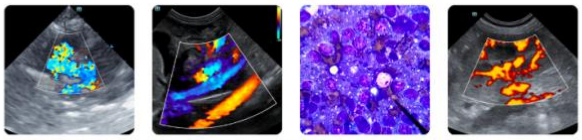


DATE

3-27-26

PATIENT

Lynx Mulka

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10/27/2017

WEIGHT

14.24lbs

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Shannahan

INVOICE

22754

PRESENTING CLINICAL SIGNS

Patient History: Lynx presents for acute vomiting with hematemesis and suspected linear foreign body ingestion Patient History: - Ate normally at 6:15 AM, vomited shortly after with red-tinged material – Multiple episodes of vomiting since morning, some containing Easter grass (ribbon-type) and hematemesis - Easter grass ingested within last 36 hours from basement - History of eating too quickly and occasional post-prandial vomiting - On prescription urinary diet - Previous urinary obstruction - Previous visit for possible glow stick ingestion -Normal stool observed this morning - Presented to referring veterinarian (Banfield) at 7:15 AM, received subcutaneous fluids, referred to ER at 9:30 AM

Current Medications: None listed.
Labwork Results: Mild leukocytosis with a neutrophilia. Mild hypoekalemia. Globulins 5.2 (Labwork attached).
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV Propofol.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS

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. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone is normal.

The left kidney is normal in size (4.48 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. Mild pyelectasia is present (0.21 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 (4.93 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. Mild pyelectasia is present (0.15 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 (0.38 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.35 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

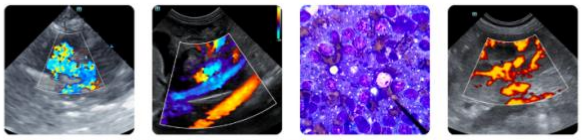
Spleen

The spleen is normal in size (0.84 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.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of suspended



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echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal
The gastric lumen is mildly distended with what appears to be ingesta. The gastric wall is normal- to mildly-thickened (up to 0.47 cm) and hyperechoic, with retention of the normal layering pattern. The mesentery effacing the serosal surface of the gastric wall is hyperechoic. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas
The left limb of the pancreas is 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 few mesenteric lymph nodes are observed visualized adjacent to the ileocecocolic junction (one measuring 0.57 x 0.28 cm).

Free Abdomen
Trace free fluid is observed.

Other
In the right cranial quadrant, a 0.59 x 0.46 cm hypoechoic structure is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gastric wall changes are most consistent with gastritis, with a lower possibility of emerging neoplasia. Mild retained ingesta is present within the lumen. Mild adjacent peritonitis is also present.
- The small intestinal wall changes could be consistent with inflammatory bowel disease or less likely, emerging lymphoma.
- Trace ascites

Secondary Findings

- Bilateral nonspecific age-related renal changes. The bilateral pyelectasia may be secondary pyelonephritis, parenchymal remodeling, PU/PD (if applicable), fluid therapy (if applicable) or some combination thereof.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The hypoechoic structure in the right cranial quadrant may represent a prominent lymph node, nodule in the pancreas, other.

