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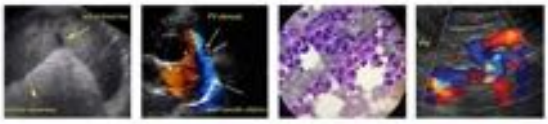


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Champ Medina

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

9 Years 11 months

WEIGHT

8.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Animal Medical Center of Reno

REFERRING VET

Dr. Taormina

INVOICE

13056

DATE

2/28/22

PRESENTING CLINICAL SIGNS

History: P has hx of being on asthma medication, was presented for PD back in November. Had rads done in January, there were some abnormal cardiac findings (see report). At that time, an echo to look for occult cardiac disease was recommended by DVM. Today P is presented for vomiting daily and it has lasted for 1.5 weeks now. P has a good appetite, and seems to eat OK. O don't notice a tremendous amount of vomit after eating, but do find areas where there is clear fluid, or hairballs. . Hyperthyroid but O have d/c'd meds as of late Heart Murmur No Blood Pressure: 150mm/Hg
Abnormal PE/Chem/CBC/UA Results: LABS hypokalemia- Physical exam findings: Mild increase in BV sounds but no crackles, no resp distress

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A moderate to large amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone is normal.

The left kidney is normal size (3.83 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.91 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.30 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

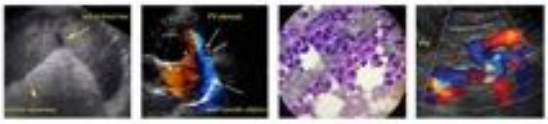
Spleen

The spleen is subjectively prominent in size (1.08 cm in width at the level of the hilus) with normal curvilinear peripheral contours. 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 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 lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

Gastrointestinal



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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 mildly thickened (up to 0.32 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments, with a 1:1 ratio in many regions. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The left limb and base are prominent in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. A 0.81 cm hypoechoic nodule is observed in the left limb. The lesion causes slight capsular expansion. In addition, a few small cystic areas are also seen at the tip of the left limb. The pancreatic duct is visible but not overtly dilated (0.13 cm in diameter). There is no evidence of peripancreatic effusion.

Free Abdomen

There is no evidence of free fluid. 1-2 prominent sublumbar lymph nodes are visualized. The largest measuring 1.01 cm in length. A 0.66 cm colic lymph node is also seen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

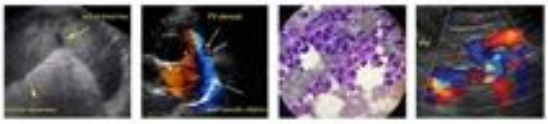
- Bowel pattern consistent with inflammatory bowel disease or emerging lymphoma.
- The pancreatic changes are consistent with chronic pancreatitis with age-related remodeling. The nodule in the left limb could be consistent with benign nodular hyperplasia. However, an emerging neoplastic process cannot be completely excluded. A few pancreatic cysts are also present. These are likely incidental.

Secondary Findings:

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- The mild splenomegaly may be a normal variant for this patient. Alternatively, lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or less likely emerging neoplasia may be present.
- The bilateral renal changes are consistent with chronic interstitial nephritis/nephrosis.
- The urinary bladder debris could be consistent with cells, crystals and/or exfoliated material.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A GI panel (sent to Texas A&M) along with a fecal evaluation for ova and giardia are recommended. Also consider a limited antigen hypoallergenic diet trial. Ultimately, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis. If biopsies are not pursued, empirical treatment for inflammatory bowel disease (i.e., corticosteroids, limited



