Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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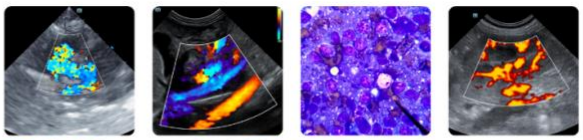

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Ringo Johnson

SPECIES

Feline

BREED

DMH

SEX

Male Neutered

AGE

4/6/09

WEIGHT

9.90

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Waterway AH

REFERRING VET

Eliza Roland

INVOICE

23021

DATE

5-15-26

PRESENTING CLINICAL SIGNS

4-day hx of vomiting, diarrhea and lethargy

Abnormal lab-work values: Albumin 2.5, Bun- 45, Neutrophils 78, Lymphocytes 14, Monocytes 5, Absolute Neutrophils 12168, Absolute Monocytes 780. T4 normal.
Current Medications: Diagel but nothing else

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A scant amount of suspended echogenic debris is observed within the lumen. 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 (3.15 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 moderate 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 (3.91 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 moderate 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 normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.57 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic 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. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.27 cm in width).

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 walls are diffusely thickened (up to 0.47 cm for jejunum / up to 0.52 cm for ileum). There is disruption in the normal 1:3 muscularis: mucosal ratio with a 1:1 in most segments. Discreet masses are not identified. The ileocecal

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colic junction and colonic wall are normal. The colonic lumen contains some shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas
The left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is dilated (up to 0.29 cm in width). There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes
A cluster of prominent- to enlarged hypoechoic mesenteric lymph nodes are visualized (one measuring 3.21 x 0.94 cm). Surrounding mesentery is mildly hyperechoic.

Free Abdomen
There is no obvious evidence of free fluid.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma.
- The mesenteric lymphadenopathy could be consistent with emerging neoplasia (i.e., lymphoma), lymphoid hyperplasia, or lymphadenitis.
- The pancreatic changes are most consistent with chronic pancreatitis with parenchymal remodeling.

Secondary Findings

- Bilateral nonspecific age-related renal changes
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fine-needle aspiration of the mesenteric lymph nodes can be considered (assuming normal clotting status). Twenty-five gauge-needles should be used.
- A GI panel including serum cobalamin and folate, TLI and PLI is also recommended.
- Depending on the results, endoscopic or surgical GI biopsies may be warranted.
- If further testing is not pursued, consider empirical treatment for inflammatory bowel disease (i.e., corticosteroids, limited antigen or hydrolyzed protein diet, +/- cobalamin supplementation) as long as the client understands the risks of treatment without a definitive diagnosis.

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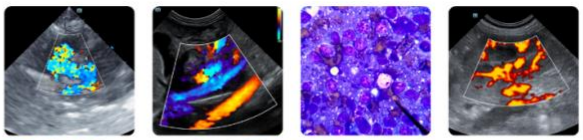

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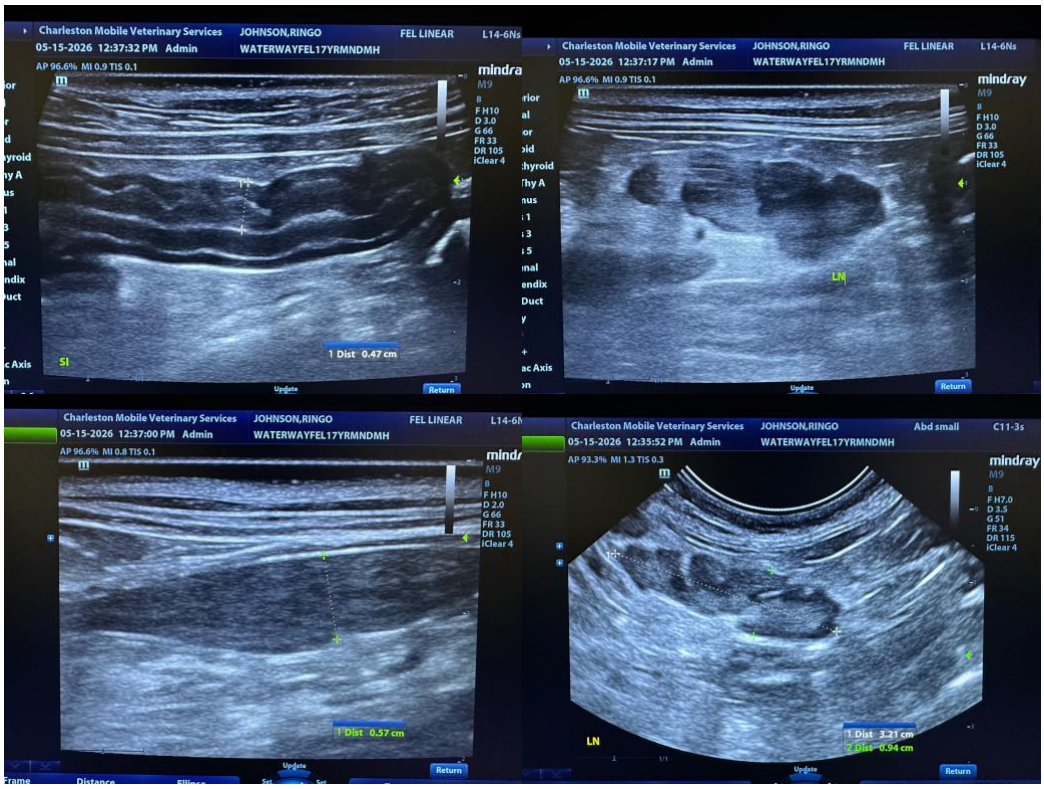

