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Clinical Sonography & Telecytology
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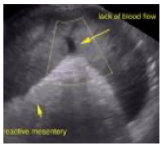
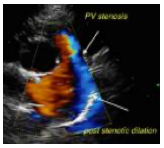
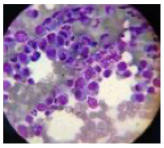
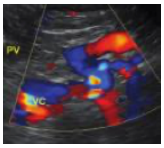

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PATIENT

Izzy Redmond

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

14 years

WEIGHT

3.5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Arias

HOSPITAL NAME

Animal EH Deland

REFERRING VET

Dr. Arias

INVOICE

12963

DATE

5.8.23

PRESENTING CLINICAL SIGNS

History: The diarrhea and intermittent vomiting has been going on since February. The owner has been to multiple veterinarians with some diagnostics performed. Today the owner was concerned because she wasn't sure if the pile of bloody liquid was diarrhea or vomit. The owner is driving to CO. The owner has found an internal medicine veterinarian in CO she is hoping to make an appointment with. The rDVM changed the diet at some point (Z/D and RCC hydrolyzed for sensitive stomach dry), and the owner saw some improvement but not resolution. Izzy was previously 8.8 lbs (now 7.7lb).

Abnormal PE/Chem/CBC/UA Results: 2/9/23 ANTECH GI PCR panel negative 4/17/23 Chem NSF SDMA 15 T4 WNL CBC mild monocystosis (844) UA NSF USG 1.016 Idexx fecal negative 5/6/23 CBC: NSF PCV/TP: 40%, 8.0 g/dL COMP: NSF EPOC: mild stress hyperglycemia ProBNP: Normal Radiographs: Lateral and ventrodorsal abdominal radiographs dated May 6, 2023, are available for review. The stomach is essentially empty, containing a small amount of gas and fluid. No gastric foreign material is identified. There is mild to moderate diffuse fluid and gas distention of the small intestine. Small intestinal segments are relatively uniform in diameter and at the upper limits of normal for overall size. No significant overdistention or intestinal plication is seen. Several small intestinal segments have the appearance of thickened intestinal walls. There is no evidence of foreign material. The colon contains unformed fecal material and gas. The abdominal serosal detail is within normal limits. The liver and spleen are unremarkable. Where seen, the kidneys and urinary bladder are within normal limits. The caudal thorax is within normal limits. There is mild spondylosis deformans within the thoracic spine and degenerative changes associated with the coxofemoral joints. Conclusion 1. Diffuse fluid and gas distention of the small intestine could be indicative of a functional ileus and may be associated with enteritis or potentially infiltrative intestinal disease. No definitive gastric foreign material or intestinal plication is seen. 2. The apparent increase in small intestinal wall thickness may be artifactual, secondary to incomplete distention and/or gas and fluid layering. Alternatively, this may represent a true increase in thickness of the intestinal wall due to infiltrative disease of inflammatory or neoplastic etiology. An abdominal ultrasound would be needed to further evaluate this finding. 3. Mild spinal degenerative changes and coxofemoral degenerative joint disease

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. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is small in size (2.54 cm in length) with a slightly irregular shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. A cortical infarct is observed suspected at the lateral aspect. There is no evidence of pyelectasia, nephroliths, or hydroureter.

The right kidney is normal in size (3.72 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature appears normal.

Adrenal Glands

The region of the adrenal glands is evaluated. No obvious pathology is observed in this region.

Spleen

The spleen is normal in size (0.92 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 appears 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 to 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/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas
The pancreas is diffusely visible with normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat. The parenchyma is homogenous. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic effusion.

Free Abdomen
There is no obvious evidence of free fluid. A few prominent mesenteric lymph nodes are visualized (the largest measuring 0.78 cm in length).

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include microscopic gastrointestinal disease (i.e., food allergy/intolerance, infectious/parasitic disease, dysbiosis, inflammatory bowel disease), underlying metabolic issue, other.

