



PATIENT

Captian Strand

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

8.46 Lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

West Eugene AH

REFERRING VET

Dr. Seyler

DATE

2/16/22

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PRESENTING CLINICAL SIGNS

History: Hx What is the primary problem? Over the past 3 months, P has lost around a pound of weight and has a decreased appetite. Breath over the past few weeks has gotten stinky. P still very interested in human food, but not eating as much of his own food. Attitude has gotten cranky around the home, very vocal overnight. Always demanding more food, but is leaving dry food alone. Still drinking water normally. Less BMs, attributes to eating less food PE: fractious, patient barely allows any exam. skin turgor is poor, muscling reduced. patient trying to bite

Abnormal PE/Chem/CBC/UA Results: chem - increased ALP (143), increased ALT (297), hyperbilirubinemia (0.8), hypokalemia (3.4), elevated TP (8.8; glob 4.5, alb 4.3). CRE 1.6 A - borderline azotemia with isosthenuria - likely stage 1 renal. elevated TP suggest dehydration, mild hyperbilirubinemia and elevated liver enzymes is concerning for liver disease UA below TIME/DATE Stamp: MD: 02-16-22 at 8:57a: Date of sample collection: MD: 02-16-22 at 8:57a: Method of collection: cysto Color: bright yellow Appearance: nsf SG: 1.022 pH: 7 Occult Blood: neg Bilirubin:neg Ketones: neg Nitrite:(+/-) neg Protein:neg Glucose:neg Ascorbic Acid: norm Urobilinogen:norm Microscopy: No sediment visually, few lipids, 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 is moderately distended. A scant amount of echogenic debris is suspended 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 (4.08 cm in length); with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.45 cm in length); with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.64 cm length; 0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.50 cm length; 0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.92 cm in width at the level of the hilus) with a normal capsular



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contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

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Liver

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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 anechoic. The cystic and common bile ducts are normal.

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Gastrointestinal

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The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. 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 to mildly thickened (up to 0.32 cm) There is disruption in the normal 1:3 muscularis: mucosal ratio in most 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

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The left limb of the pancreas is visible/prominent 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 not overtly dilated.

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Free Abdomen

There is no evidence of free fluid. A 0.56 cm epigastric lymph node is visualized. 1-2 prominent mesenteric lymph nodes are also seen, the largest measuring 1.11 cm in length.

ULTRASONOGRAPHIC FINDINGS

IMAGING PERFORMED BY

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Primary Findings

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- The small intestinal wall changes are most consistent with inflammatory bowel disease. Emerging lymphoma is possible. However, neoplasia is considered less likely at this point in time.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

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Secondary Findings

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- Bilateral minor age-related renal changes with trace pyelectasia

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- A thorough oral exam is also recommended to assess for dental disease as a possible cause for the patients inappetence.

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- The following additional diagnostic/treatment recommendations can be considered:

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- Serum cobalamin, folate, PLI and TLI
- A fecal evaluation for ova/Giardia
- A 6-week hypoallergenic diet trial to assess for food allergies

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- Three-view thoracic radiographs are recommended to assess for occult neoplasia and esophageal disease.

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- If all tests are inconclusive, endoscopic or surgical gastrointestinal biopsies may be warranted.

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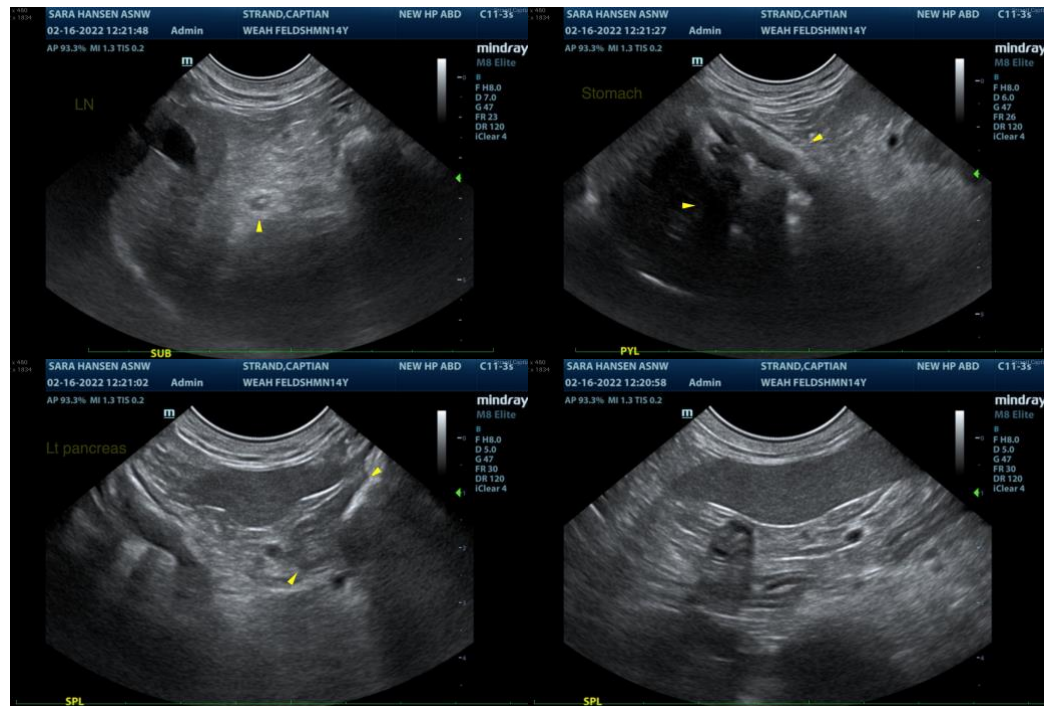
Dr. Seyler

