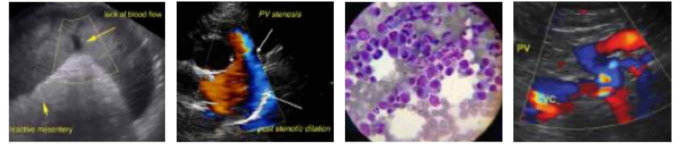

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1-800-838-4268 info@sonopath.com

PATIENT
Remi Heisick

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
11 years

WEIGHT
5.6 kg

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

IMAGING PERFORMED BY
Erin Wicks

HOSPITAL NAME
Shores Vet Emerg Ctr

REFERRING VET
Dr Christian

INVOICE
11978

DATE
11.7.22

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for ataxia, vomiting, and diarrhea. O stated P started having decreased appetite this past Thursday. P vomited earlier this week, and always has intermittent diarrhea with a history of pancreatitis. Today, P was ataxic and "twitching."
Previous Health Concerns: pancreatitis
Current Medications: ondansetron (12a today), Cerenia (last night), Mirataz (couple of days ago), prednisolone (1/2 tab EOD), high calorie gel last night

Neurological: mild generalized tremors, normal reflexes, no noted ataxia
Bloodwork- stress leukogram (neutrophilia, lymphopenia), basophilia, erythrocytosis, azotemia (BUN 76.4, creat 2.3), hyponatremia, hypochloremia, hypocalcemia, hyperlactatemia, hyperglycemia, hyperphosphatemia, hyperproteinemia (hyperalbuminemia), elevated cholesterol, mild hyperlipemia
Radiographs- moderately to severely gas distended stomach/SI/colon, abnormal irregular lumen surface of the colon (feces/diarrhea adhered to walls vs inflammation vs neoplasia)
Urinalysis-++ protein, ++ leukocytes, USG 1.048 , few waxy casts, cocci

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 moderately distended. A scant amount of suspended, echogenic debris is observed within the lumen. The region of the trigone and the visible portion of the proximal urethra are normal.

The **left kidney** is normal size (4.19 cm in length); normal shape and architecture with smooth peripheral margins. 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. Renal vasculature is normal.

The **right kidney** is normal size (4.20 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

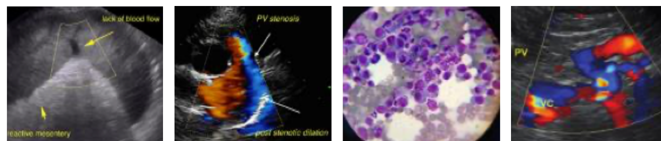
Adrenal Glands
The **left adrenal gland** is normal size (0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is upper limits of normal size (0.52 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
The **spleen** is normal in size (0.88 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 **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.



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Gastrointestinal
The **gastric lumen** is minimally fluid-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 diffusely and mildly fluid-distended. The small intestinal wall is normal in thickness 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 visible/prominent with slightly irregular 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
The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern consistent with gastroenteritis. There is no obvious evidence of a foreign body/obstruction, although a partial obstruction cannot be completely excluded.

Secondary Findings

- Bilateral, chronic age-related pancreatic remodeling renal changes with left trace pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the chronicity of the patient's GI signs, consider the following:

1. Fecal evaluation for ova and Giardia
2. Prophylactic deworming with Fenbendazole
3. Malabsorption panel, including serum cobalamin and folate, TLI and PLI (send to Texas A&M.)
4. Limited antigen diet or hydrolyzed protein diet trial
5. Depending on the results of the above diagnostic/therapeutics, GI biopsies (i.e., endoscopic, or surgical) may be necessary to get a definitive diagnosis. If pursued three-view thoracic radiographs should be performed prior to anesthesia.

Given the patient's azotemia, consider the following:

1. Urine culture and sensitivity
2. UPC (if proteinuria is present in the absence of infection)
3. Baseline blood pressure measurement

Regarding the neurologic signs, consider performing an ionized calcium. If substantially low, calcium supplementation may be warranted.

A T4/free T4 by equilibrium dialysis is also recommended, if not already performed.

Consultation with a board-certified neurologist should also be considered.

