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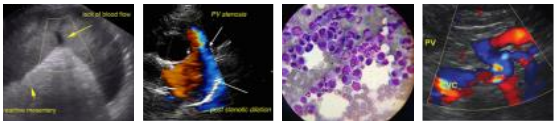


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Quinault Urquhart

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10 Years

WEIGHT

7.5 Lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Forest Valley VC

REFERRING VET

Dr. Urquhart

DATE

12/17/21

INVOICE

13088

PRESENTING CLINICAL SIGNS

History: P has been doing well on transdermal methimazole until early December 2021 when P began vomiting approximately once per day to once every other day. Improved on oral cerenia (vomiting ceased, more energetic). Appetite is mediocre. P stools had improvement on Hills GI biome (switched after ultrasound one year ago). Currently stool semi-solid to solid/formed. Primary Question/Differential to Be Answered in This Exam Any reason for P's vomiting and poor appetite. Recheck of ultrasound findings with Animal Sounds from 12/23/20 (suspect inflammatory bowel disease {rule our GI lymphoma], mildly enlarged LN near ileocolic junction, suggestion of active pancreatitis, changes to splenic parenchyma consistnet with lymphoid hyperplasia, moderate loss of corticomedullary renal distinction). Subsequent to ultrasound one year ago, P had cobalamin, folate, PLI/TLI performed which was all WNL. Does this patient need GI biopsies or empirical treatment for IBD?

Abnormal PE/Chem/CBC/UA Results: Current Medications Transdermal methimazole 2.5mg BID, Cerenia 16mg 1/2 tab SID, Hills GI biome T4 stable since October. 9/16 - 7.6, 10/15 - 2.3, 12/7 - 2.8. Otherwise NSF.

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 mildly distended with mostly anechoic urine. 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 (3.37 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (xxx cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is mild to moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. A few nonobstructive nephroliths are present. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

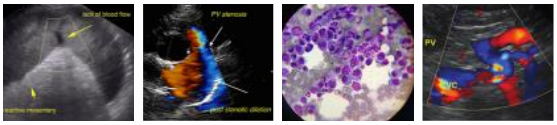
Adrenal Glands

The left adrenal gland is normal size (0.94 cm length; 0.32 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (1.15 cm length; 0.33 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.78 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.23 cm x 0.20 cm hypoechoic nodule



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with a hyperechoic center is observed approximately mid spleen. 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 is of normal contours and contains some gravity dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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 thickness is normal with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The left limb of the pancreas is visible/prominent with minimal deviations from the normal 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

There is no obvious evidence of free fluid. A few prominent mesenteric and colic lymph nodes are visualized, the largest measuring 0.84 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern most consistent with inflammatory bowel disease with lower potential for emerging lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The pancreatic changes are suggestive of chronic pancreatitis. However, correlation with clinical findings is recommended
- The splenic nodule could be consistent with benign change (i.e., a focus of lymphoid hyperplasia or extramedullary hematopoiesis). Alternatively, emerging neoplasia is possible.

Secondary Findings

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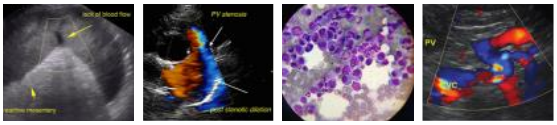

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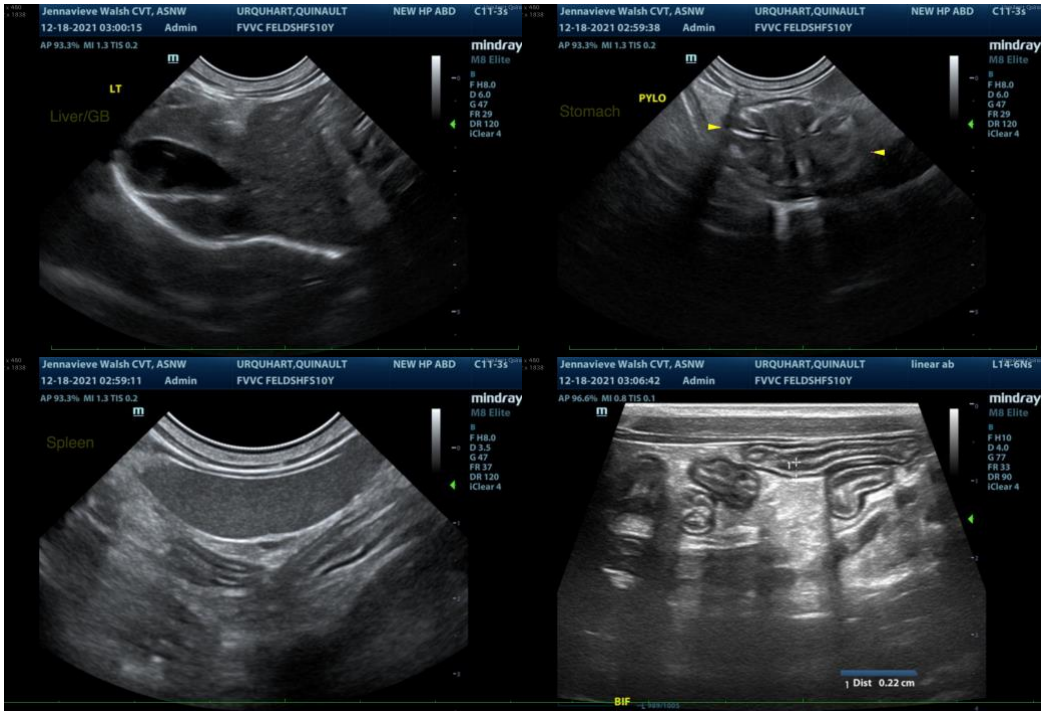
- Bilateral age-related renal changes with right nonobstructive nephrolithiasis

