

PATIENT PRESENTING CLINICAL SIGNS

Jordy Cherry

History: 7.5YO MN DSH 8.08# 4+ year history of chronic GI disease - was chronically constipated in 2016-2017, was manually deobstipated 2x, eventually controlled with GI Biome diet, Cisapride 7.5mg BID, and Mirolax mixed into food. Weight in 2017 was 14.3#, BCS 6/9 Some weight loss noted on exam in 2019 (12.2#) but pt eating well (commercial diet) and passing feces normally, BCS 5/9 Continued weight loss noted in 8/21 (9.7#) with BCS 4/9. Decreased appetite, increased vomiting episodes and intermittent soft stool/ diarrhea. Owner administering Cisapride only once weekly, pt seemed to vomit more after taking it. Return to GI Biome diet helped firm up feces. Seen again on Oct 27, 2021 - continued weight loss (8.08#), BW showed high TP (9.1g/dL) w/ high globulins (7.1g/dL) and low albumin (2.0g/dL), mild nonregenerative anemia (29%), T4 normal (2.1ug/dL), spec fPL normal (1.8ug/L), fecal NEG for parasites. suspect chronic IBD or early LSA. Abd US performed

SPECIES

Feline

BREED

Domestic Mediumhair

SEX

Neutered Male

AGE

7.5 Years

WEIGHT

8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Incline VH

REFERRING VET

Dr. Kris Moger

INVOICE

12480

DATE

11/7/21

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. A scant 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 (4.03 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (4.21 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

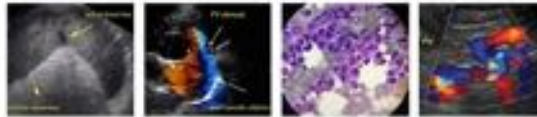
The right adrenal gland is normal in size (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.64 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. The parenchyma is hypoechoic relative to the spleen. A 1.17 x 0.69 cm, irregular anechoic cyst is observed at the tip of the left lateral lobe. The lesion causes mild capsular expansion. The remaining parenchyma is homogenous. Vascular and biliary tracts are of normal



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volume with no evidence of congestion. 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

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The gastric lumen is mildly fluid distended. A 2.5 cm area of gastric wall in the region of the fundus is thickened (up to 0.58 cm) with suspected loss of the normal layering pattern. The remaining gastric wall is 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 0.29 cm) with a normal layering pattern and appropriate mural detail. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. The ileocecal colic junction is normal. A focal area of colonic wall is borderline thickened with apparent retention of the normal layering pattern. No obstructive disease is noted.

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Pancreas

The left limb of the pancreas is visible with minimal deviation from the normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and subtly mottled in appearance. The pancreatic duct is visible but not overtly dilated (0.19 cm in diameter).

AGE

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Free Abdomen

Trace free fluid is observed. The mesentery adjacent to the gastric wall is mildly hyperechoic. A few prominent cranial and mid-abdominal lymph nodes are visualized, the largest measuring 0.82 cm in length. Surrounding mesentery is hyperechoic.

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(*Small Animal Internal
Medicine*)

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gastric wall changes in the region of the fundus are concerning for infiltrative neoplasia (i.e., lymphoma, adenocarcinoma). However, severe inflammation cannot be excluded.
- The diffuse small intestinal wall changes are most consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Mild cranial peritonitis, likely secondary to GI and/or pancreatic pathology.

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Secondary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Left hepatic cyst, likely benign and incidental.
- Bilateral age-related renal changes.

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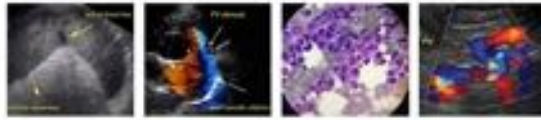
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the hyperglobulinemia, a serum protein electrophoresis is recommended.



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- Regarding the patient's clinical signs, gastrointestinal biopsies, preferably surgical, are recommended along with a malabsorption panel (i.e., serum cobalamin, folate, TLI and PLI).
- Three-view thoracic radiographs should also be considered to assess for occult neoplasia in the chest.

