

PATIENT

Sweet Pea Amoux

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

15 years

WEIGHT

NP

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Sara Hansen

HOSPITAL NAME

The Veterinary
Hospital

REFERRING VET

Dr Yamada

INVOICE

12575

DATE

3.29.23

PRESENTING CLINICAL SIGNS

History: Sweet Pea presented 03/10/2023 for about 2 month's duration of decreased appetite, inappetence. P throws up bile +food sometimes shortly after eating. O describes P getting excited for food and rushing to their automatic feeder, only to not eat anything. P has been losing weight (last exam at TVH was 04/20/2021 and has lost 2.5lbs since then). P does cough every so often. P does sometimes have nasal discharge, which has been going on since O moved to Oregon 10 years ago. Exam: T: 100.9, HR: 230, RR: 40 with normal auscultation, dental tartar 2/4. Moderate generalized cachexia. Normal abdominal palpation w/o mass effects, abnormalities and formed stool in colon. Soft, small bladder.

Abnormal PE/Chem/CBC/UA Results: CBC - Slight normocytic normochromic anemia of 24.8%, slight leukopenia 4.17k (all cell lines low-normal other than neuts at 3.0); thrombocytopenia 72k reported on analyzer but manual blood smear confirmed value ~80k with large clumps. Comprehensive Plus - High amylase at 2,220 with normal lipase 38; otherwise WNLs; good renal/hepatic/pancreatic function Lytes - WNLs T4 - WNLs at 2.1 SDMA - Slightly high at 15 UA - WNLs - USG 1.022, pH 6.0, pro 1+, gluc/ket/ubg neg, bil neg. Bld 4+. WBC 2/HPF, RBC >50/HPF, sedivue suspected rods but none seen on manual sediment (no bacteria, just debris); no casts/crystals seen on manual or sedivue. Cysto draw. Current Medications Rxd 1 wk supply of cerenia 8mg PO SID PRN, omeprazole 2.5mg PO SID on 3/10/23, started RC HP diet trial, receiving vitamin B12 0.3ml SQ weekly x1 mo then monthly Radiographic Findings None

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small 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 (3.77 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. The cortex is hyperechoic relative to the spleen. Several small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.11 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. The cortex is hyperechoic relative to the spleen. Several small, nonobstructive nephroliths are visualized. There is a suspected cortical infarct at the caudal pole. Mild pyelectasia is present (0.19 cm in the longitudinal plane). There is no evidence of hydroureter. Renal vasculature is normal.

Adrenal Glands

One still image of the left adrenal gland is available for interpretation. The gland is mildly enlarged (0.78 cm width) with smooth peripheral contours. Glandular echogenicity and detail appear normal. Surrounding vasculature appears normal.

One still image of the right adrenal gland is available for interpretation. The gland is normal in size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.



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Spleen

The spleen is normal in size (0.88 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 normal to prominent in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is minimally fluid-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 gas-distended. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The left limb is visible/prominent with slightly irregular peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat. A few ill-defined cystic areas are observed within the parenchyma. The pancreatic duct is not overtly dilated.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

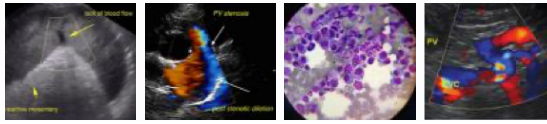
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. Given the chronic inappetence, emerging hepatic lipidosis is a primary concern.
- The pancreatic changes are most consistent with age-related remodeling +/- fibrosis with parenchymal cysts. Pancreatitis or a previous episode of pancreatitis are also possible.

Secondary Findings

- Bilateral degenerative renal changes with nonobstructive nephrolithiasis and right pyelectasia with a cortical infarct
- The mild left adrenomegaly may be a normal variant for this patient or may be due to hyperplastic change, stress, an emerging tumor, adrenalitis, other.



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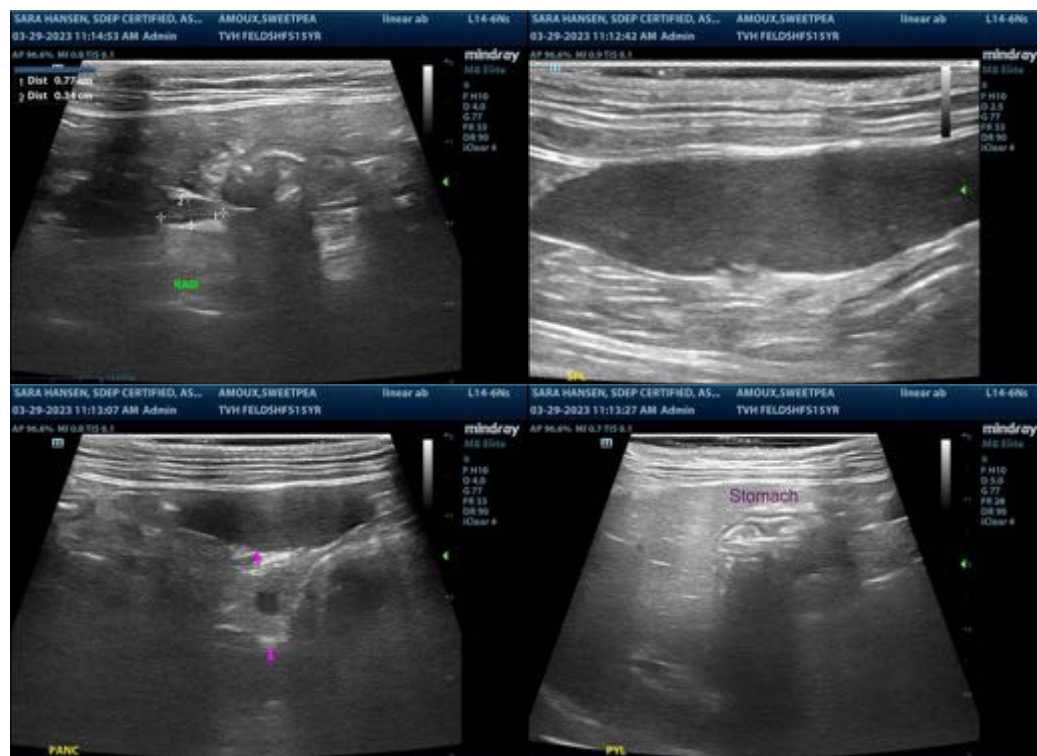
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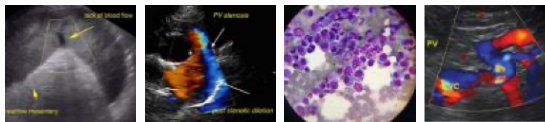
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult neoplasia in the chest, as well as possible esophageal disease. Other diagnostics/therapeutic considerations include the following:
 1. Fecal evaluation for ova and Giardia
 2. GI panel including serum cobalamin and folate, TLI and PLI (send to Texas A&M)
 3. 2–4-week limited antigen or hydrolyzed protein diet trial
 4. Initiation of a probiotic
 5. Ultimately, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis.
- Regarding the sonographic hepatic changes, consider a fine-needle aspirate (if clotting status is appropriate). A 25-gauge needle should be used. If hepatic lipidosis is confirmed, nutritional support (i.e., via a temporary feeding tube) may be warranted.





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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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