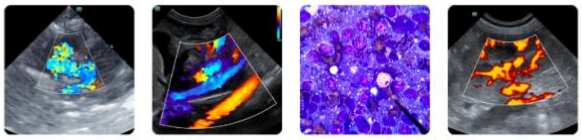


DATE

2-2-26

PATIENT

Reesie Rohrbach

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2/1/2014

WEIGHT

3.2kg

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Mason Dixon AEH

REFERRING VET

Dr. Moore

INVOICE

22494

PRESENTING CLINICAL SIGNS

Patient History: Presenting for losing weight, vomiting with blood in it. Losing weight off and on over 3 years, vomited on way here with blood in it-- vomited 3 times tonight all had blood in it.

Current Medications: Maropitant, pantoprazole x 1, B12 injection.
Labwork Results: Labwork submitted. Reported as CBC--normal. Pcv/Ts: 36/6.0. T4: 2.77. Fpli: 13.9 consistent with pancreatitis. CHEM--BUN 36.1, BG 203, ALT 207. Radiographs--ABD: poor serosal detail due to being so thin; suspect renoliths R kidney. POCUS - no FF noted; GB sludge visible but no halo; small intestinal loops have very prominent and thickened walls.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Propofol.
Stat Report: Requested.
Imaging Performed by: Andi Parkinson, BS, RDMS.
Sedated with Propofol for this study.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A scant amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.19 cm in length) with an irregular shape. There is mild loss of corticomedullary distinction. The cortex is hyperechoic relative to the spleen. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia or hydronephrosis.

The right kidney is normal in size (3.98 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. The cortex is hyperechoic relative to the spleen. A few, small, nonobstructive mineralized foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.49cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

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

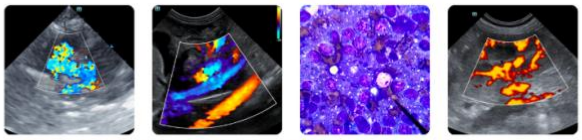
Spleen

The spleen is normal in size (0.55 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 peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. There is an increase in hepatic portal markings. Hepatic vasculature is of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are visible/tortuous, but not overtly dilated.



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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 borderline thickened (up to 0.26 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments, with a 1:1 ratio in some regions. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

A few prominent mesenteric lymph nodes are visualized (one measuring 1.06 x 0.34 cm).

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma.
- The increase in hepatic portal markings is suggestive of an inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis).

Secondary Findings

- Bilateral nonspecific age-related renal changes with nonobstructive nephrocalcinosis
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

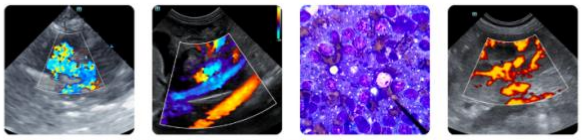
The following diagnostic/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia
3. 3-4-week limited antigen or hydrolyzed protein diet trial to assess for food allergies
4. Initiation with a probiotic may also prove beneficial.
5. Also consider heartworm antigen and antibody testing as heartworm disease can be a cause of chronic vomiting in cats.
6. If the above diagnostics/therapeutics are inconclusive, endoscopic or surgical gastrointestinal biopsies may be warranted. Thoracic radiographs are recommended prior to anesthesia.
7. For patients where chronic vomiting is present but additional diagnostics are not to be performed, consider empirical treatment for Helicobacter gastritis, which includes a 14–21-day course of amoxicillin, metronidazole, clarithromycin and an acid blocker (i.e., omeprazole or famotidine).

