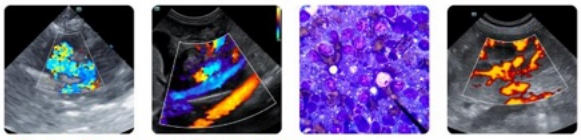


DATE

12/16/25

PATIENT

Titan Callahan

SPECIES

Feline

BREED

Domestic mediumhair

SEX

Male, neutered

AGE

9/12/2011

WEIGHT

9.6 oz.

INTERPRETED BY

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

HOSPITAL NAME

Cat Sense Feline Hospital

REFERRING VET

Dr. Sinclair

INVOICE

13440

PRESENTING CLINICAL SIGNS

Patient History: Titan, who has presumptive IBD and pancreatitis issues and is on 0.4mg dexSP sq sid + 0.25ml B12 sq siw for the intestinal disease, presented on 12/11 for a decreased appetite and really watery diarrhea (not his usual diarrhea). The owner is not able to easily orally medicate Titan and he is very particular about food
so a food allergy diet trial was not able to be tried. Titan had lost 3/4# and his intestines felt thickened. An in-house glucose (191mg/dL) and blood ketone level(0.2mmol/L) was taken via ear prick and both were just very slightly elevated. Full bloodwork and a urinalysis was sent out and his serum glucose was 153 but he had a 3+ glucosuria. It was felt that the glucosuria was due to the stress of the 45-1 hour car-ride here. He has a very low s.g. which is probably due to ckd but also may be from the high steroid dose he is getting. He was placed on Mirataz to increase his appetite. On Saturday the owner noticed that although Titan did eat with having the Mirataz on board, he would stop in the middle of eating and then go get a big drink then he would go back to his food. He also started urinating a lot more than he had been. The owner brought him back in on 12/15 and brought a small amount of urine she collected from home. It had 3+ glucosuria. An ear prick check of his glucose was 187mg/dL,on the Catalyst it was 213 (he was stressed during the blood pull) . A fructosamine has been added to his bloodwork but isn't back yet. We also ran a UPC and it is 0.4 so right on the low proteinuria borderline. He has a grade 3/6 heart murmur.

Current Medications: 0.1ml DexSP 4mg/ml sq sid, 0.25ml cyanocobalamin (1000ug/ml) sq siw, mirataz once daily
Labwork Results: Labwork reported as: 12/11 glucose (ear prick)=191, lab=153 mg/dL
ketones (ear prick)=0.2mmol/L. Urine s.g.=1.010, 3+ glucosuria, 1+ protein; 3+ blood (that I am sure was from the needle stick for the cystocentesis), 24,000 neutrophils, 1700 monos, 283 basos, hct=25%. 12/15 urine from home collection glucose 3+, UPC=0.4, glucose (ear prick)=187, Catalyst (213) mg/dL
USG 1.010, T4 1.6, fructosamine normal at 269
Date of Previous IntraPet Ultrasound: 8/29/23.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is distended. A small 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 in size (4.23 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Trace pyelectasia is present (0.12 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.57 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Trace pyelectasia is present (0.16 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.31 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.59 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 curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

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 thickness is normal. There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

