



PATIENT

Calvin Ostraco

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

02/26/2014

WEIGHT

14.8 lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

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

HOSPITAL NAME

Dr. Jen Brogie

REFERRING VET

Park West VA

INVOICE

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DATE

4.24.23

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: AUS for unregulated Diabetes. P previously well-regulated on 4U glargine BID and DM diet. About 1 month ago P had fructosamine (293) and lab work and BG (51) was low. He was lowered to 2U glargine BID, then trying to find a balance for him. P has been lethargic and not eating great. Weight loss progressing. P had some loose stool. Freestyle libre applied on 4/13/2023 but P also dehydrated and obstipated. GA for manual deobstipation and started on Miralax. Persistent BGs in 400s, so increase to 3U glargine last week and started to curve with NADR 280, but over the weekend again at 400s throughout the day.

Abnormal lab-work values: 4/7/2023

Chem

- Phos: 1.9 (L)

- K: 3.5 (L)

- Cl: 100 (L)

- Albumin: 4.1 (H)

- AST: 125 (H)

- Cholesterol: 512 (H)

CBC - wnl

Fructosamine:

4/7/23: 716

3/8/23: 295

Current Medications: Glargine 3U BID, Miralax 1/8 tsp BID

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. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (4.59 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is hyperechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.42 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is hyperechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

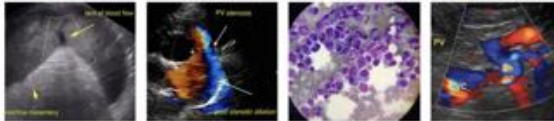
Adrenal Glands

The left adrenal gland is upper limits of normal size (0.51 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.49 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is contracted (0.54 cm in width at the level of the hilus) with normal curvilinear peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic



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vasculature is normal.

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Liver

The liver is subjectively enlarged with slightly swollen 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.

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The gall bladder is moderately distended. A bilobed conformation is suspected. The wall is normal in thickness. A scant amount of echogenic debris is suspended within the lumen. The cystic and common bile ducts are normal/not seen.

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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 in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. The colonic lumen is diffusely distended with hard, shadowing fecal material. There is no obvious evidence of an obstructive pattern.

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Pancreas

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The left limb is visible/prominent with slightly irregular peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat and homogenous in appearance. No focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.20 cm in diameter). The mesentery effacing the serosal surface may be slightly hyperechoic.

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Free Abdomen

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

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Other

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

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Primary Findings

- The pancreatic changes are suggestive of mild chronic +/- active pancreatitis

Secondary Findings

- The hepatic parenchymal changes are most consistent with a diabetic hepatopathy. However, concurrent inflammatory disease or infiltrative neoplasia are also possible. Correlation with the patient's liver values is recommended.

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- Bi-lobed gall bladder – incidental

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- Bilateral chronic age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

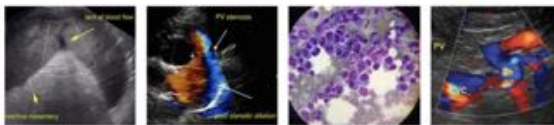
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- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma.