Imaging performed by

IntraPet Imaging

IntraPet.com



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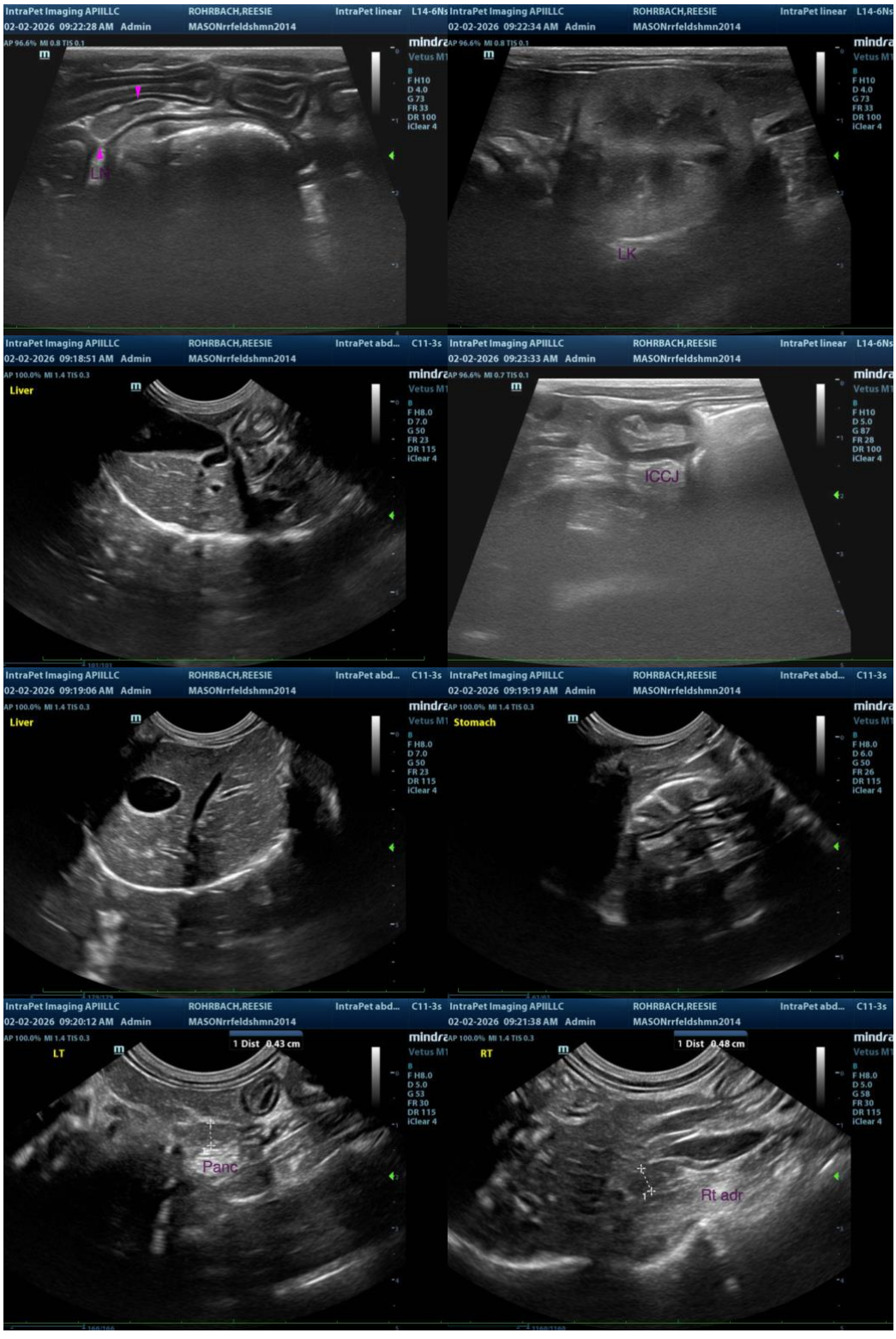

Imaging performed by IntraPet Imaging
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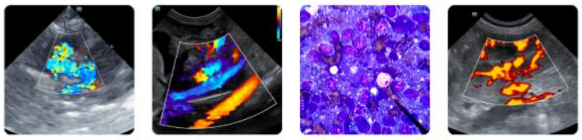

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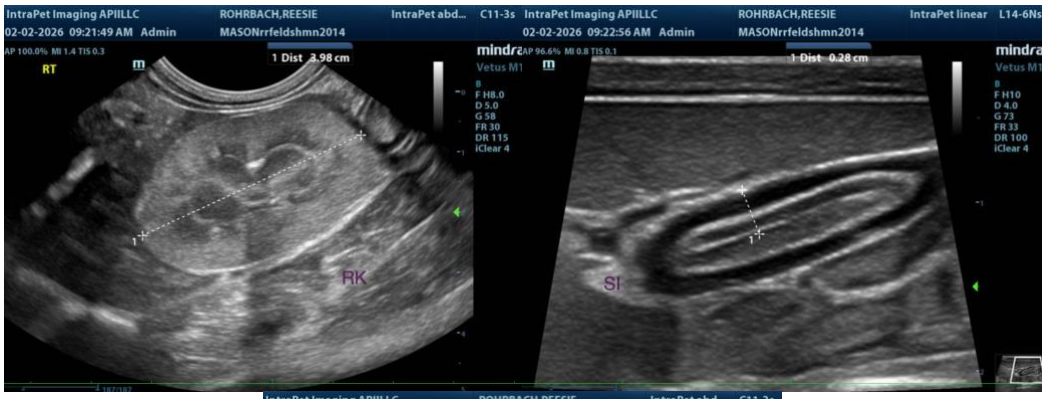

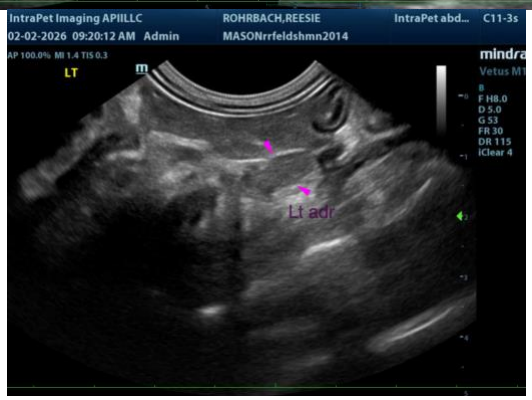

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com