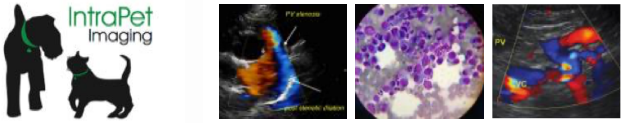
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

4.10.2023

PATIENT

Olivia Ogidan

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

3/30/2017

WEIGHT

7.5 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Perry Hall AC

REFERRING VET

Dr. Miller

INVOICE

12731

PRESENTING CLINICAL SIGNS

Patient presents for evaluation of weight loss and decreased appetite on 03/30/2023. Increased ALT noted on BW - owner declines ER referral at this time. Patient presents today neurological. Owner is limited on funds - we will do AUS, recheck lab-work, and Toxoplasmosis testing. Owner reports unstable/unable to use legs. Today legs are warm and able to move, no evidence of thrombotic event. No cardiac murmur. Recheck liver values 4/10/23- now anemic, ALP, GGT, bili increased.

Current Medications: None current - sent home SQF, Cerenia, and Entyce when owner declined ER referral
Lab Results: See attached.
Radiographs: Diffuse increase in interstitial and bronchial opacity throughout the lungs. In the absence of a clinical history of respiratory signs this is likely an incidental finding. Rule out aging change versus asthma. Further evaluation is only recommended if indicated clinically. Slight fluid distention of the small intestine. In the absence of a definitive clinical history of gastrointestinal signs this is a finding of equivocal certificates. Nonetheless, given the history of hyporexia, I am concerned that this may be a significant finding. Rule out inflammatory enteric disease such as enteritis, inflammatory bowel disease, pancreatic disease, etc. A surgical small intestinal disorder is not identified. Nonobstructing colonic foreign material. Clinical correlation is necessary to described significance to this finding. Further evaluation is only recommended if indicated clinically.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested by DVM.
Imaging Performed By: Andi Parkinson, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is mildly distended. Luminal contents are anechoic. 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 (3.41 cm in length) with a normal shape, architecture and 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.

The right kidney is normal in size (3.58 cm in length) with a normal shape, architecture and 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.

Adrenal Glands

The region of the adrenal glands is evaluated. No obvious pathology is observed in this region.

Spleen

The spleen is normal in size (0.56 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 prominent to enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen, homogenous and attenuating in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

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 is normal to 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 (some/most) segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The right limb is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat. No focal lesions are observed. 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

- The hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia (i.e., lymphoma), or other hepatopathy.

Secondary Findings

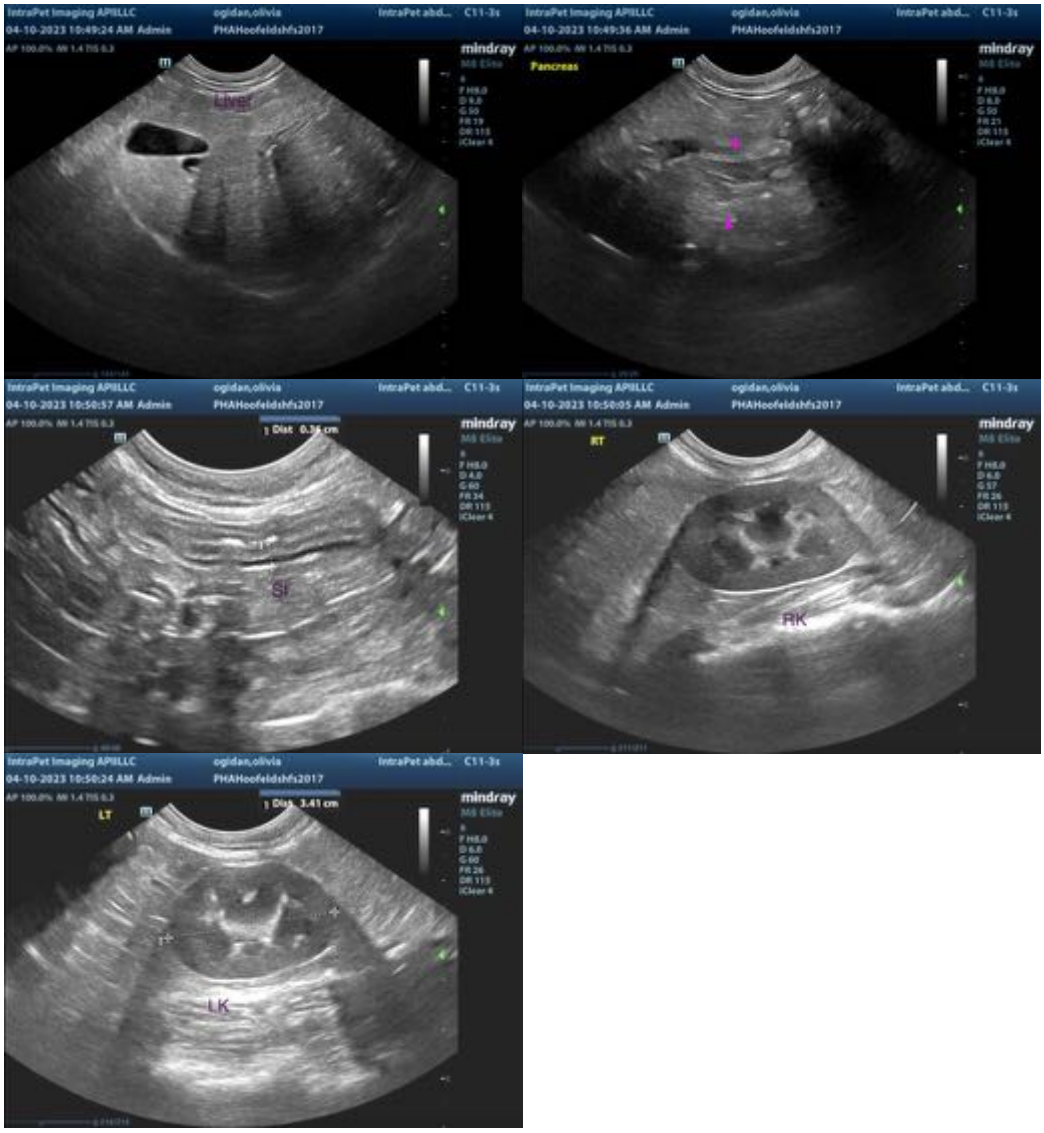
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

- Bowel changes consistent with inflammatory bowel disease with some potential for emerging lymphoma

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A blood ammonia level +/- pre-and postprandial serum bile acids should be considered to assess for hepatic encephalopathy. If hepatic encephalopathy is suspected, consider initiation of treatment (i.e., lactulose +/- appropriate antibiotic therapy). Also consider a fine-needle aspirate of the liver (if clotting status is appropriate). A 25-gauge needle should be used.

- While awaiting test results, empirical treatment for bacterial cholangiohepatitis/hepatic lipidosis is recommended, including broad-spectrum antibiotics, hepatic antioxidants and nutritional support (i.e., via a temporary feeding tube) as well as symptomatic measures. If the patient's clinical status does not improve with symptomatic care, liver biopsies with aerobic and anaerobic bile cultures may be necessary to get a definitive diagnosis.



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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