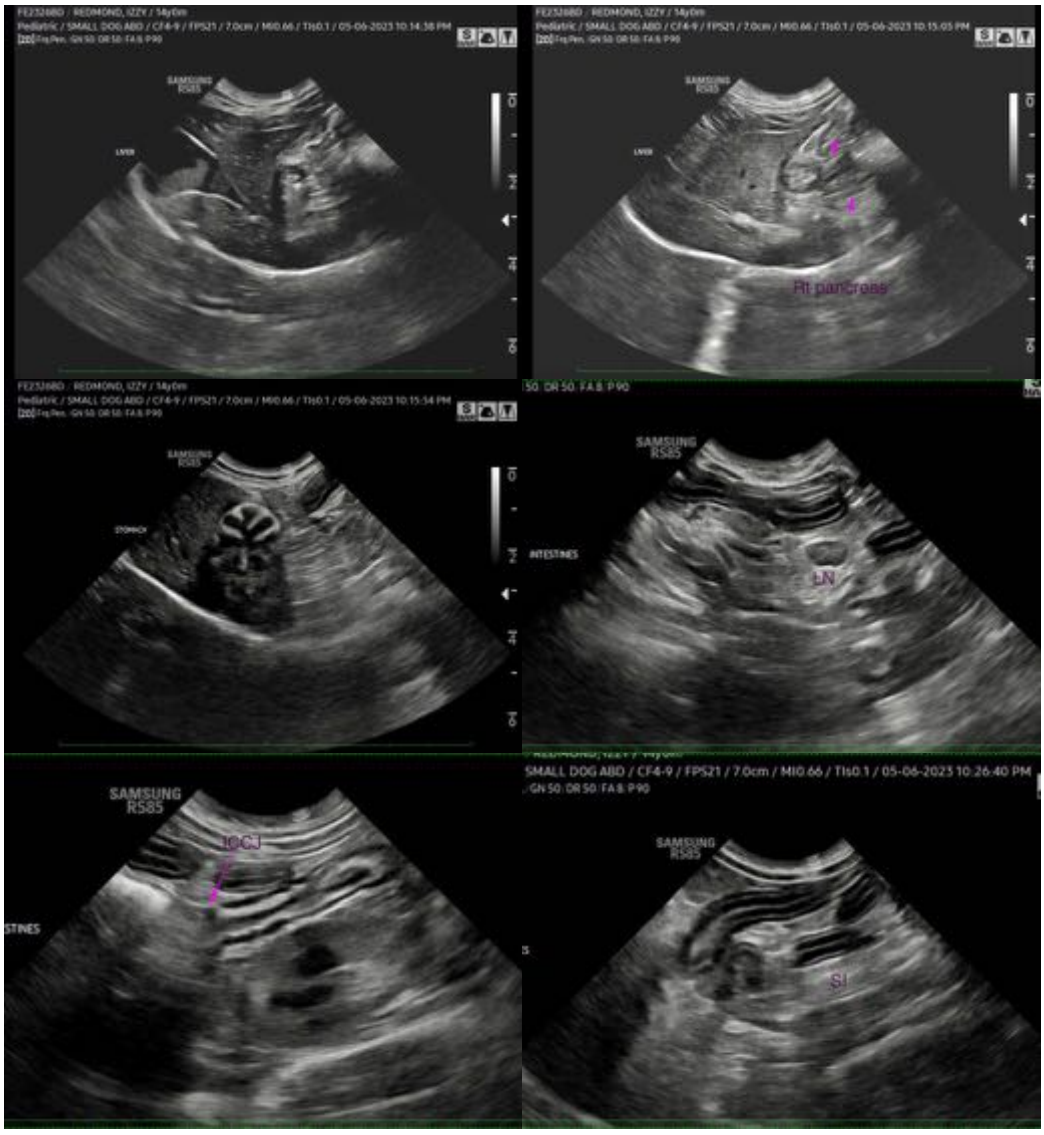
Secondary Findings

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- Minor bilateral age-related renal changes with a suspected left cortical infarct
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Despite the negative fecal evaluation, consider prophylactic deworming with Fenbendazole.

- A malabsorption panel, including serum cobalamin and folate, TLI and PLI is also recommended.
- Also consider initiation of a probiotic along with a fiber supplement (i.e., psyllium).
- Ultimately, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. If pursued, three-view thoracic radiographs should be performed prior to anesthesia. If biopsies are not pursued, empirical treatment for inflammatory bowel disease (i.e., corticosteroids, hypoallergenic diet) can be considered as long as the client understands the risks of treatment without a definitive diagnosis.



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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