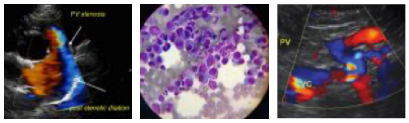
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

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DATE

11.6.2022

PATIENT

Sebastian Geppi

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2014

WEIGHT

15 lbs

INTERPRETED BY

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

HOSPITAL NAME

Animal EH

REFERRING VET

Dr. Ruby

INVOICE

11983

PRESENTING CLINICAL SIGNS

Presenting Complaint: Vomiting. Not Defecating. Not Urinating. Not Eating. Lethargic.
History: Date: 11-04-2022 Notes: No food in 24 hours. Here last night. Vomited twice on the way home. Still vomiting, mostly white foam. Vomited seven more times over night.

Previous History "Mainly is on Urinary Diet (Purina UR) but about once a week will vomit so sometimes owner mixes with regular food. Has not had any urinary symptoms since last visit here. This morning appetite was normal, but he vomited multiple times; first couple times contained food; one of the later times there was some plastic; then vomited 1-2 more times and it was clear/foamy. After that he seemed lethargic. As soon as he got to hospital owner feels like he perked up and looks more normal."

Assessment: Vomiting.

Current Medications: Maropitant Citrate (Cerenia) 10mg/mL Solution Injection, Mirtazapine 1mg, Ondansetron 2mg/mL Injection, Vitamin B12 1000mcg/mL Injection, Gabapentin Capsules 100mg, Ampicillin 125mg/vial Injection, Pantoprazole (Protonix) 40mg/vial Injection, Maropitant Citrate (Cerenia) 10mg/mL Solution Injection, Ketamine 100mg/mL, and Acepromazine 10mg/mL Injection.
Lab Results: Attached.
Radiographs:
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 1-2 cm, are normal.

The **left kidney** is normal size (4.76 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. Mild pyelectasia is present (0.21 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (5.06 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. Mild pyelectasia is present (0.17 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal to slightly prominent in size (0.95 cm in width at the level of the hilus) with normal curvilinear peripheral contours. 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 **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 **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 is normal to mildly thickened (up to 0.31 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen is mildly distended with liquid-appearing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The **pancreas** is diffusely visible and normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

Trace free fluid is observed. A few prominent **lymph nodes** are observed at the ileocecocolic junction and at the mesenteric root (the largest measuring 1.08 cm). The nodes are normal in shape and echogenicity. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes are most consistent with inflammatory bowel disease with some potential for emerging lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Trace ascites.

Secondary Findings

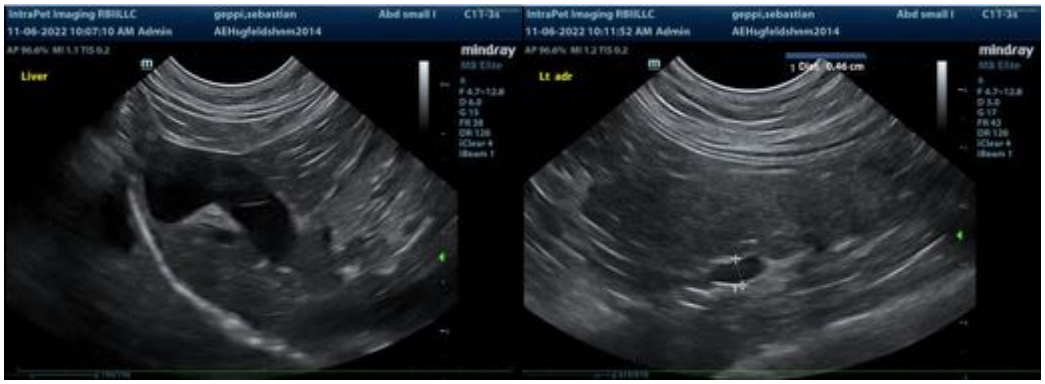
- Bilateral chronic renal changes with mild pyelectasia.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

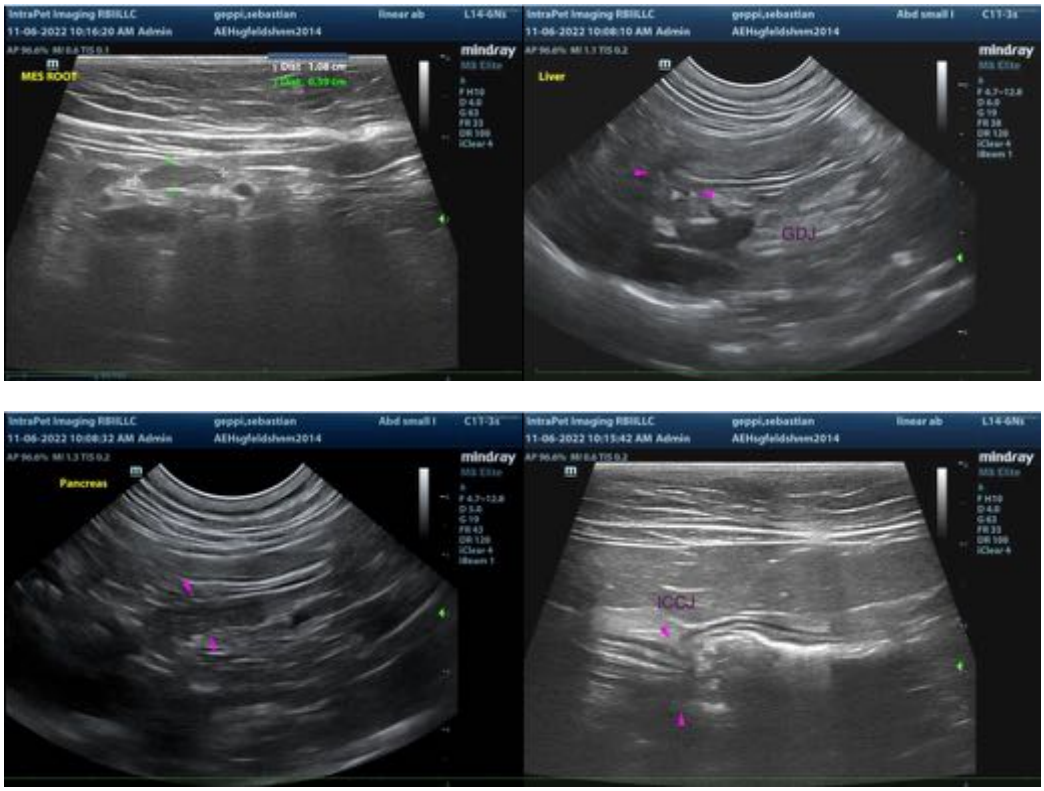
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If the patient's clinical signs are acute in nature, supportive care for gastroenteritis is recommended.

If the patient's clinical signs are chronic and/or intermittent, consider the following:

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
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.





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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