



PATIENT

Claus Caprile

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

11.2 Lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jo Goodman

HOSPITAL NAME

Evandale-Blue Ash PH

REFERRING VET

Dr. Stephanie Wehmer

INVOICE

13074

DATE

12/15/21

PRESENTING CLINICAL SIGNS

History: Patient presented 3/15/21 for a wellness with CBC/Chem/UA/T4 and weight showed he had lost about 3lbs in a year, unintentionally, along with decreased appetite. A new dog was brought into the house in the last year that he was not a fan of. BW showed slightly elevated glucose but no glucose or ketones in urine. Performed fructosemine on 5/5/21 and it came back low. Presented on 12/2/21 for continued weight loss and another CBC/Chem/T4/UA performed and was unremarkable. Gallop rhythm heard upon auscultation of heart, which is a new finding. Owners declined chest radiographs. Presented today for abd u/s and Texas GI Panel, results pending. Has been eating and drinking fine at home. intermittent vomiting and loose stool noted.

Abnormal PE/Chem/CBC/UA Results: 3/16/21: Glucose - 248 5/5/21: Fructosemine - 173.5 Weight history: 4/9/2020 - 16.16lbs 3/15/21 - 13.86lbs 5/5/21 - 13.44lbs 12/2/21 - 11.7lbs 12/15/21 - 11.2lbs

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 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 (3.94 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.

The right kidney is normal size (3.69 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.

Adrenal Glands

The left adrenal gland is normal size (0.45 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

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

Spleen

The spleen is normal in size (0.77 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Several varying sized hyperechoic nodules are observed throughout the parenchyma. 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.



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The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal.

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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) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. There is also thickening of the submucosal layer in several segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

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Pancreas

The left limb and body of the pancreas are prominent in size 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 dilated (0.31 cm in diameter). The mesentery effacing the serosal surface is mildly hyperechoic.

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Free Abdomen

There is no evidence of free fluid. A few visible/prominent colic lymph nodes are visualized Surrounding mesentery is hyperechoic.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The pancreatic changes are consistent with chronic active pancreatitis
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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Secondary Findings

- The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, or less likely, infiltrative neoplasia. Cytology or histopathology would be necessary to get a definitive diagnosis. The hyperechoic splenic nodules trend toward the benign (i.e., myelolipomas or foci of lymphoid hyperplasia) with low potential for emerging neoplasia.
- Bilateral age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- The following diagnostic/treatment recommendations can be considered:
 1. A fecal evaluation for ova/Giardia
 2. A 6-week limited antigen diet trial to assess for food allergies



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3. Three-view thoracic radiographs are recommended to assess for occult neoplasia in the chest
4. If the above diagnostics/therapeutics are inconclusive, endoscopic or surgical gastrointestinal biopsies may be warranted.

