


PATIENT

Little Grey Brandt

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

5 years

WEIGHT

6.74 lbs

PRESENTING CLINICAL SIGNS

History: History of inappropriate urination since first seen here in June 2020. She was treated initially with Fluoxetine, but owner discontinued shortly after starting due to sedative effects. Inappropriate urination restarted in July 2021 so owner started Fluoxetine again. She was also started on Hill's C/d stress due to struvite crystalluria. In August 2021 owner began noticing straining to defecate with some hard stool, started Miralax. Seen here in February 2022 for vomiting, decreased appetite, and weight loss. Bloodwork reveal elevated T4 levels at 5.1 (0.8-4.7) and elevated ALT 202 (12-130) and hypocholesterolemia 43 (65-225). She was started on Methimazole. Little Grey was rechecked on 3/14/22 for continued weight loss and hyporexia to anorexia. Recheck labwork revealed ALT 252 (12-130) AND t4 1.6. Radiographs revealed distended colon with non-formed stool. She was given an enema and started on Miralax/Cisapride. She was rechecked the next day and passed stool on her own and urinated. A bile acids panel was performed- pre 8 post 32 and GI panel- TLI normal, folate increased 23, cobalamin low normal 470, PLI normal. Vitamin B12 250 mcg SQ once weekly was started, Cisapride, Miralax, Mirtazapine continued. Methimazole dose reduced by 50 %. Fluoxetine was discontinued due to possibly relation to decreased colonic motility. Since then, Little Grey's appetite has continued to wax and wane, responsive to Mirtazapine used PRN. She continued to have diarrhea, so Miralax and Cisapride have been discontinued. She has 0-3 bowel movements a day, on rare occasion will have slight form to stool. No blood, mucous or straining to defecate noted. She does have inappropriate defecation at times. She has continued to lose weight (now 6.74 pounds- was 9 # last fall). Inappropriate urination is not currently occurring. Diet is Royal Canin GI fiber response and Friskies pate.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
Urinary System

The urinary bladder is moderately distended with mostly anechoic urine. The majority of the bladder wall is normal in thickness with a smooth mucosal surface. In the dorsal portion of the cystourethral junction, a 0.31 x 0.31 cm focal thickening is observed. No cystic calculi are seen. The proximal urethra, visible to a depth of 1-2 cm, is normal.

The left kidney is normal size (3.42 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.54 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.70 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

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 (Small Animal Internal
 Medicine)

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 Oakland

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vasculature is normal.

Little Grey Brandt

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 portal vein to caudal vena cava ratio is approximately 1: 1.

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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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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 thickness is normal with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Additionally, there is thickening of the submucosal layer. Discreet masses are not identified. The ileocecal junction and colonic wall are normal. The lumen of the descending colon contains granular-appearing fecal material. There is no evidence of an obstructive pattern.

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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.

WEIGHT

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Free Abdomen

There is no evidence of free fluid. A few prominent colic lymph nodes are seen, the largest measuring 0.57 cm in length.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern consistent with inflammatory bowel disease with some potential for emerging lymphoma.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

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Secondary Findings

- The medullary band seen in both kidneys may be a benign incidental finding. Alternatively, this sometimes can be associated with subclinical renal disease. Correlation with clinical findings is recommended.
- The significance of the focal bladder wall thickening in the region of the dorsal cystourethral junction is unclear. It may be artifactual due to bladder position, or may represent a focal inflammatory process, or less likely, emerging neoplasia.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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- Given the sonograph changes and the patient's clinical history, consider further GI workup, including the following:
 - Fecal evaluation for ova and Giardia
 - Prophylactic deworming with fenbendazole
 - 6-week hypoallergenic diet trial, if the patient will tolerate it
 - Ultimately endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis.
- Regarding the focal bladder wall thickening, consider a recheck ultrasound in 4-6 weeks to assess for progression/changes.
- If the patient's inappropriate urinations recur, a urine culture and sensitivity should be considered.