ULTRASONOGRAPHIC FINDINGS

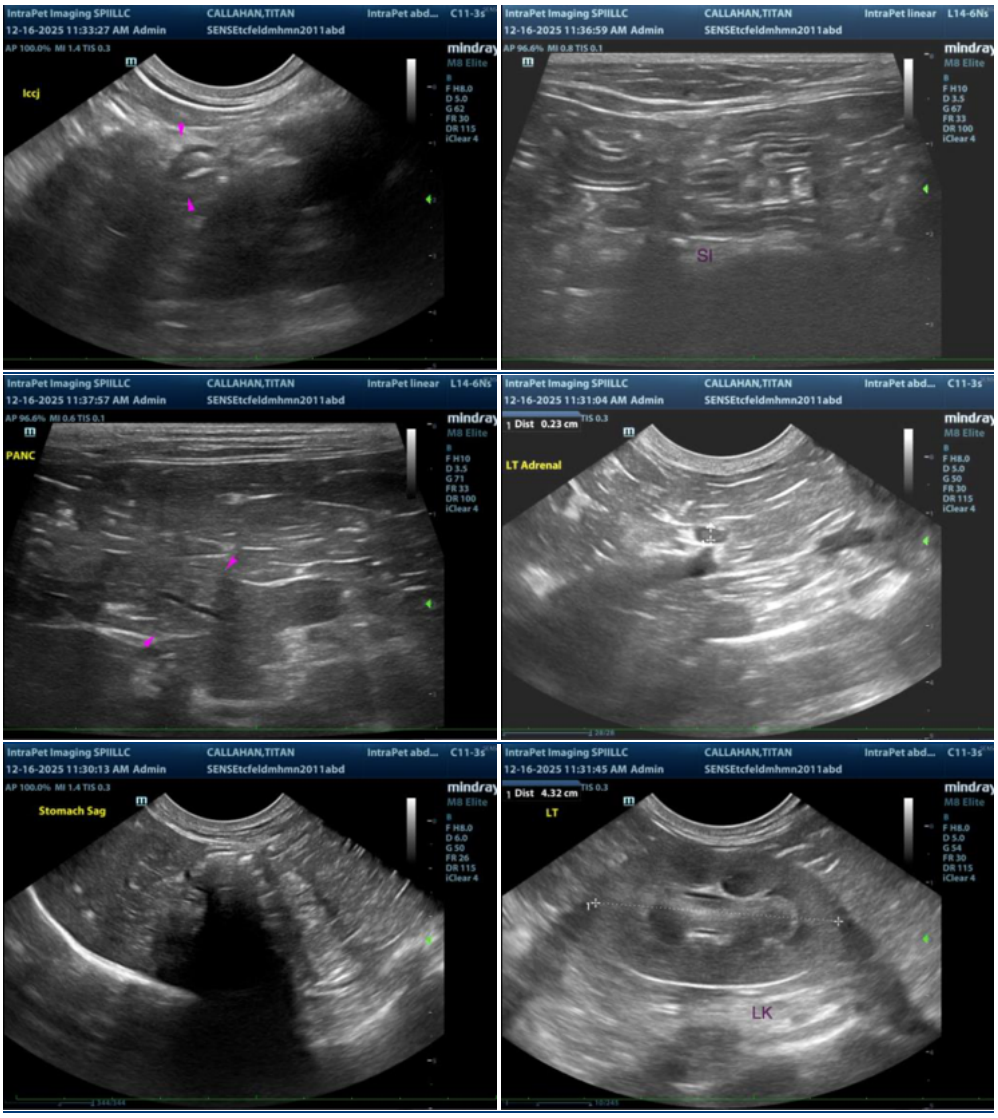
- The small intestinal wall changes could be consistent with inflammatory bowel disease or less likely, emerging small cell lymphoma. Changes are similar to the previous sonogram.
- Bilateral nonspecific, age-related renal changes. The bilateral pyelectasia may be secondary to chronic parenchymal remodeling, pyelonephritis, PU/PD (if applicable) or some combination thereof.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

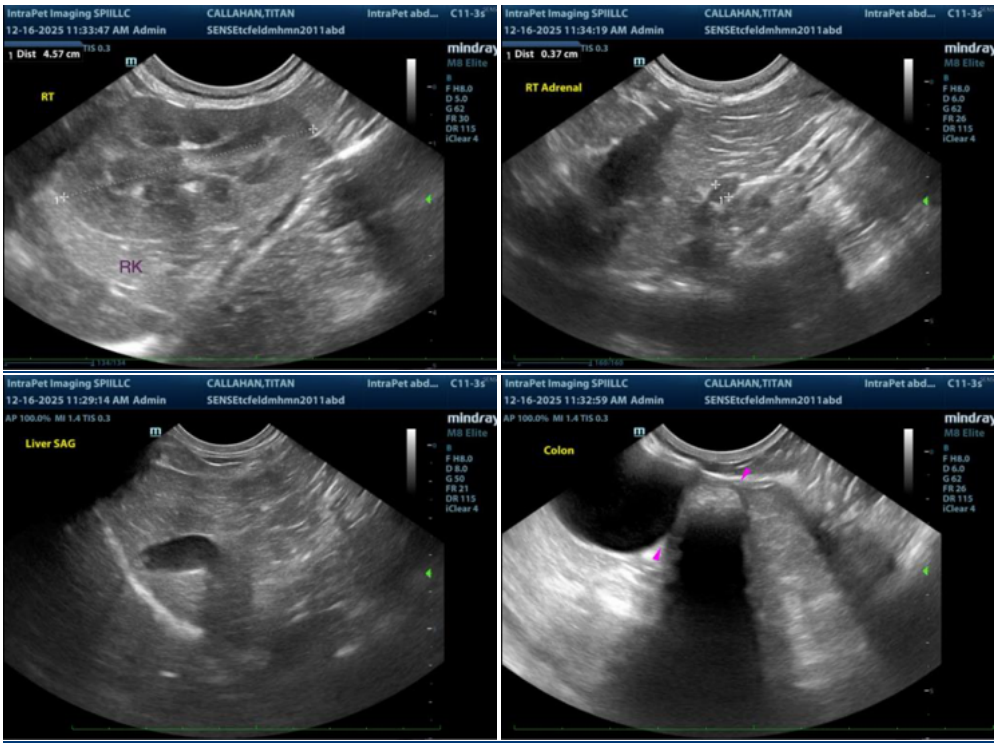
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's clinical history, consider the following:

1. Fecal evaluation for internal parasites

2. +/- prophylactic deworming with Fenbendazole
3. Initiation of a probiotic along with a fiber supplement (i.e., psyllium)
4. Consider a hypoallergenic diet trial (i.e., homemade). A nutritional consult with the University of Tennessee may be beneficial.
5. Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis.
6. In the meantime, symptomatic care is recommended.





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) info@SonoPath.com