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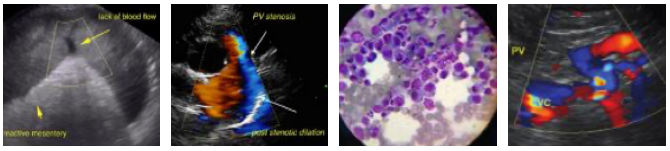

PATIENT
Jetta Wachal

SPECIES
Feline

BREED
Domestic shorthair

SEX
Female, spayed

AGE
10 Yrs.

WEIGHT
7.9 lbs.

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

IMAGING PERFORMED BY
Sarah Pender, CVT

HOSPITAL NAME
SVS Imaging QC

REFERRING VET
Dr. Hartmann

INVOICE
13345

DATE
5/10/22

PRESENTING CLINICAL SIGNS

History: vomiting, poor appetite. diarrhea over the weekend but not in the last few days. Currently eating SO diet (because another cat in household needs it. She doesn't like this diet and is reluctant to eat it). Also has a premolar that needs extraction and could be affecting appetite some. We plan to do dental when thyroid is stable. Weight loss. Recently diagnosed with Hyperthyroid disease. Started on felimazole and owner say that she has been giving meds well until the last couple days as she has been vomiting. History of pancreatitis in the past.
Abnormal PE/Chem/CBC/UA Results: complete blood workup / UA (wellness screen on 4/20/2022). Diagnosed with hyperthyroid disease. All BW and UA - unremarkable, except Hyperthyroid. T4 today 1.8

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. A small to moderate amount of suspended echogenic debris is observed within the lumen. 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 size (3.59 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.43 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.32 cm cranial; 0.30 cm caudal; 0.85 cm length). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.36 cm cranial; 0.21 cm caudal; 0.97 cm length). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.89 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. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of mostly gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

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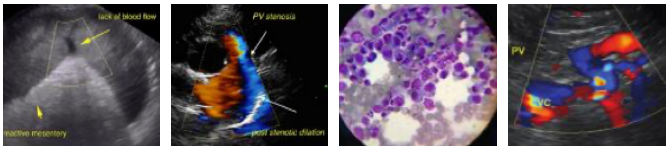

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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly fluid 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. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The pancreas is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. A 0.69 cm gastric lymph node is visualized. In addition, a few prominent mesenteric nodes are seen, the largest measuring 1.38 cm in length. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes are most consistent with inflammatory bowel disease. However, there is some potential for emerging lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is possible but considered less likely.

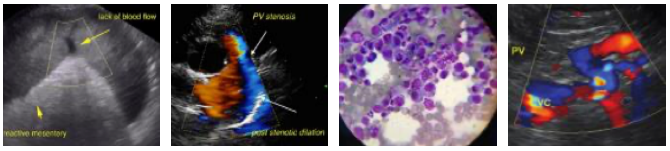
Secondary Findings:

- Minor, chronic age-related renal changes.

*Although small intestinal disease could certainly explain the patient's clinical signs, an adverse reaction to Felimazole cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Serum cobalamin, folate, PLI and TLI.
- A fecal evaluation for ova/Giardia.
- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
- A 6-week limited antigen diet trial to assess for food allergies.
- Consider discontinuation of Felimazole temporarily to see if the patient's clinical signs improve.



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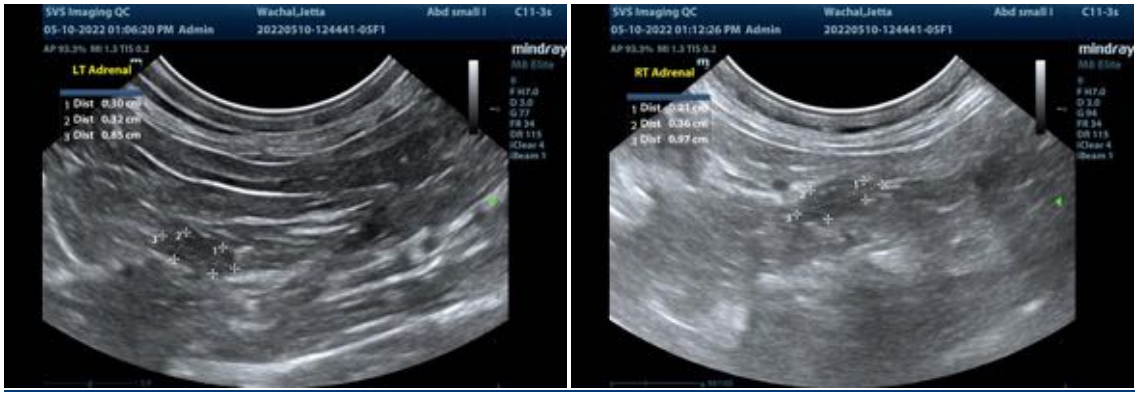
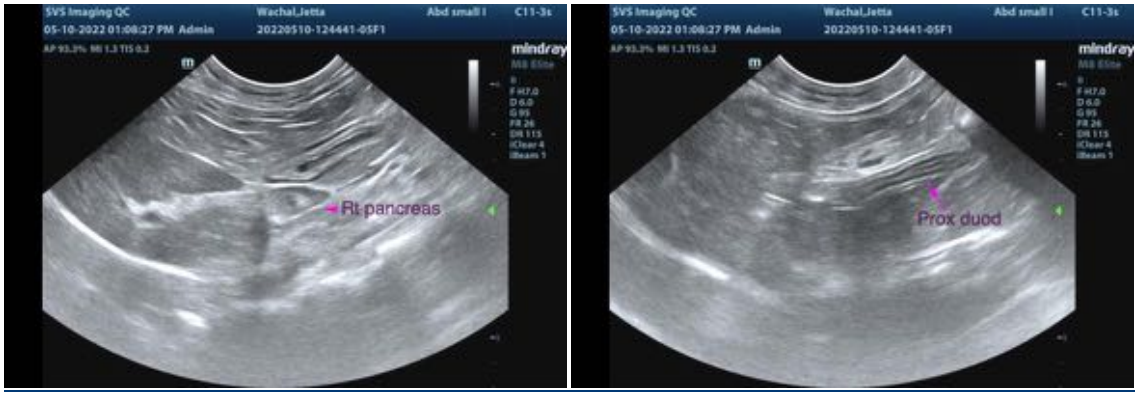
- Depending on the results of the above diagnostics/therapeutics, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis. Thoracic radiographs should be performed prior to anesthesia to evaluate cardiopulmonary status.





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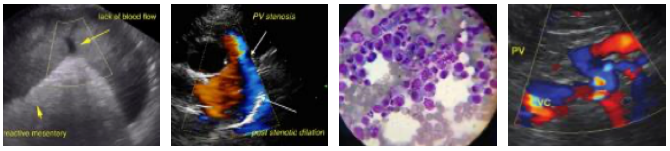

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.nicastro@sonopath.com