

**DATE PRESENTING CLINICAL SIGNS**

2/28/22

PATIENT

Daisy Raguzin

SPECIES

Feline

BREED

Domestic shorthair

SEX

Female, intact

AGE

6/7/2021

WEIGHT

3.12 kg.

INTERPRETED BY

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

HOSPITAL NAME

Banfield Columbia

REFERRING VET

Dr. Wendell

INVOICE

13059

Patient presents for recheck illness. History of intermittent appetite changes, concerns about stool production (only defecates about every 3 days). Patient was examined elsewhere on 2/15 for malaise, decreased appetite, defecating infrequently- started on Laxatone and Mirtazapine. After giving Laxatone, patient gagged, client discontinued. Currently on Mirtazapine (mirtaz topical) and appetite is back to normal. FELV/FIV test in 10/2021 negative per owner. Patient's appetite, per owner is typically voracious and will eat the same diet for a few weeks, then she will refuse to eat that particular diet. Will eat at least 4 cans a day. Only canned food. Client has tried several ways to entice patient to eat dry food (soaking, crushing and soaking, mixing in with canned food). Stools have always been about every 3 days, except the time when patient was started on Miralax, but stools became runny and client discontinued. Patient does not spend a lot of time in litter box, or seem to otherwise have difficulty defecating. Stools are always formed but soft, never hard. Stools are approximately a finger's width in diameter. No vomiting.

Current Medications: Mirtaz PRN.

Lab Results: Superchem/CBC/T4/UA- Eos 1476 (0-1000) : r/o eosinophilic enteritis, L-P enteritis, other enteropathy vs. Asthma, HWD, etc. Alb 4.3 (2.5-3.9) r/o dehydration. GI panel results pending. Felv/FIV negative per owner, results not available to review. Fecal results pending.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Torbugesic and Midazolam.

Stat Report: Not requested.

Imaging Performed By: Stephanie Pearce RDCS, RVT.

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 moderately 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 (3.47 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.50 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.31 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.38 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.77 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 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 portal vein: caudal vena cava ratio is approximately 1:1. 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

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. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. The colonic lumen contains granular appearing fecal material. There is no obvious 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.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. 1-2 prominent colic lymph nodes are visualized, the largest measuring 1.04 cm in length.

Other

The uterine body is visible and is normal in size (0.39 cm in width). No obvious pathology is observed.

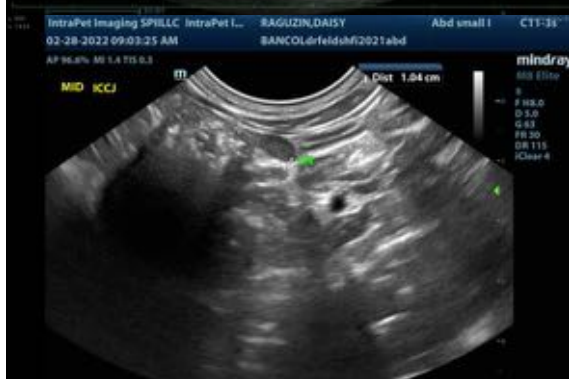
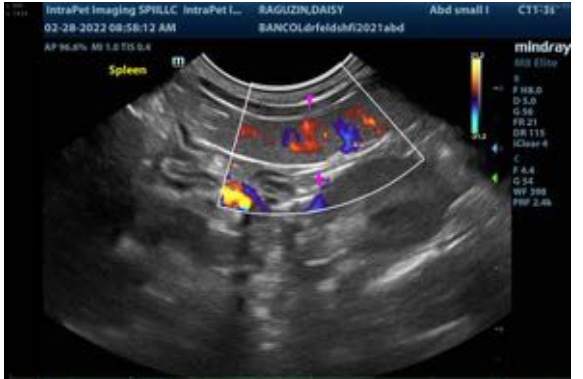
The left ovary is visible (1.12 x 0.55 cm) with a normal shape. A small cystic structure is observed within the parenchyma. No obvious pathology is observed. The region of the right ovary is evaluated. No obvious pathology is observed.

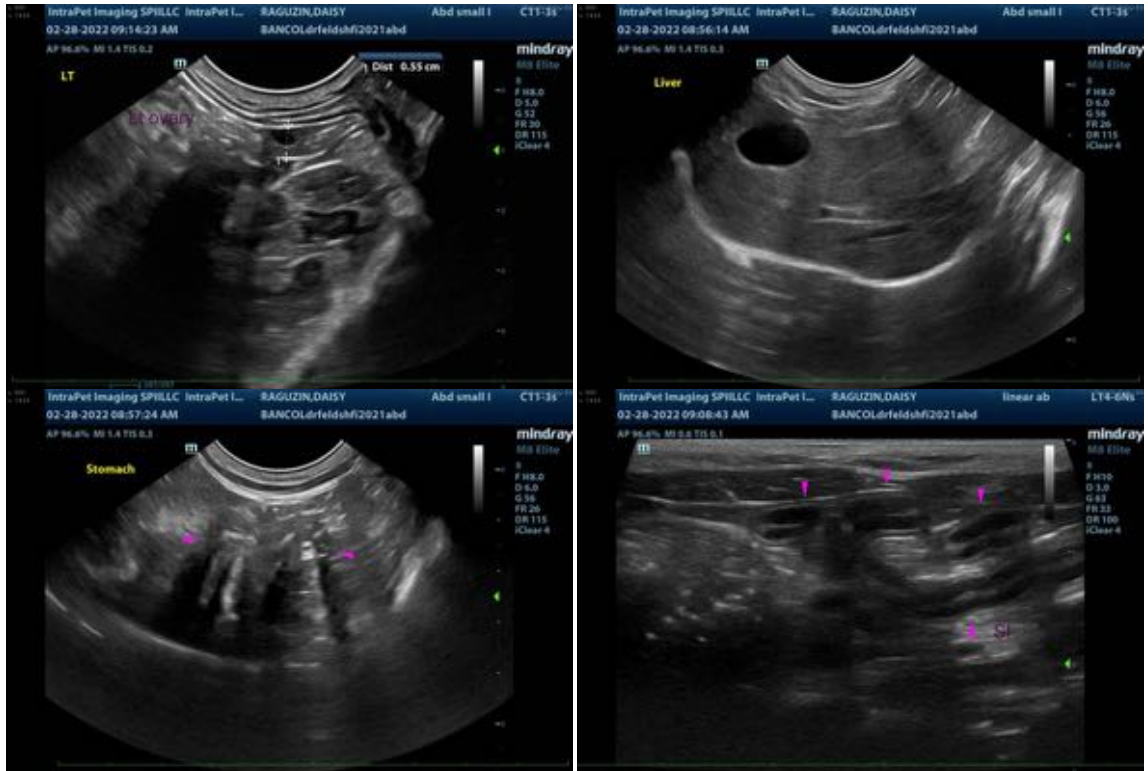
ULTRASONOGRAPHIC FINDINGS

The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. The abdomen is otherwise unremarkable. An obvious cause for the patient's clinical signs is not identified in this study.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider three-view thoracic radiographs to assess for occult disease in the chest.
- Given the eosinophilia, consider prophylactic deworming with Fenbendazole as well as a limited antigen diet trial.
- Ultimately, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.





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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