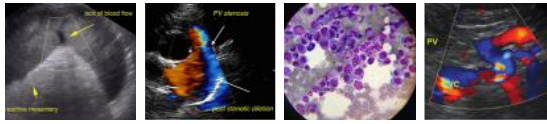
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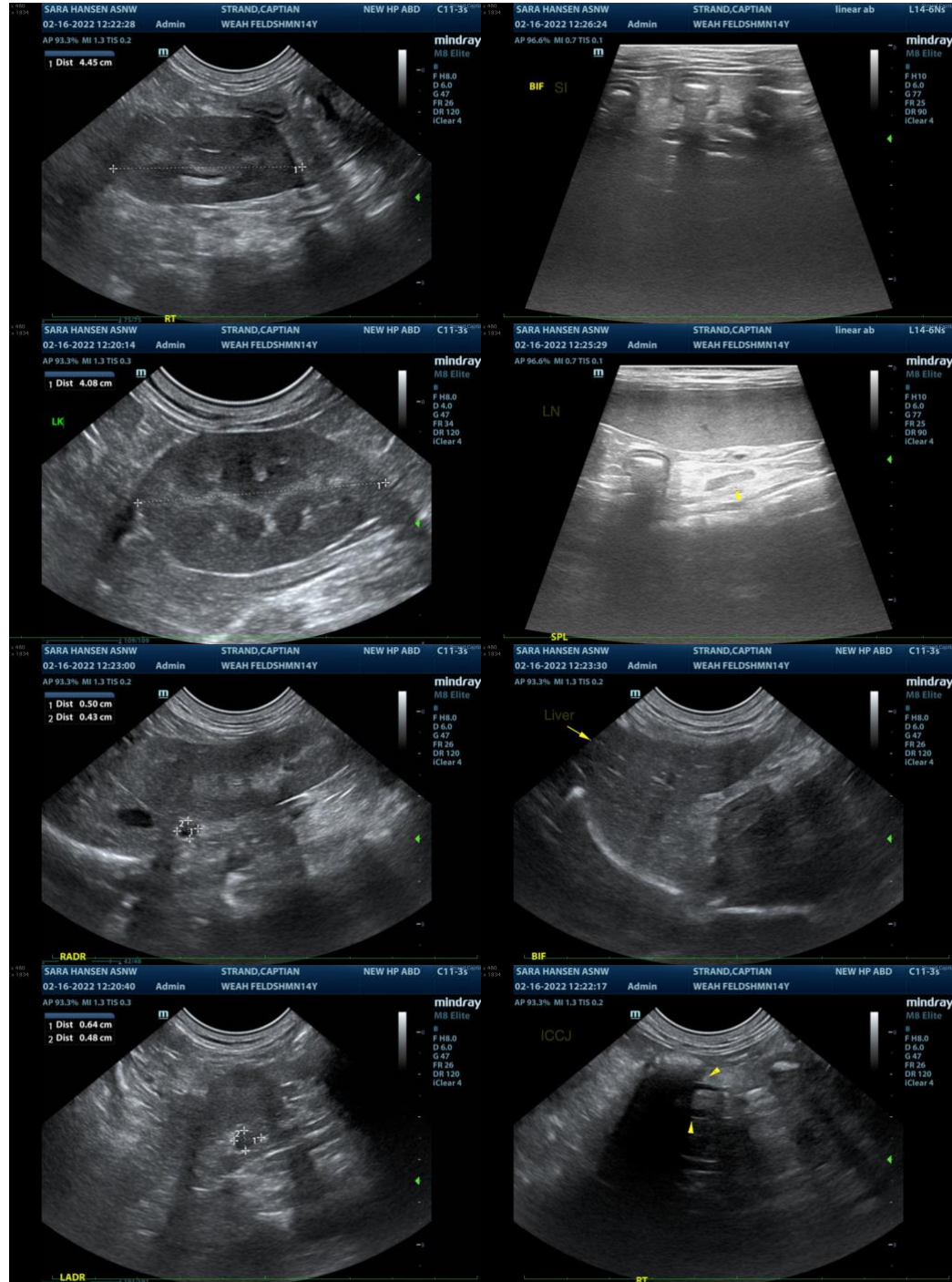
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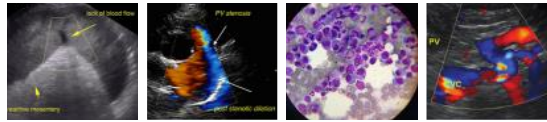
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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