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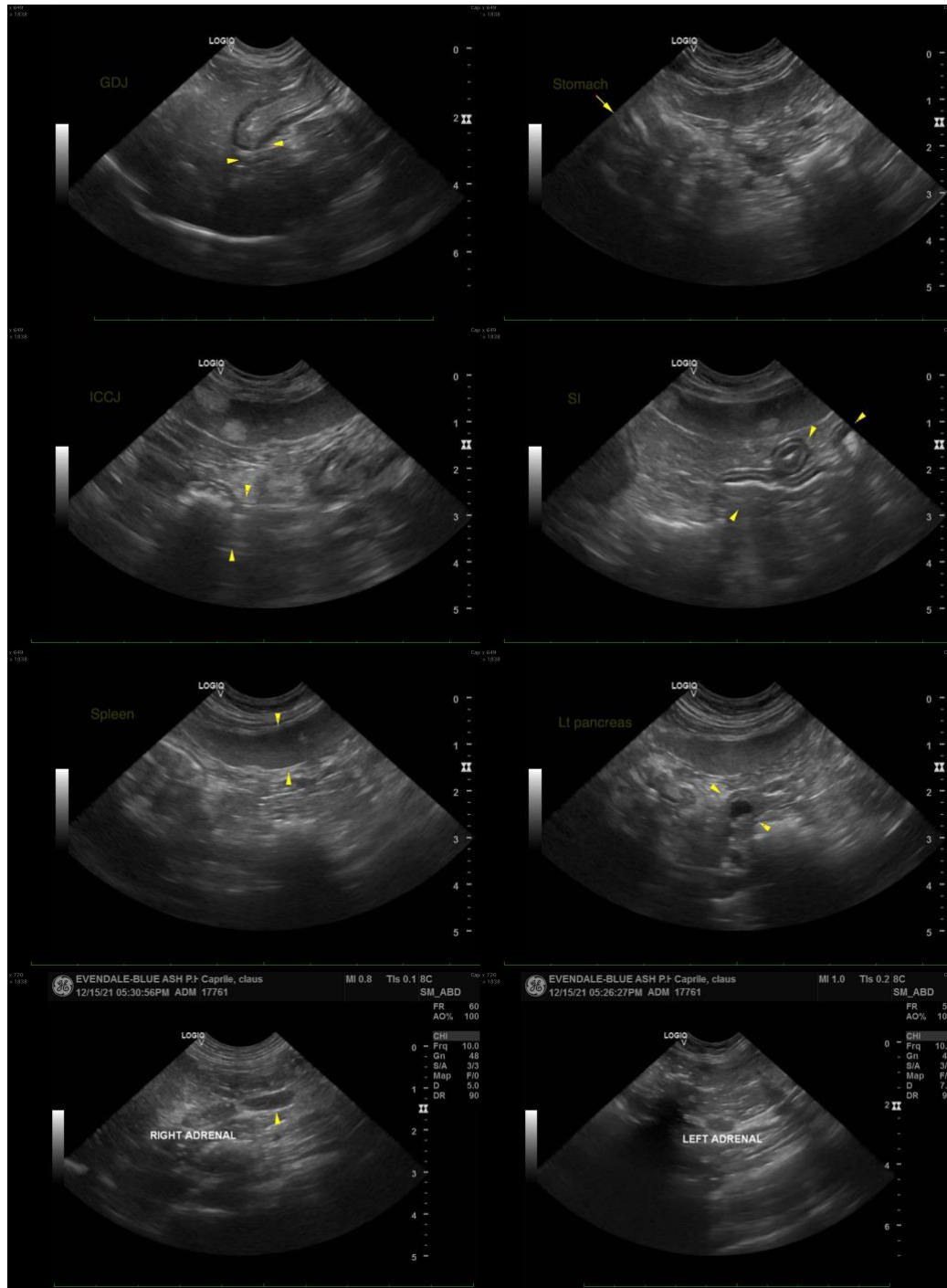
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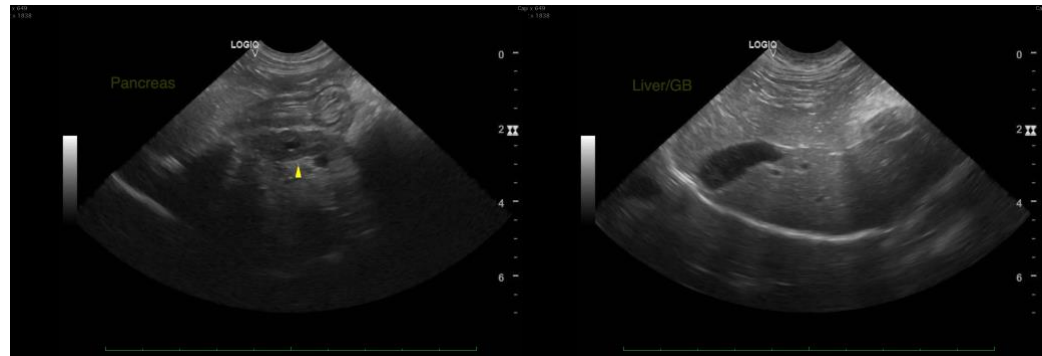
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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