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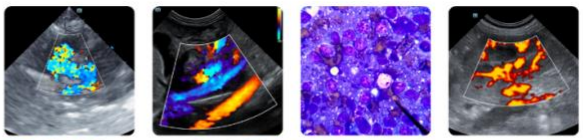

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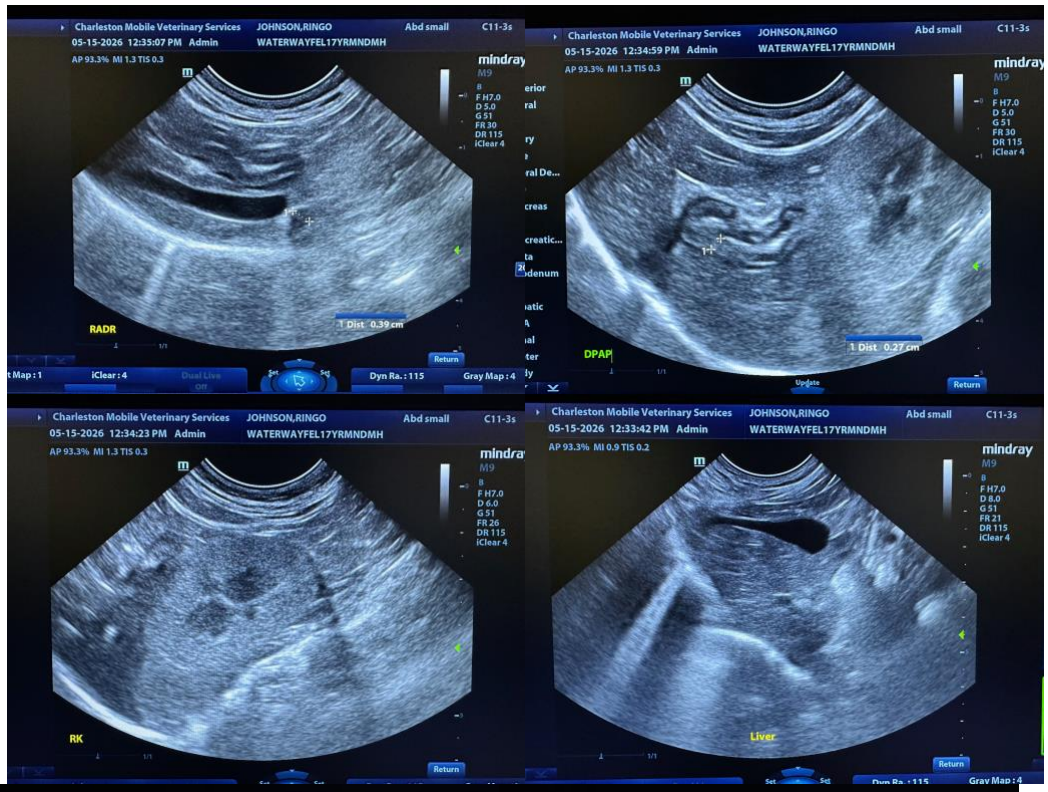

