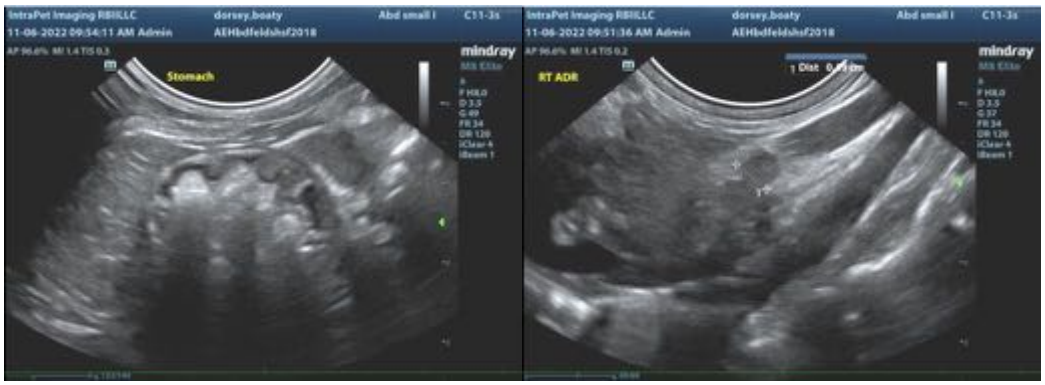
  *Given the patient's clinical history and sonographic changes, primary gastrointestinal disease is of primary concern. Top differentials include inflammatory bowel disease, infectious/parasitic disease, food allergy/intolerance, or less likely, infiltrative neoplasia. An underlying metabolic issue is also a consideration.

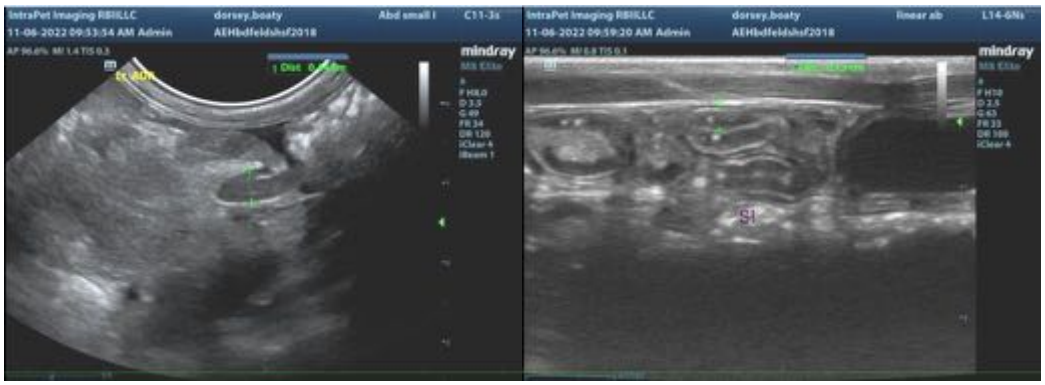
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three-view thoracic radiographs are recommended to assess for occult neoplasia in the chest.

Other diagnostic/therapeutic considerations include the following:

1. Despite the negative fecal evaluation, prophylactic deworming with Fenbendazole should be considered.
2. A malabsorption panel, including serum cobalamin and folate, TLI and PLI (send to Texas A&M.)
3. Limited antigen diet or hydrolyzed protein diet trial
4. Gi biopsies (endoscopic or surgical) may be necessary to get a definitive diagnosis. Surgical biopsies are preferred in that the stomach can be assessed for foreign material.





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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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