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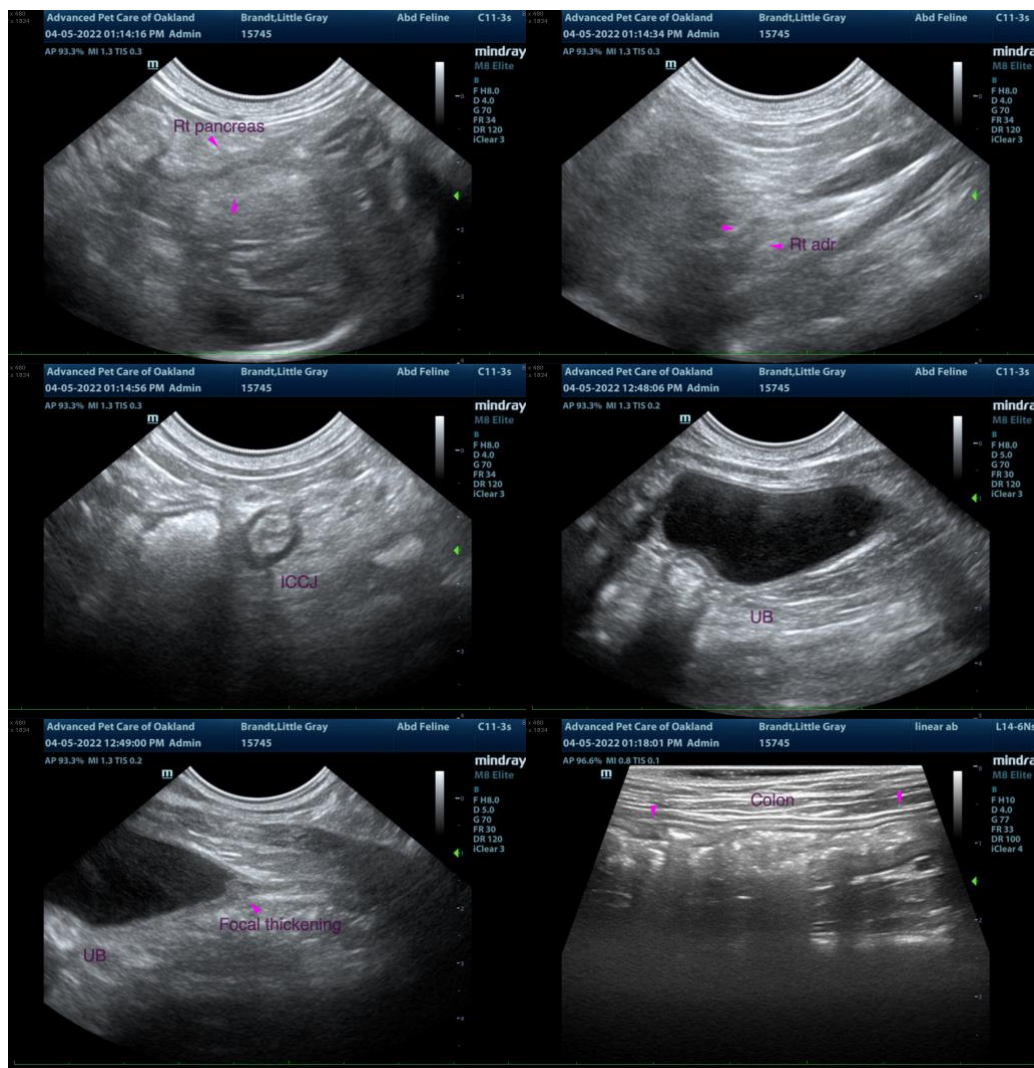
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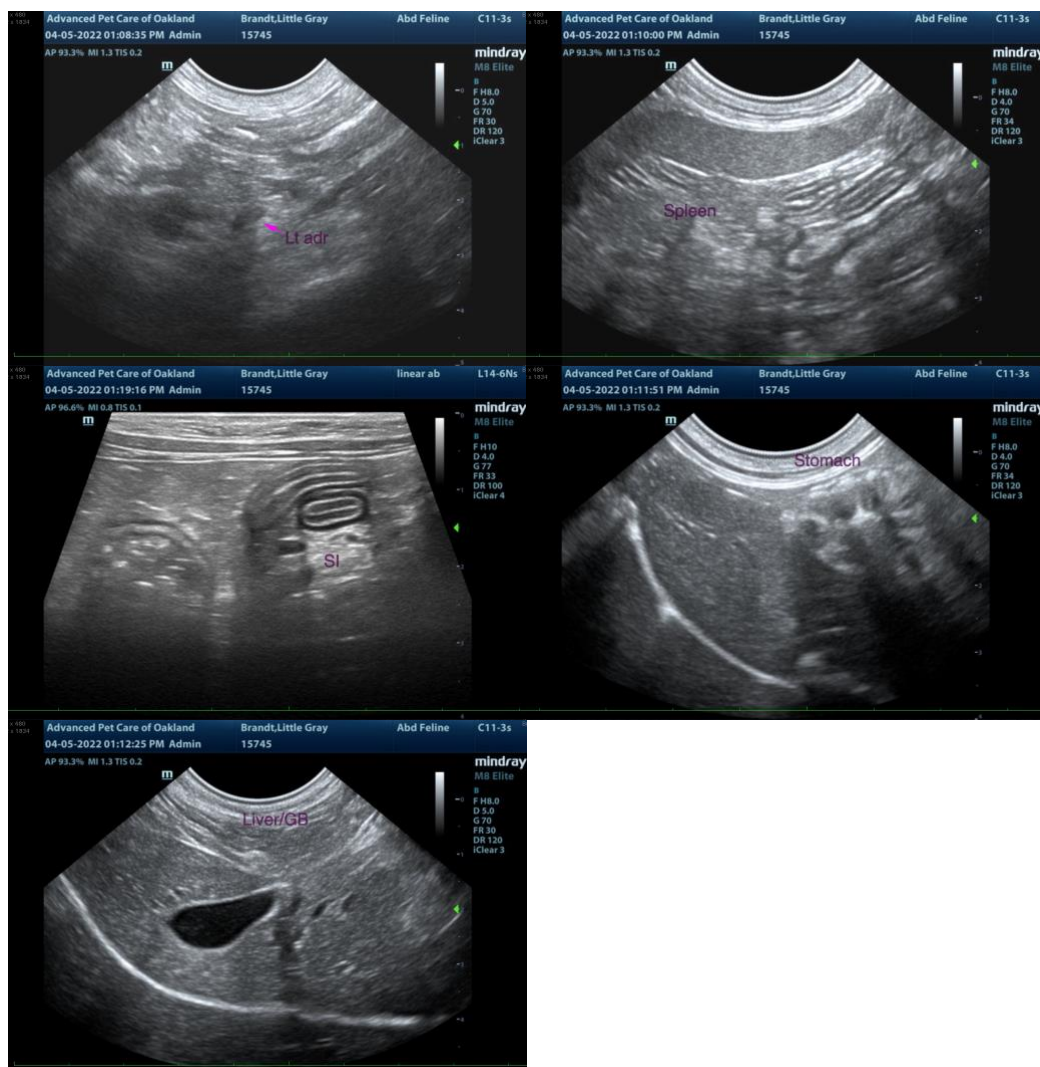
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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