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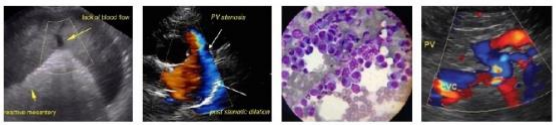

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Alex Doucette

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 years

WEIGHT

4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Chippawa AH

REFERRING VET

Dr. Dowell

INVOICE

10741

DATE

4/14/22

PRESENTING CLINICAL SIGNS

History: Elevated Ca that keeps going up. Proteinuria. Suggestive bloodwork of malabsorption issues. Some weight loss. Fed on multi cat microchip feeders. History of vomiting and diarrhea with gurgly guts on palpation

Abnormal PE/Chem/CBC/UA Results: Ca has climbed again. Recommended a fasted ionized Ca level. Discussed proteinuria. Recommended rechecking protein on a stick test IH (no charge) and submitting for UP:C testing if remains elevated. Apologized re:B12 injection given in advance of sample collection as value would be inaccurate. Folate; however, is still suggestive of a possible malabsorption issue. Reviewed diet trial vs ultrasound vs possible bx. O thinks P appetite has improved since his B12 injection. He is brighter overall. O likely to give B12 a month to see what happens with his weight before considering ultrasound or diet trial.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. An apparent 0.28 cm cystic calculus is observed within the lumen. Luminal contents are otherwise anechoic. The region of the trigone is normal.

The left kidney is normal in size (3.57 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few, small, nonobstructive nephroliths are visualized. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.91 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Several nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of the left adrenal gland is evaluated. No obvious pathology is observed.

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

Spleen

The spleen is subjectively normal in size (0.64 cm in width at the level of the hilus) with a slightly irregular lateral contour. A 0.91 x 0.50 cm hypoechoic nodule is observed at the lateral aspect. The lesion causes mild capsular expansion. The remaining parenchyma is homogenous. Splenic vasculature appears normal with no evidence of thrombosis.

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

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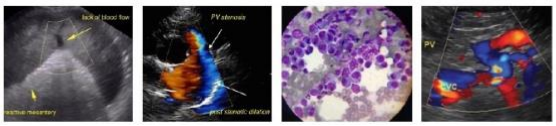

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Gastrointestinal

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 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 region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

There is no evidence of of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.04 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

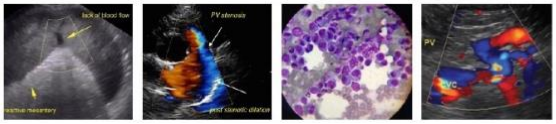
- Bowel changes are most consistent with inflammatory bowel disease with some potential for emerging lymphoma
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The splenic nodule could be consistent with a benign process (i.e., a focus of lymphoid hyperplasia or extramedullary hematopoiesis). However, an emerging tumor cannot be completely excluded.
- Suspected small cystic calculus

Secondary Findings

- Bilateral age-related renal changes with nonobstructive nephrocalcinosis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia
- Consider a 6-week hypoallergenic diet trial.
- Ultimately, GI biopsies, endoscopic or surgical, may be necessary to get a definitive diagnosis.
- Three-view thoracic radiographs are recommended to assess for occult neoplasia in the chest.
- Consider a fine-needle aspirate of the splenic nodule (if clotting status is appropriate).
- Given the hypercalcemia, an ionized calcium +/- PTH/PTHrP should be considered. Given the proteinuria, a UPC is also recommended.



