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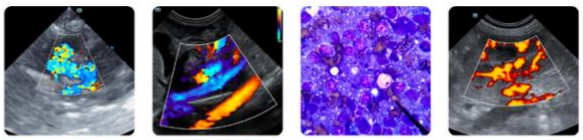

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Scotty Rickenbacker

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

09/03/2014

WEIGHT

11.3 lb

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Kind Care AH

REFERRING VET

Dr. Marino

INVOICE

22625

DATE

2-27-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Patient has a history of coughing and has also been on Mirtazapine due to a decreased appetite.

Abnormal lab-work values: CBC/Chemistry 10: Results revealed a slightly elevated eosinophil count. Kidney values, liver values, and glucose were within normal limits. USG 1.020, no proteinuria, inactive sediment.

Urinalysis: Urine is dilute. No protein, glucose, or evidence of infection was noted.
Current Medications: Miratax ointment
Radiographic Findings: will be emailed

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 small- to moderate amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (3.56 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. The cortex is hyperechoic relative to the spleen. Trace pyelectasia is present (0.15 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.37 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. Trace pyelectasia is present (0.14 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.48cm 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 (0.91 cm in width at the level of the hilus) with a normal capsular contour. Using a high-frequency probe, a light micronodular pattern is observed throughout the organ. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal peripheral contours. The parenchyma is isoechoic relative to the spleen. A 2.2 x 1.5 cm hyperechoic- to heterogenous, slightly cystic macronodule is observed on the right side, adjacent to the diaphragm. The remaining parenchyma is homogenous. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is minimally distended. The wall is of appropriate thickness for the level of repletion. luminal contents are mostly anechoic. The cystic and common bile ducts are normal.

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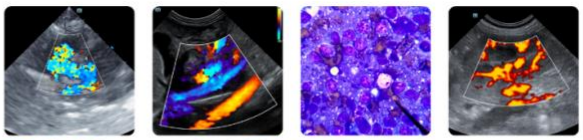

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Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with gas and chyme. The small intestinal wall thickness is normal. 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 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
A 0.74 x 0.63 cm mesenteric lymph node is visualized.

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

- The small intestinal wall changes could be consistent with inflammatory bowel disease, or may be a normal variant for this older feline patient. Correlation with the patient's clinical history is recommended.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral nonspecific age-related renal changes with trace pyelectasia. The pyelectasia may be secondary to parenchymal remodeling, pyelonephritis, PU/PD (if applicable), or some combination thereof.
- The right cystic hepatic macronodule could be consistent with biliary cystadenoma, biliary cystadenocarcinoma, other.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The prominent mesenteric lymph node is likely reactive, with a lower possibility of emerging neoplasia.
- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the patient's inappetence, consider the following:

1. Fecal evaluation for ova and Giardia
2. T4/free T4 by equilibrium dialysis (if not already performed)

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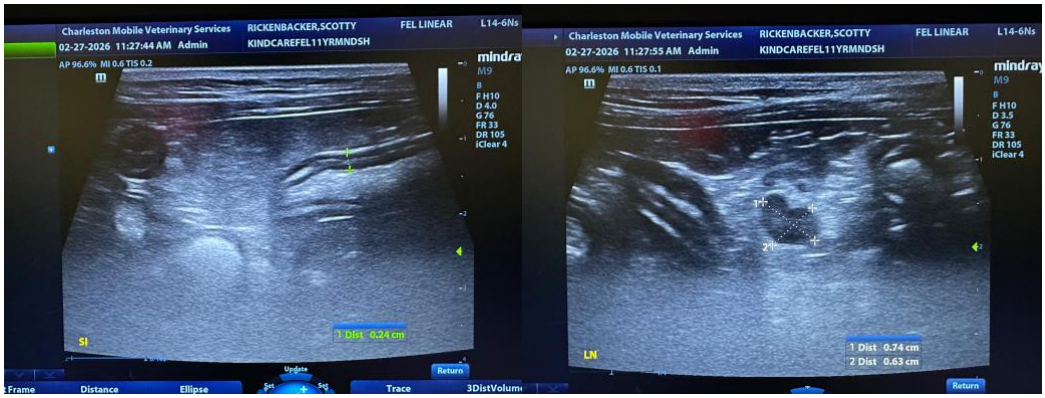
3. GI panel including serum cobalamin and folate, TLI and PLI
4. Three-view thoracic radiographs to assess for occult pathology in the chest
5. Depending on the results of the above diagnostics further work-up (i.e., GI biopsies) may be indicated.