*Overall, the sonographic changes are similar to the previous scan.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider repeating a GI panel, in light of the worsening clinical signs.
- Three-view thoracic radiographs are also recommended to assess for occult esophageal disease.
- Ultimately, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. If biopsies are not to be pursued, empirical treatment for inflammatory bowel disease with a hypoallergenic diet and corticosteroids can be considered as long as the client understands the risk of treatment without a definitive diagnosis.



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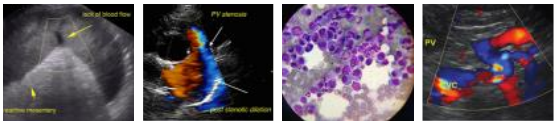

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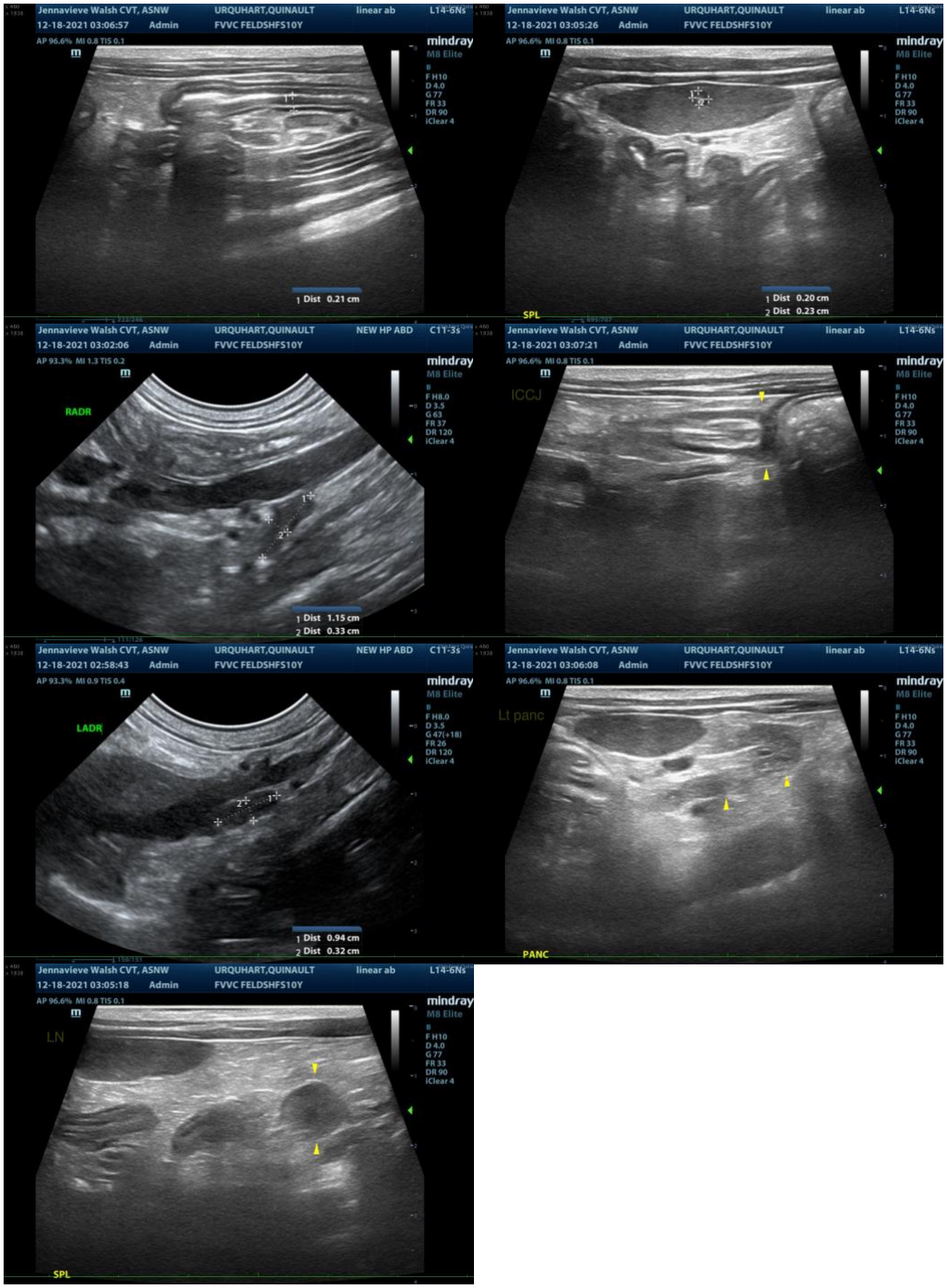
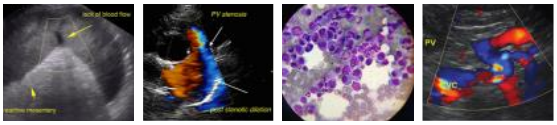


The information and recommendations provided are based on the images presented by the



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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 ACVIM (*Small Animal Internal Medicine*)

andrea_nicastro2@hotmail.com