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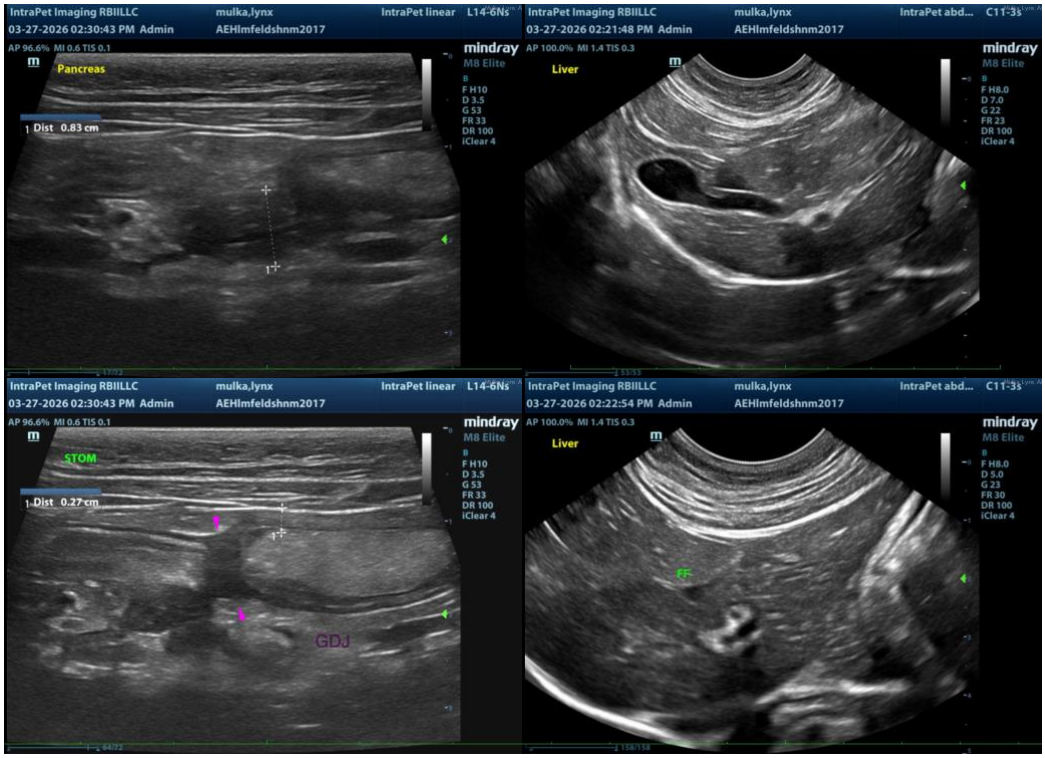
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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).



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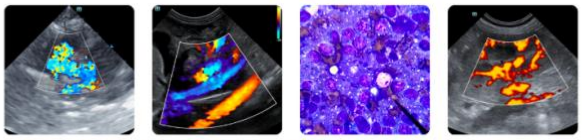

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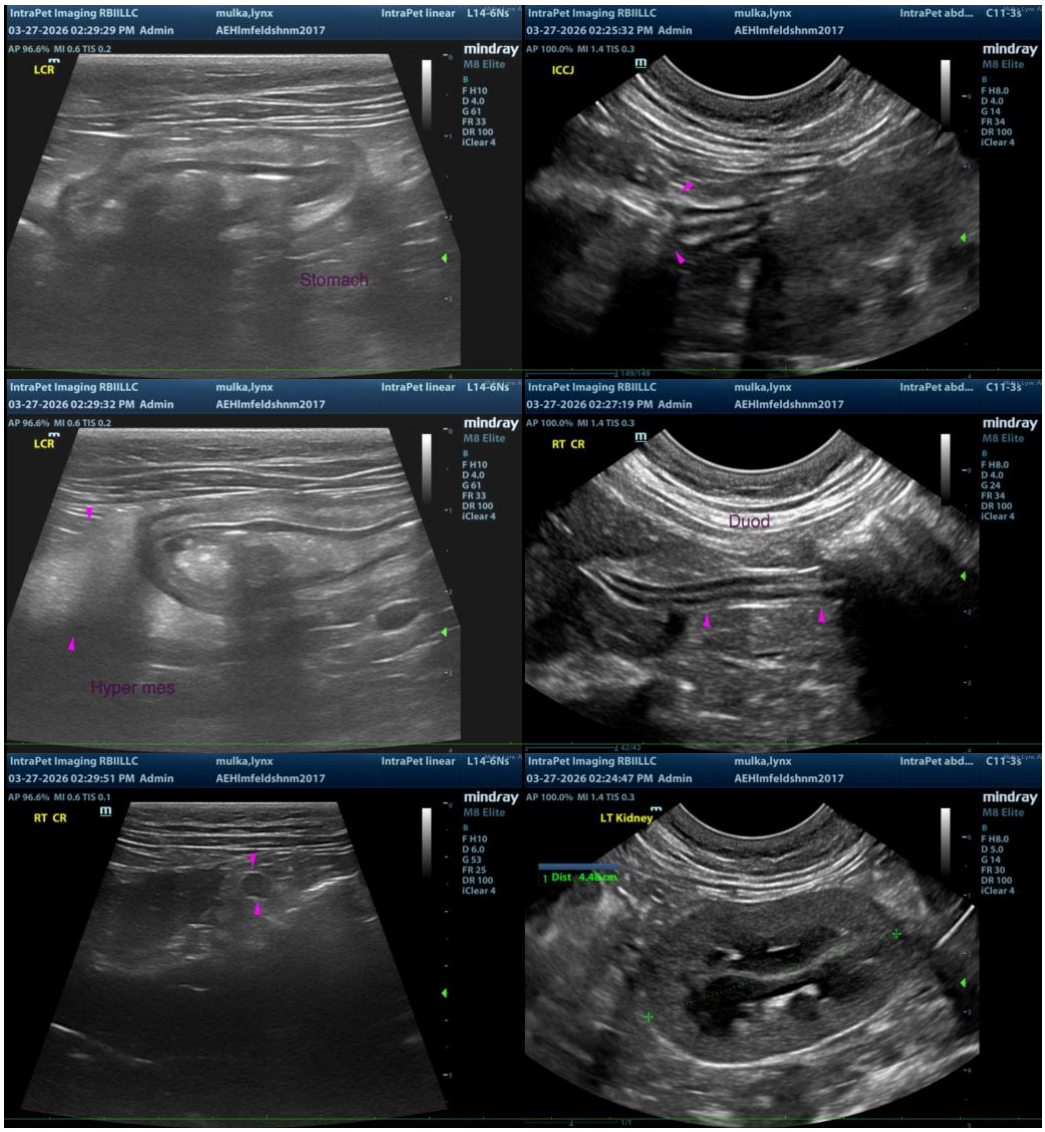