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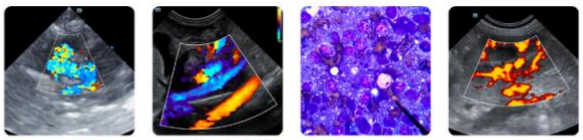

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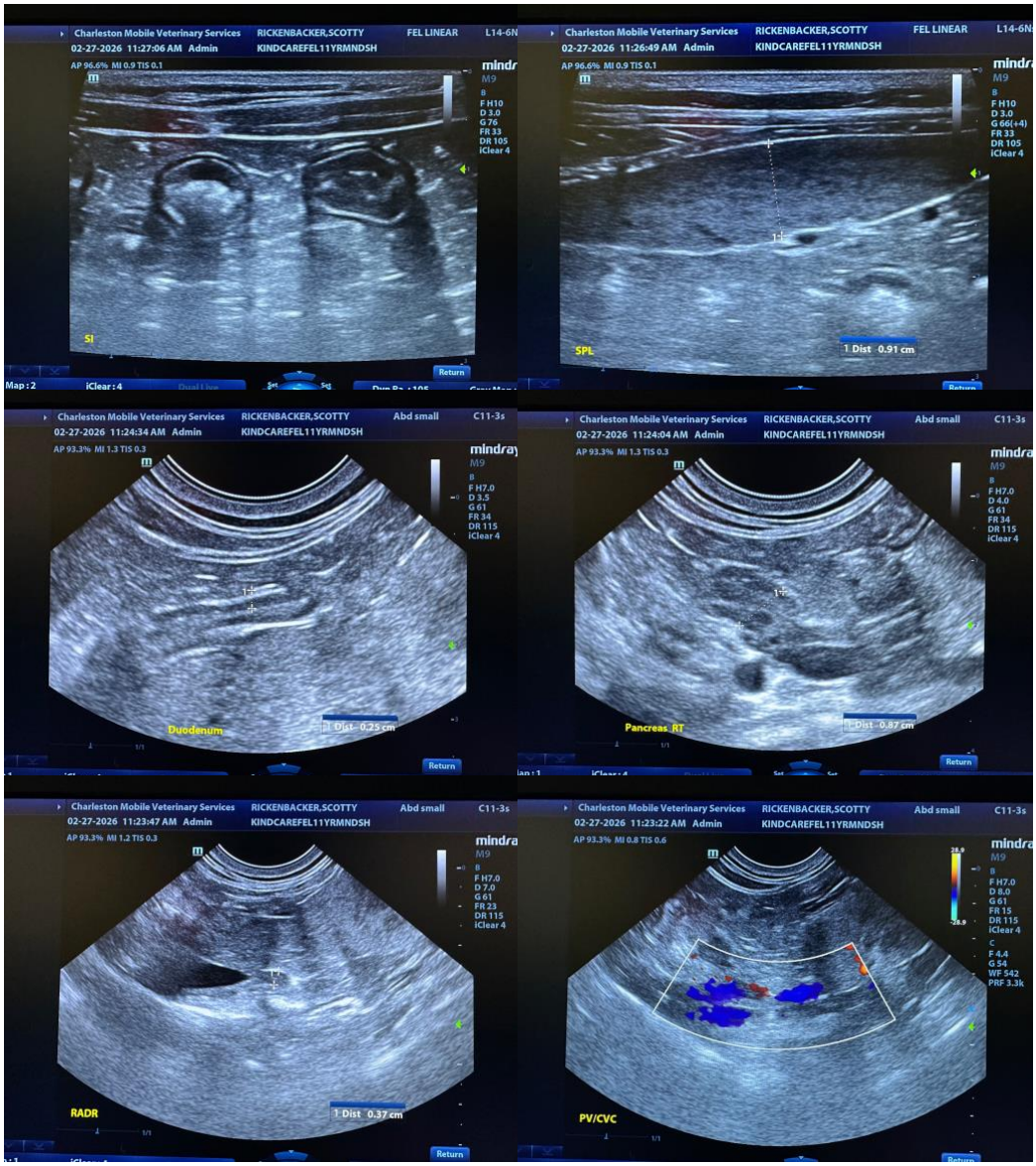