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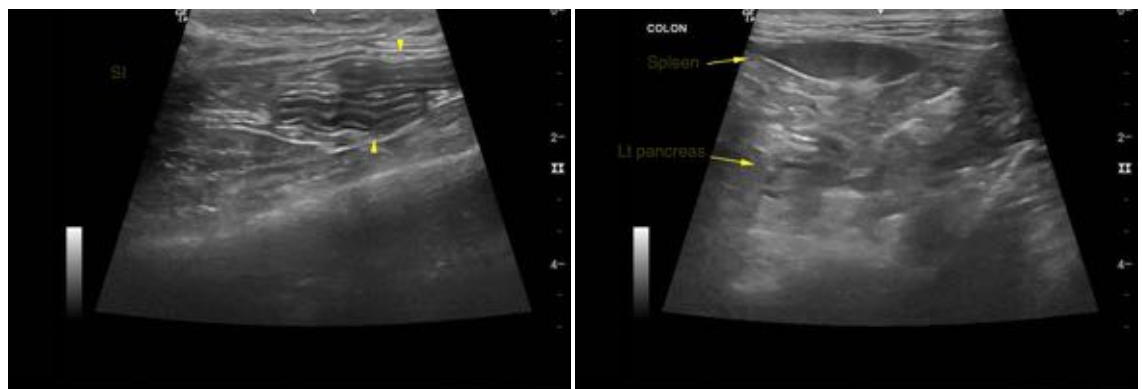
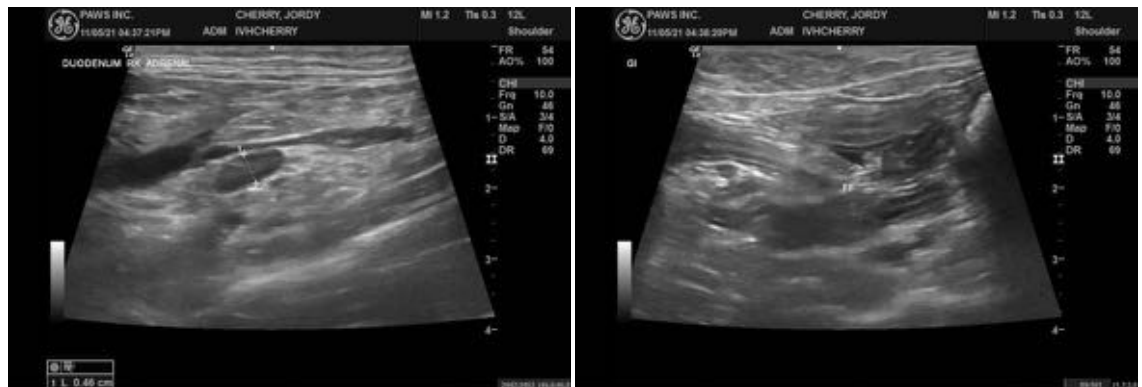
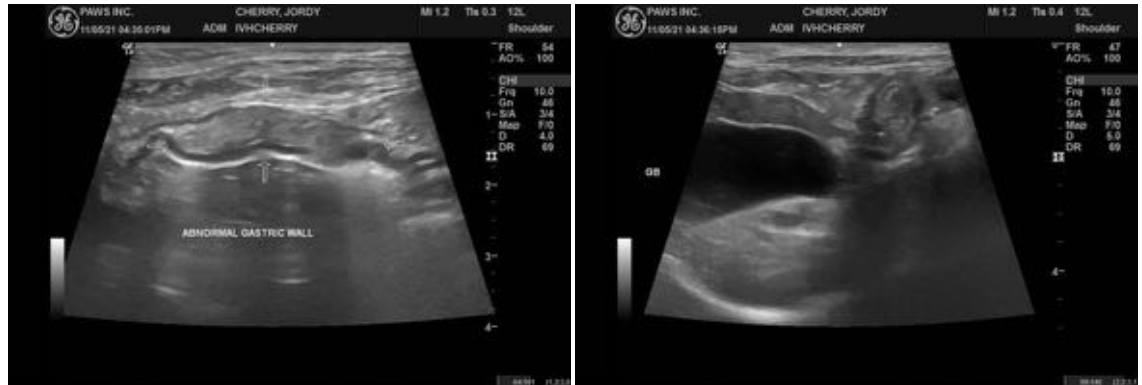
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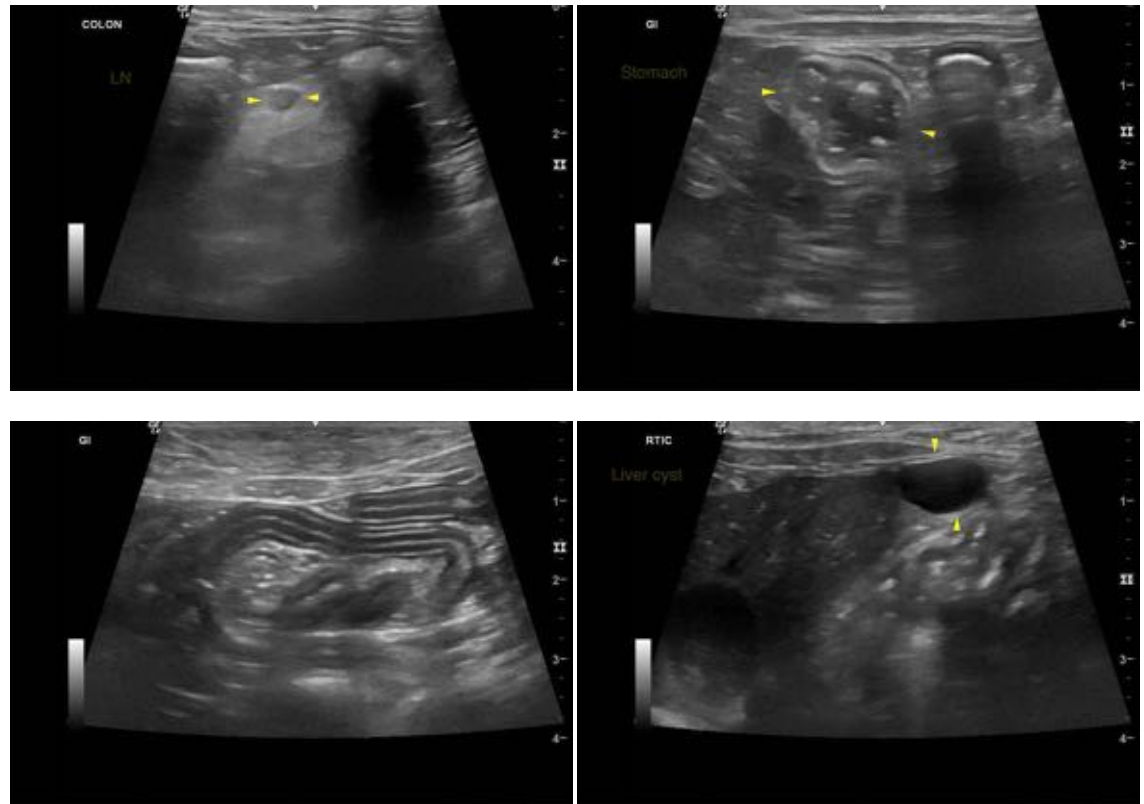
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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