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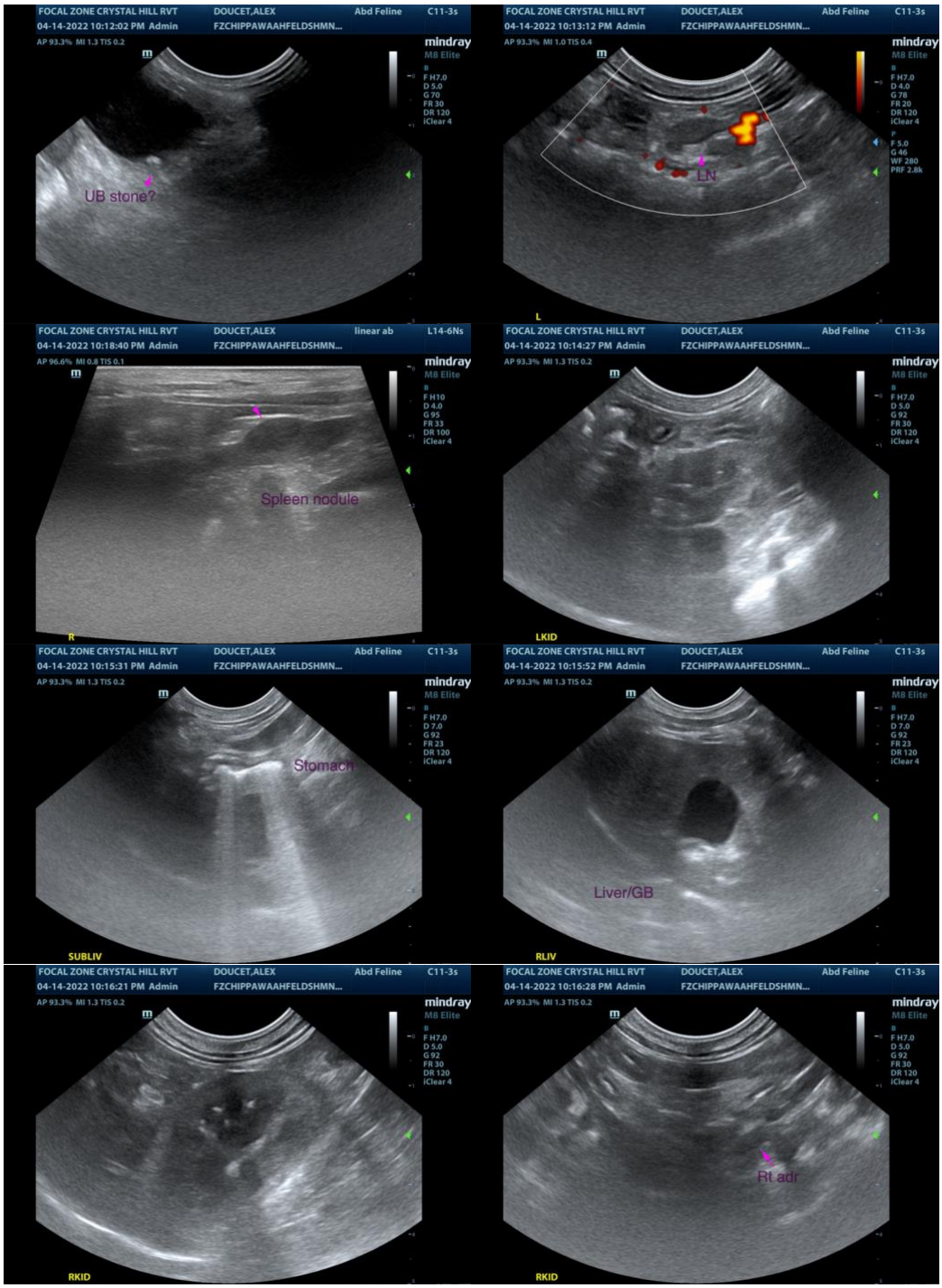
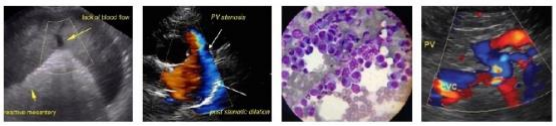
- Regarding the suspected cystic calculus, consider a repeat ultrasound in 3-4 weeks to determine if the stone is still persistent. If so, consider an attempt at medical dissolution via prescription urinary diet and broad-spectrum antibiotics. Alternatively, a cystotomy with stone removal, analysis and culture can be considered.





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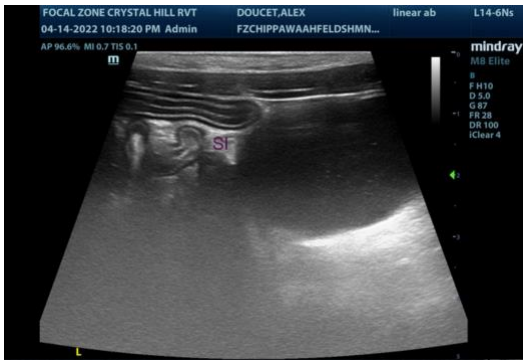

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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