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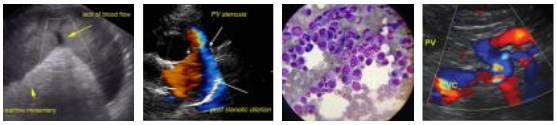

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Muffin Qualman

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

13 years

WEIGHT

15.4 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

West Eugene AH

REFERRING VET

Dr. Sundholm

DATE

4/13/22

INVOICE

10724

PRESENTING CLINICAL SIGNS

History: 3/23/22 - History: P having off and on diarrhea (more frequent) for the past 3 months. Diarrhea is pretty soft but not liquid. Large volume happens almost every day. Sometimes multiple times a day. Sometimes it has a small amount of blood in it, occasionally mucous and smelly. More needy lately. Doesn't want to poop in the litterbox within the last month. Will poop outside of the litterbox. -- Patient's diarrhea may have improved with fortiflora in the past - Patient has chronic vomiting, at least every other week. Has been present most of life it seems - Patient has had a cough in the past. O states that vomiting is typically non-productive- unsure if cough or vomit when asked PE: profound entropion BCS 5/9 No abn palpable

Abnormal PE/Chem/CBC/UA Results: 3/23/22 -- Fecal - Clear of common parasites -- Patient had CBC/CHEM/T4 done 12/2021 that showed CR 1.9 BUN 48, no urinalysis, t4 3 Current Medications Proviable, RC Fiber Responsive diet

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 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 in size for the patient's weight (4.85 cm in length) with a slightly irregular shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is small in size (3.47 cm in length) relative to the left kidney; with an irregular shape. The cortex is variably thickened. There is poor corticomedullary distinction. There is no evidence of pyelectasia, nephroliths or hydroureter. There is a questionable cortical infarct at the lateral aspect. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.72 cm length; 0.44 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.81 cm length; 0.42 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0,81 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.

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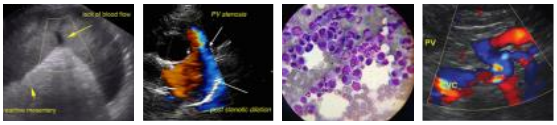

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The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is moderately distended with ingesta. 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 dilated with chyme and occasional soft, shadowing material (i.e., hair?) The small intestinal wall is normal to borderline thickened (up to 0.26 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The left limb is enlarged with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is borderline-dilated (0.23 cm in diameter). There is no evidence of peripancreatic effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. One to two prominent jejunal lymph nodes are visualized, the largest measuring 1.40 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern consistent with inflammatory bowel disease, with some potential for emerging lymphoma
- The pancreatic changes are most consistent with chronic pancreatitis. However, emerging neoplasia cannot be completely excluded.

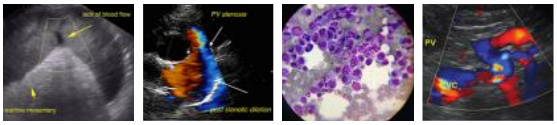
Secondary Findings

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Bilateral age-related renal changes (more severe on the right), with left dystrophic mineralization

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. A 6-week limited antigen diet trial to assess for food allergies