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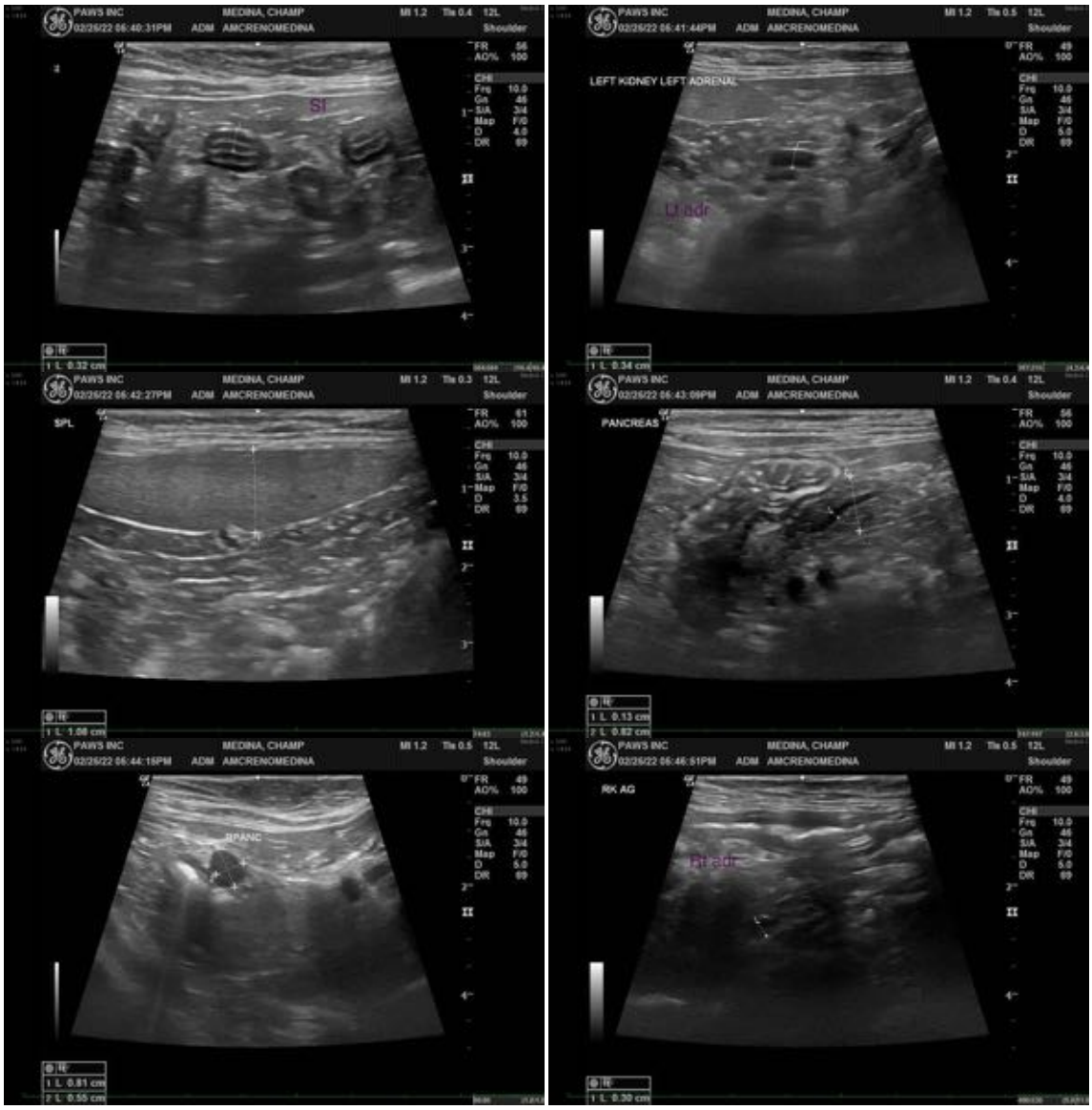
antigen diet) can be considered as long as the client understands the risks of treatment without a definitive diagnosis.

- Regarding the urinary bladder debris, a urinalysis +/- urine culture and sensitivity is recommended.
- Given the pancreatic nodule, a recheck ultrasound is recommended in 4-6 weeks to assess for growth.



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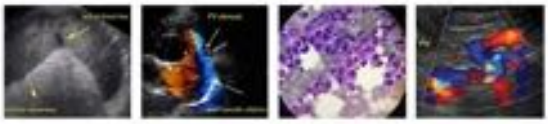