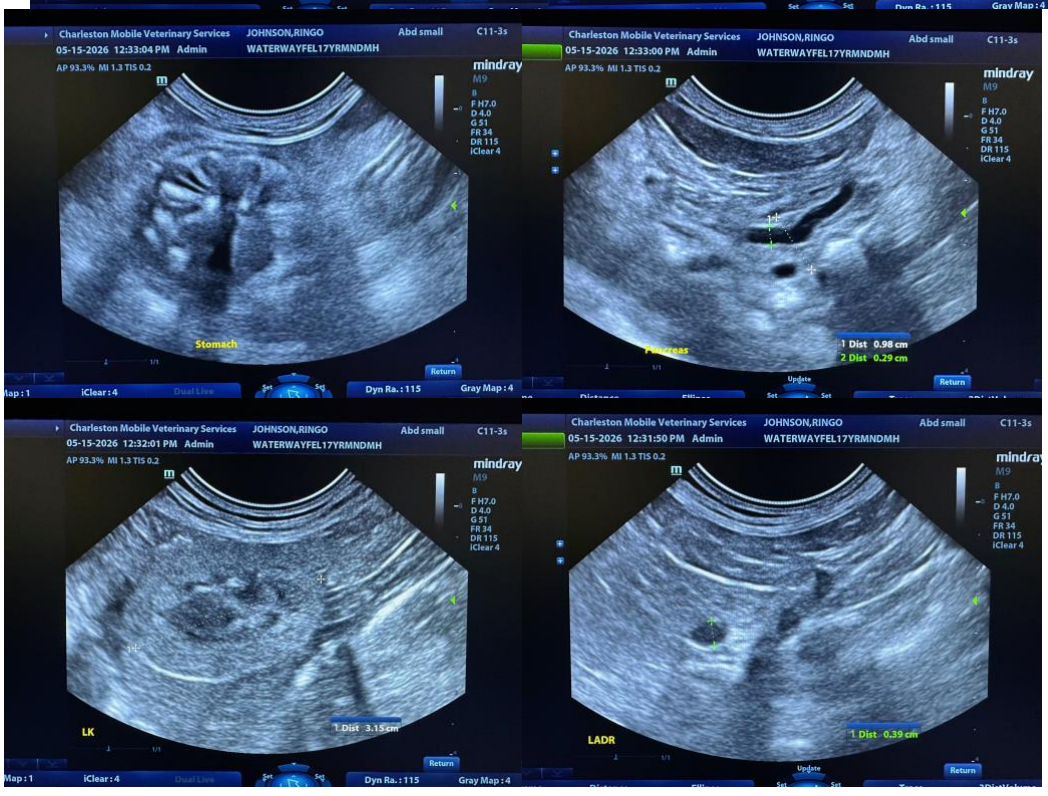

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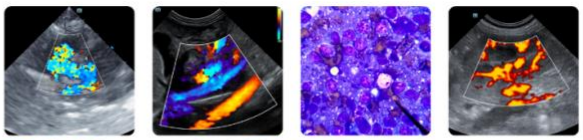

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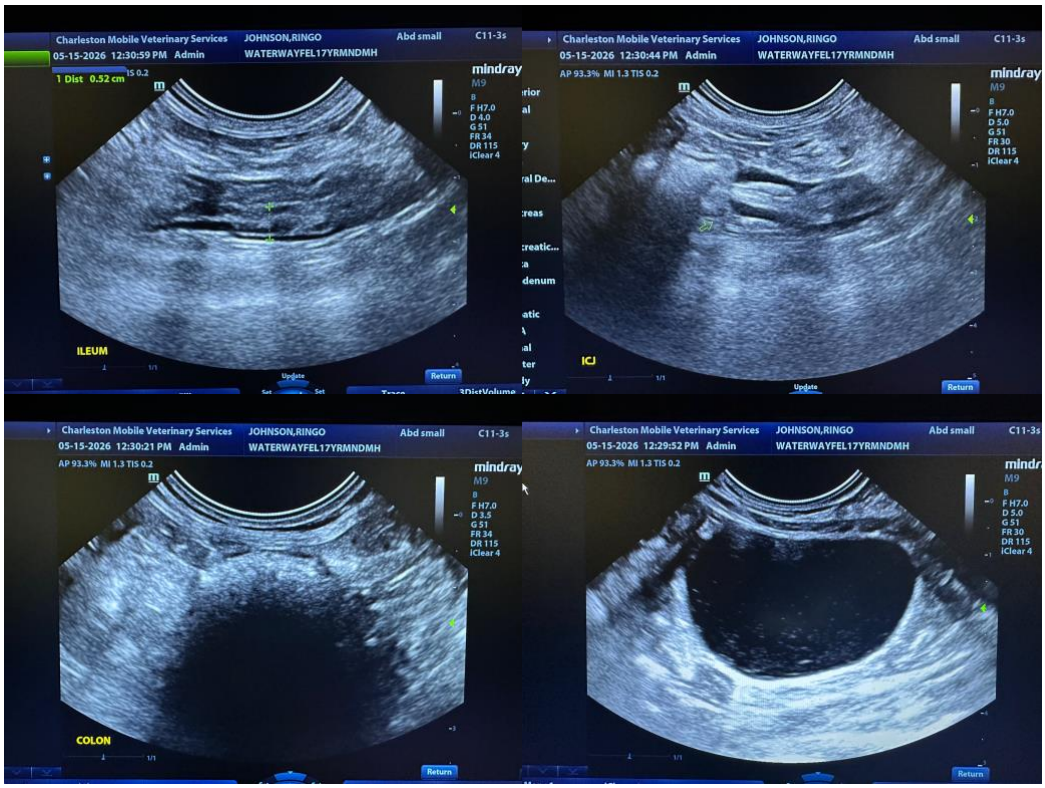

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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