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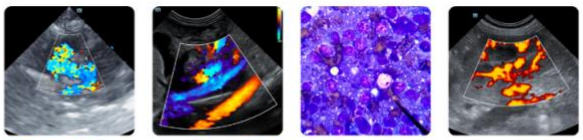

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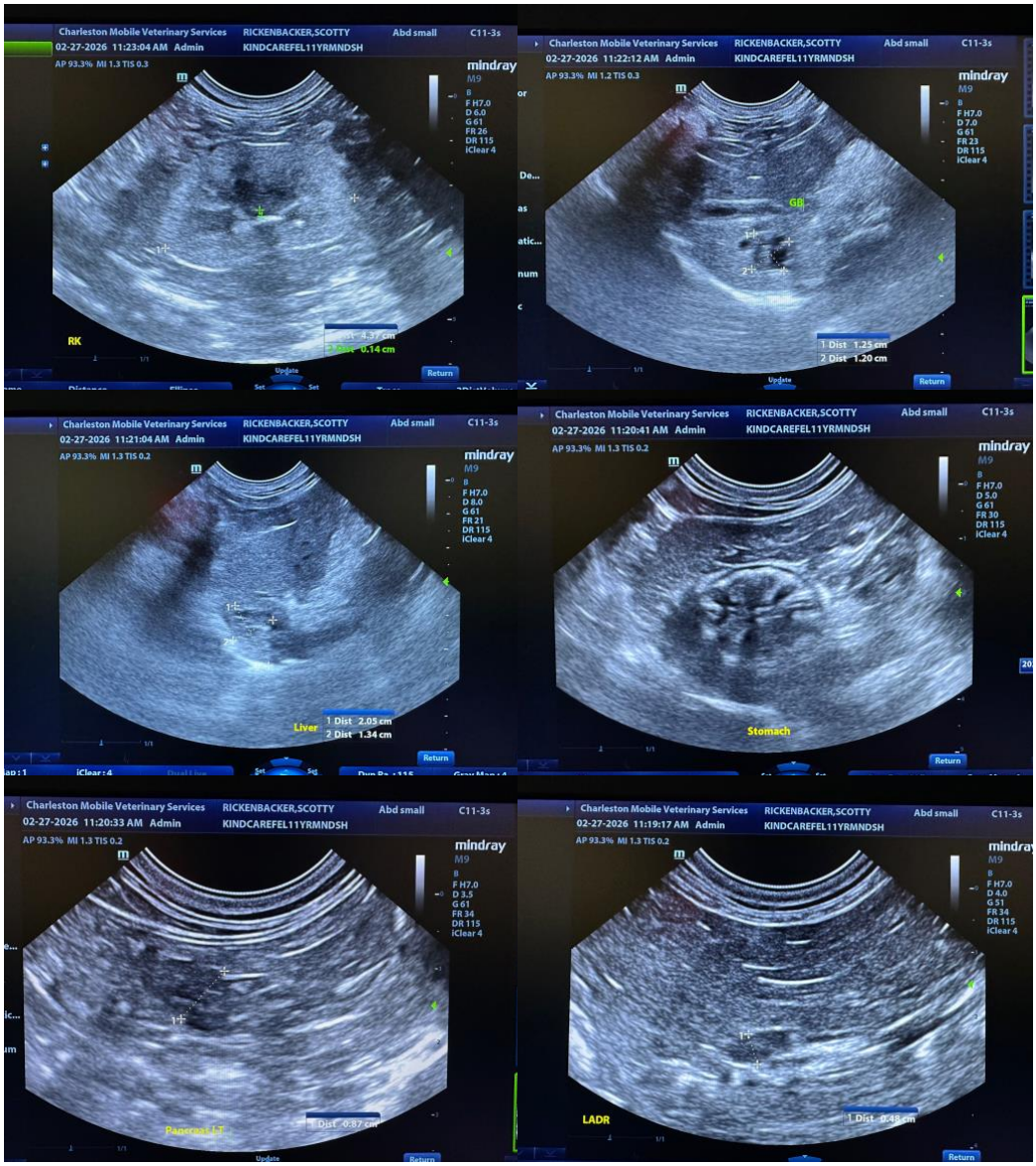