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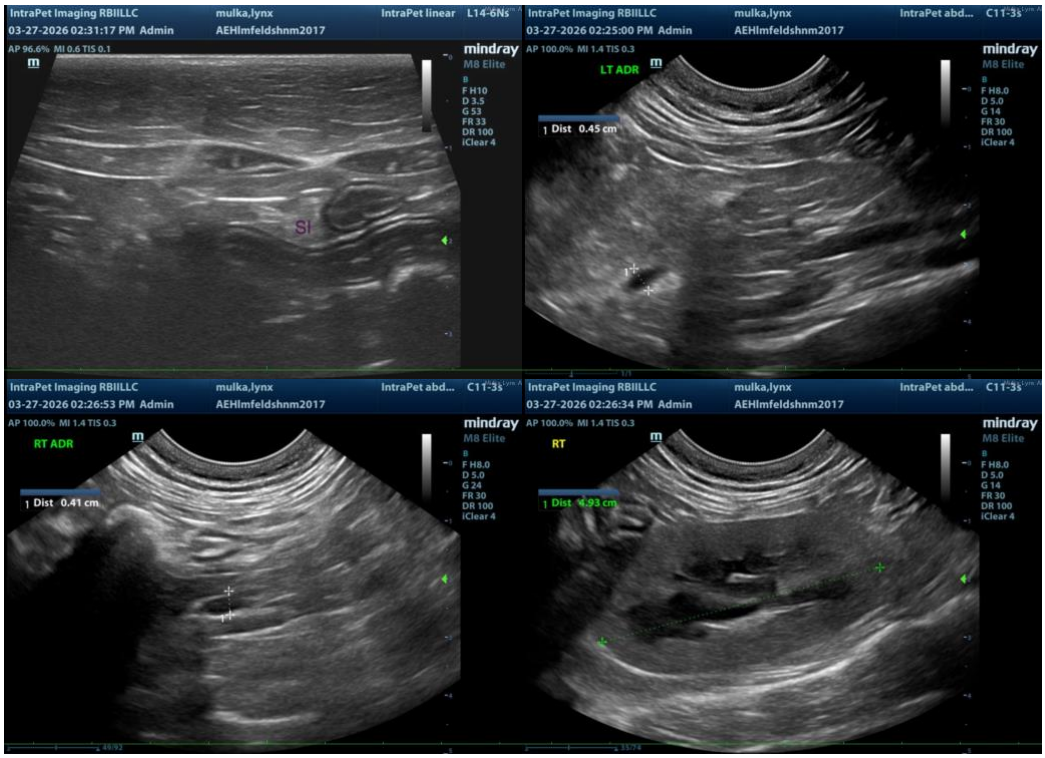

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com