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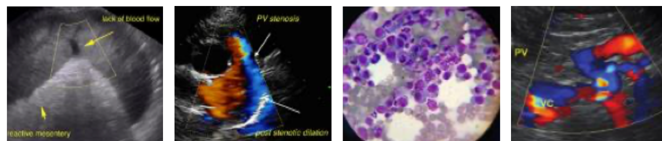

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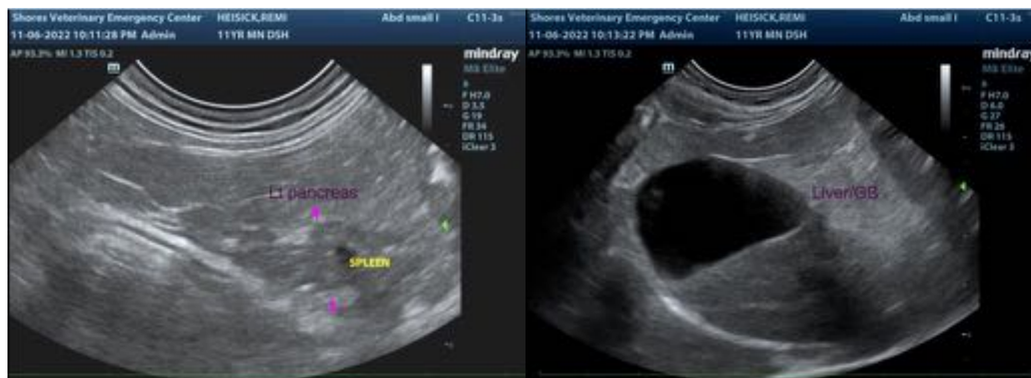

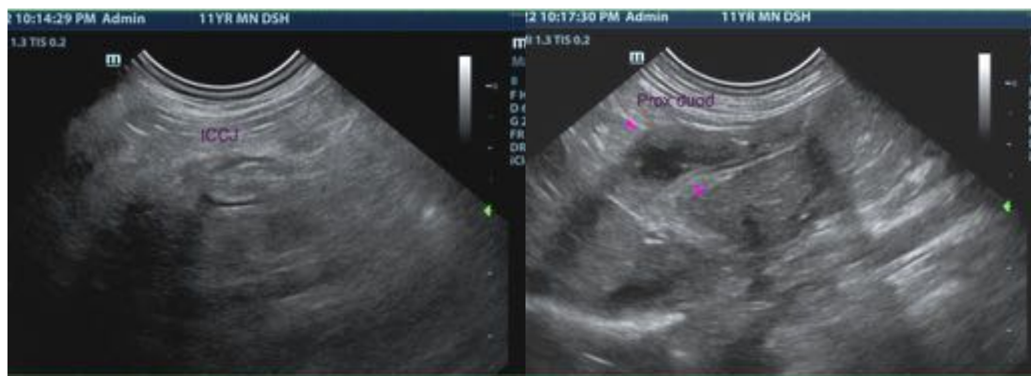

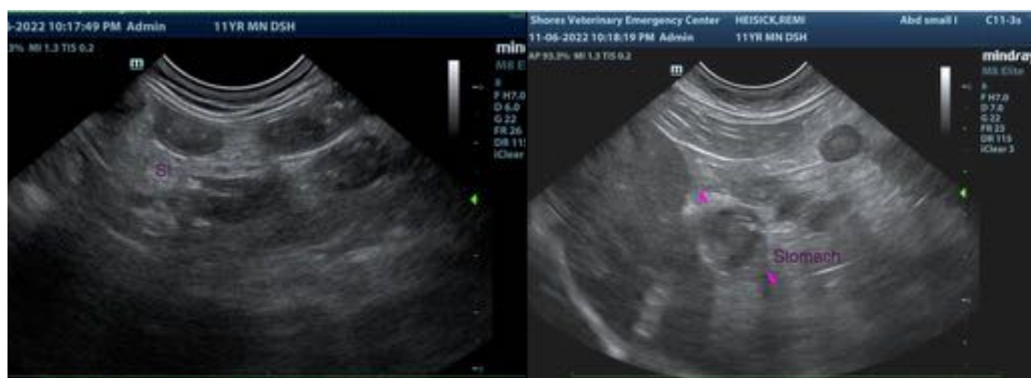

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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