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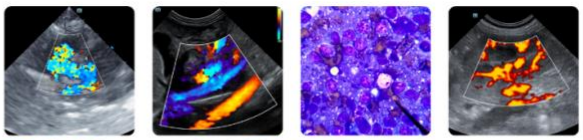

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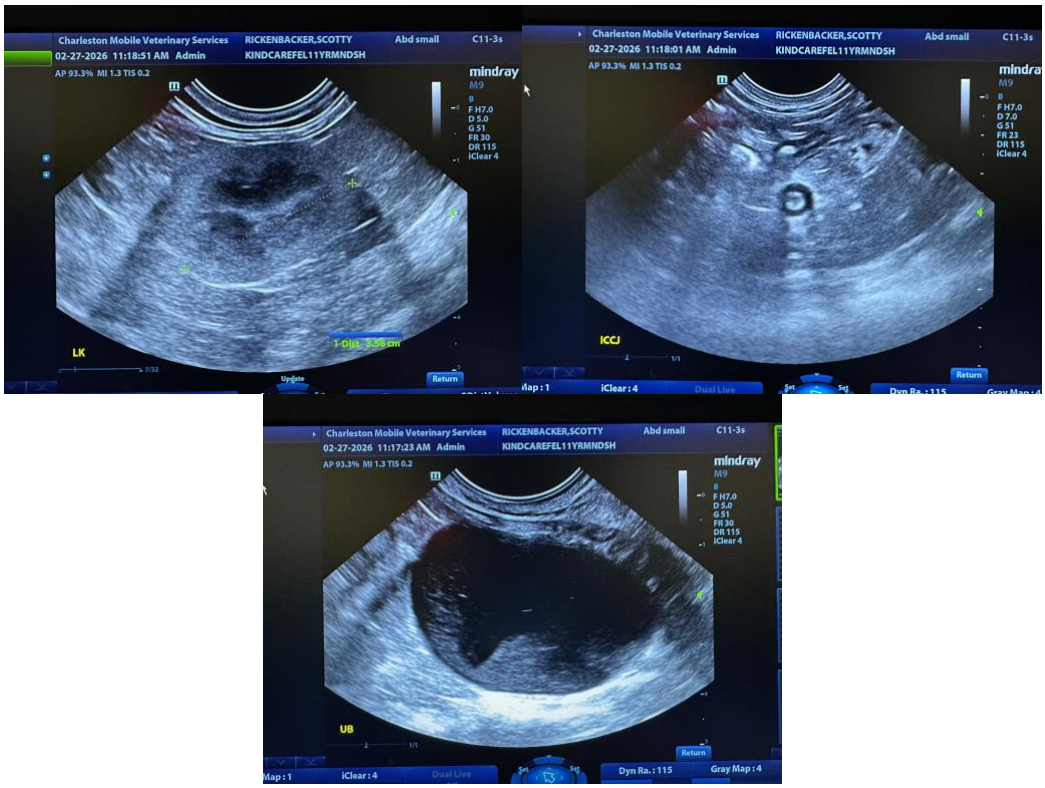

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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