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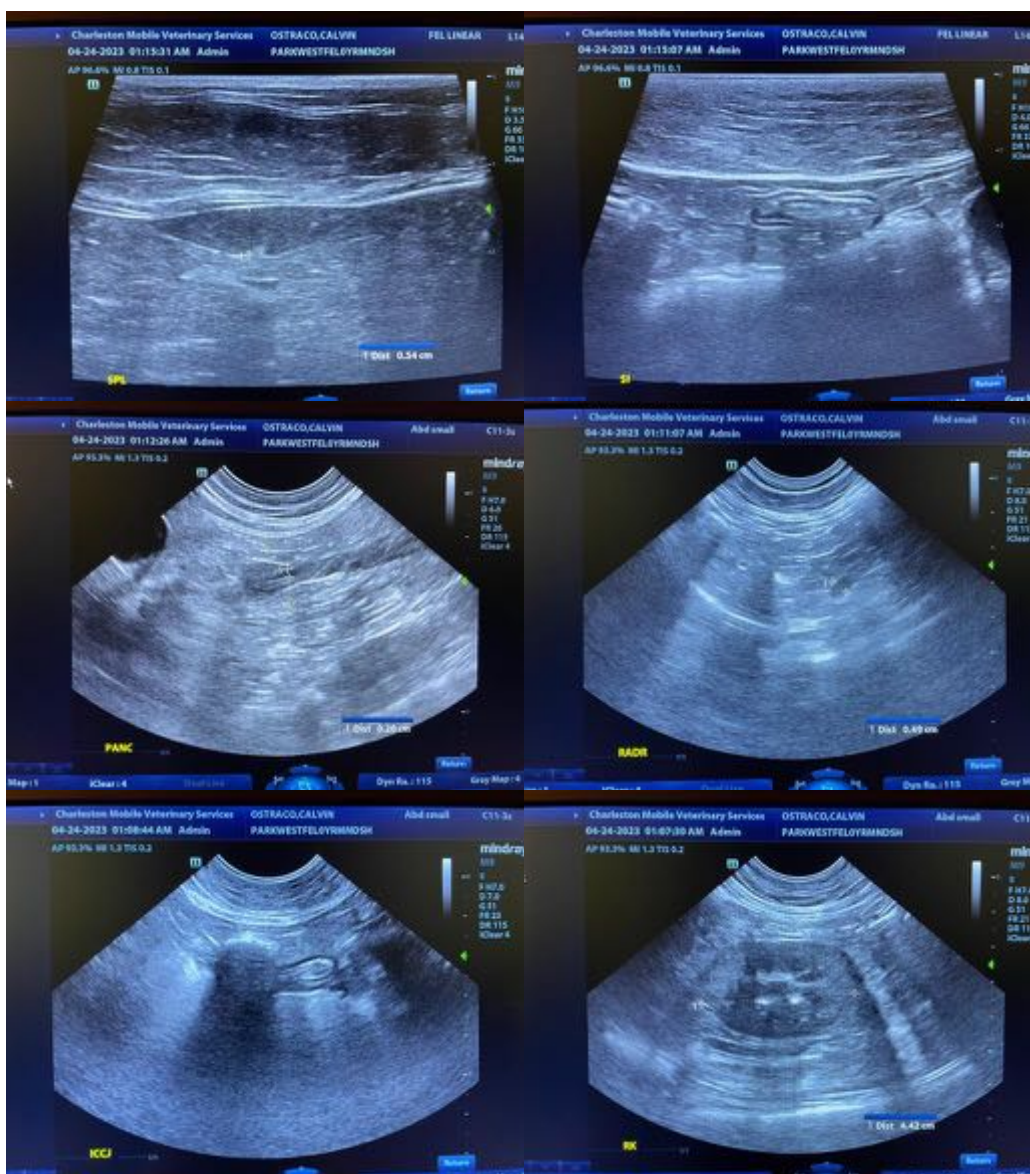
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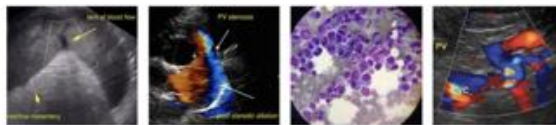
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- Given the patient's questionable disorientation, consider the following:

1. Urine dipstick to assess for ketonuria +/- full urinalysis with culture and sensitivity
2. Baseline blood pressure measurement
3. Consider three-view thoracic radiographs to assess cardiopulmonary status.
4. T4 +/- free T4 by equilibrium dialysis
5. A neurologic examination is also recommended.
6. Continued hourly glucose monitoring with Freestyle Libre to help determine if the patient is undergoing the Somogyi phenomenon or is persistently hyperglycemic.