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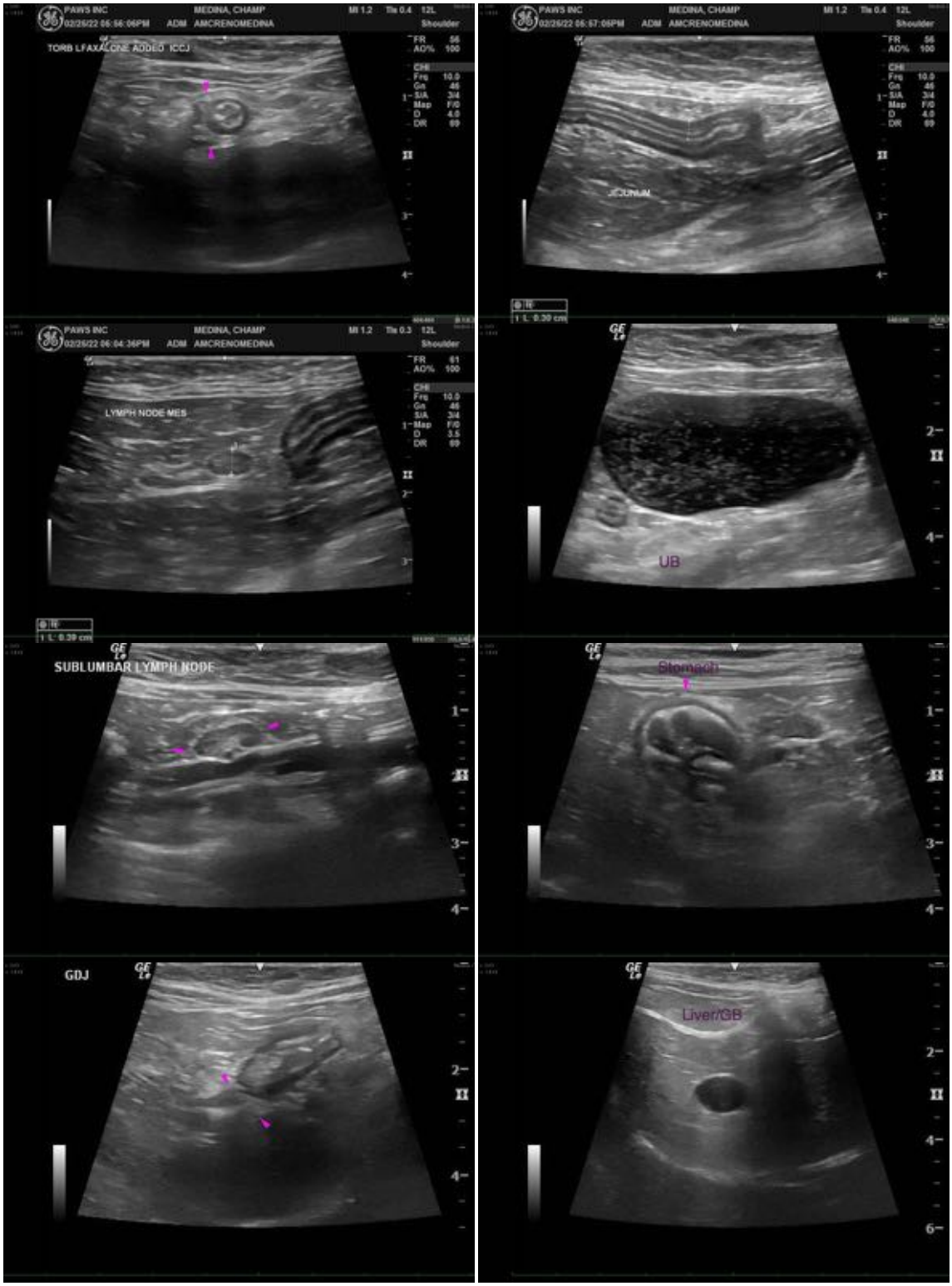

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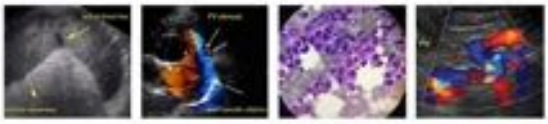

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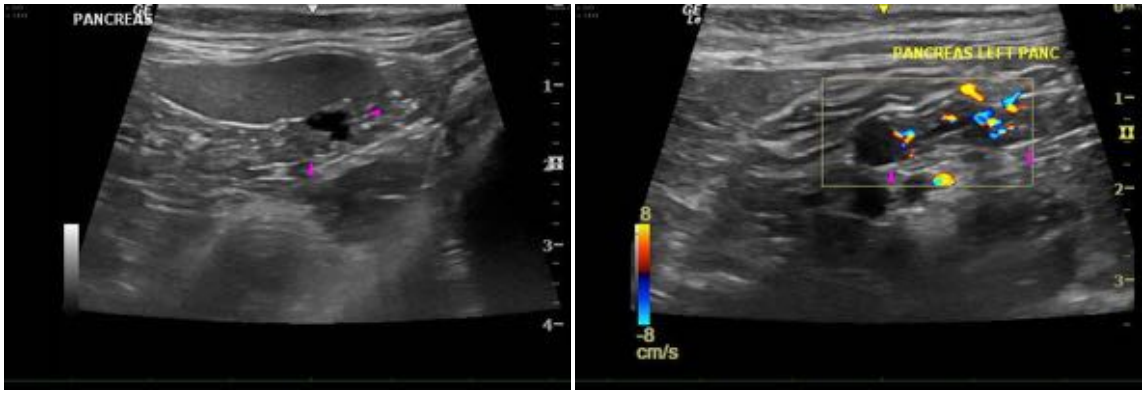

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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