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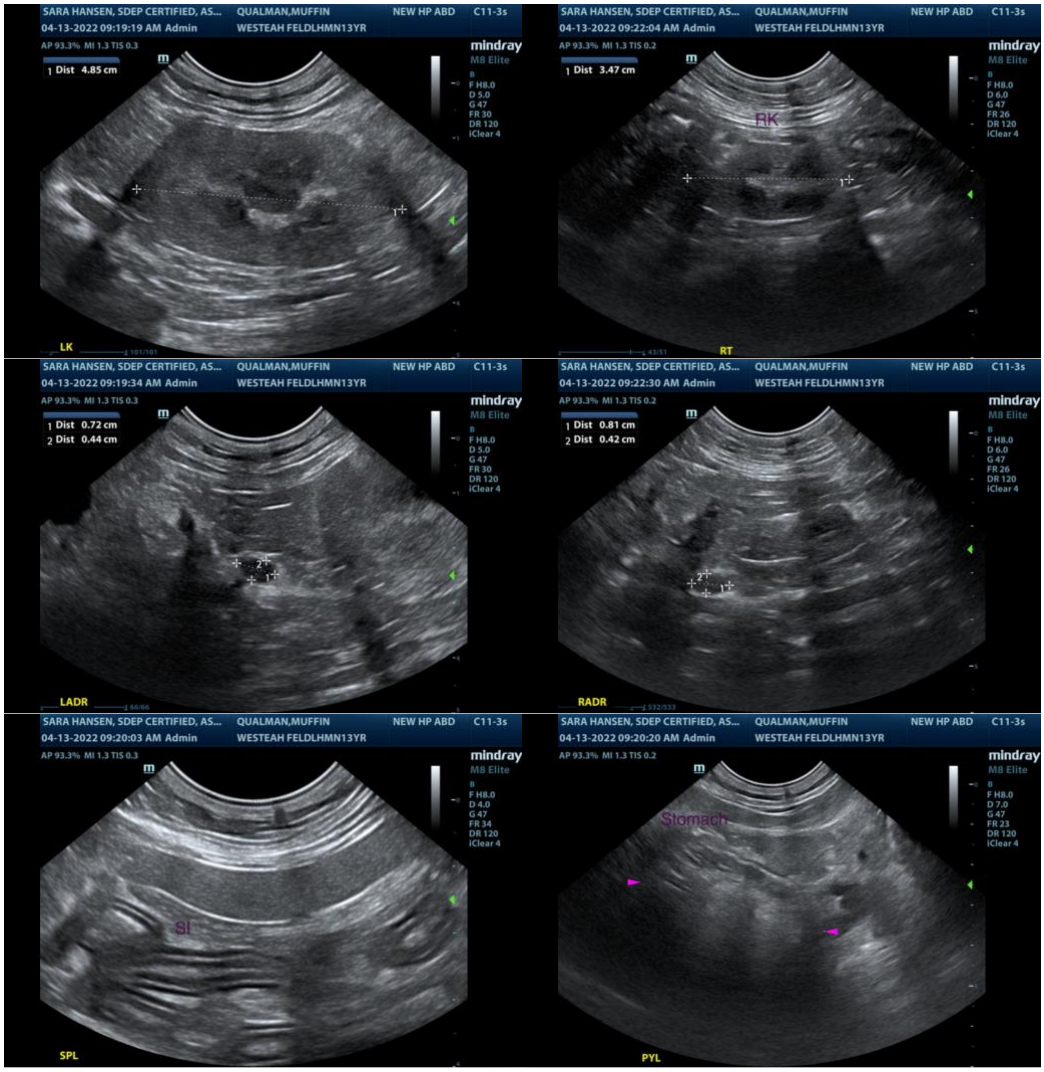
4. If the above diagnostics/therapeutics are inconclusive, endoscopic or surgical gastrointestinal biopsies may be warranted. Given the patient's age, three-view thoracic radiographs are recommended prior to any anesthetic event. If biopsies are not pursued, empirical treatment for inflammatory bowel disease (i.e., corticosteroids, hypoallergenic diet) can be considered, as long as the client understands the risks of treatment without a definitive diagnosis.

5. Serial sonographic monitoring (i.e., every 4-6 weeks) of the pancreas is recommended to assess for changes that may suggest emerging neoplasia.



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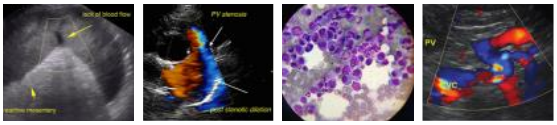

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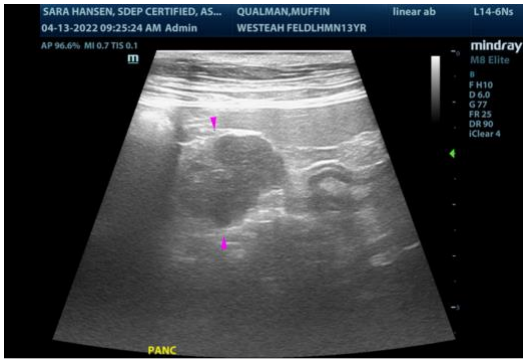

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)
andrea_nicastro2@hotmail.com