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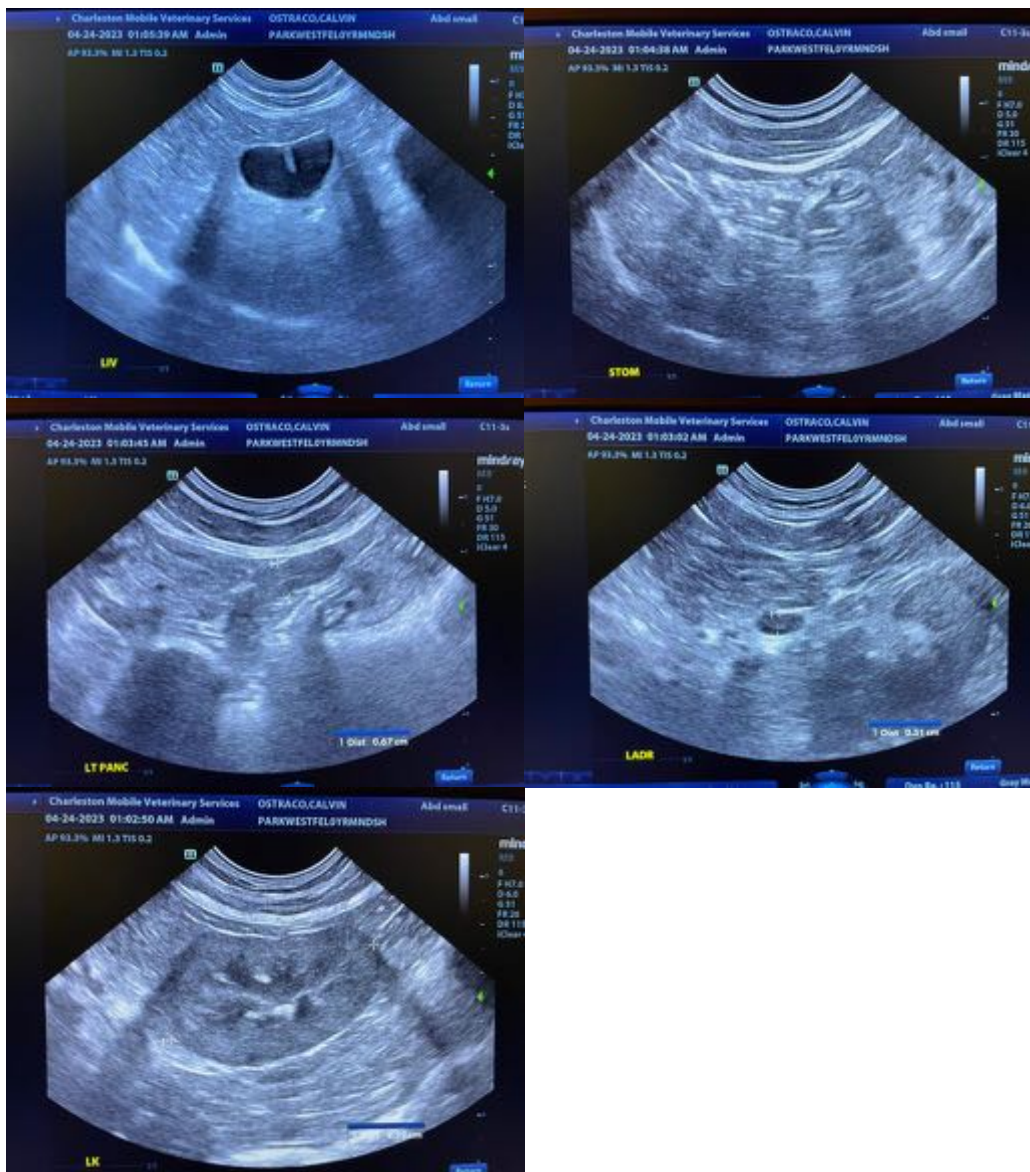
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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info@SonoPath.com