



PATIENT

Blue Rice

SPECIES

Feline

BREED

Siamese

SEX

Male, castrated

AGE

10 Yrs.

WEIGHT

3.99 kg.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Arias

HOSPITAL NAME

Animal Emergency
Hospital of Volusia

REFERRING VET

Dr. Arias

INVOICE

14905

DATE

5/9/23

PRESENTING CLINICAL SIGNS

Blue, 10Y MC Siamese, vomited 5 times this morning. He was taken to rDVM this afternoon. They ran bloodwork- O was unsure of results but remembers something about elevated liver values. They also gave cerenia inj and cerenia TGH.

P did well after the visit until approx 7pm when he started crying again. She gave him the oral cerenia 4mg thinking he was nauseous again. He then had foamy vomit. He ate a little before vomiting.

Per O, P only drinks out of the running sink and he drinks and urinates alot.

P has a history of azotemia, anorexia with open diagnosis in 2018. Is on Purina NF.

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 is normal.

The left kidney is normal size (3.80 cm in length) with an irregular shape. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A cortical infarct is observed at the cranial medial aspect. There is no evidence of pyelectasia, nephroliths or hydroureter.

The right kidney is normal size (4.09 cm in length) with an irregular shape. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A cortical infarct is observed at the caudomedial aspect. There is no evidence of pyelectasia, nephroliths or hydroureter.

Adrenal Glands

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

The right adrenal gland is normal in 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 (0.83 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 to caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.



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Gastrointestinal

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In the first set of images, the gastric lumen is empty. 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. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted. In the second set of images (which appear to be obtained approximately 5.5 hours earlier than the first set), the gastric lumen is mildly to moderately fluid distended. The wall is normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated.

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Pancreas

The base and limbs of the pancreas are 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 visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

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Free Abdomen

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- An obvious cause for the elevated liver enzymes is not identified in the study. However, a microscopic hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, emerging hepatic lipidosis, infiltrative neoplasia (less likely) should be considered.
- Trace ascites.

Secondary Findings:

- Bilateral chronic nephropathy with suspected cortical infarcts.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the patient's history of elevated liver values and the sonographic findings, consider the following:
 1. Repeat baseline labwork (CBC, chemistry, urinalysis, T4) is recommended.
 2. Pre- and post-prandial serum bile acids to assess for hepatic dysfunction.
 3. Hepatic tissue sampling (i.e., fine needle aspirate or biopsies (laparoscopic or surgical) if clotting status is appropriate). If biopsies are pursued, aerobic and anaerobic bile cultures are also recommended.
 4. Also consider Toxoplasmosis testing (i.e., IgM, IgG).



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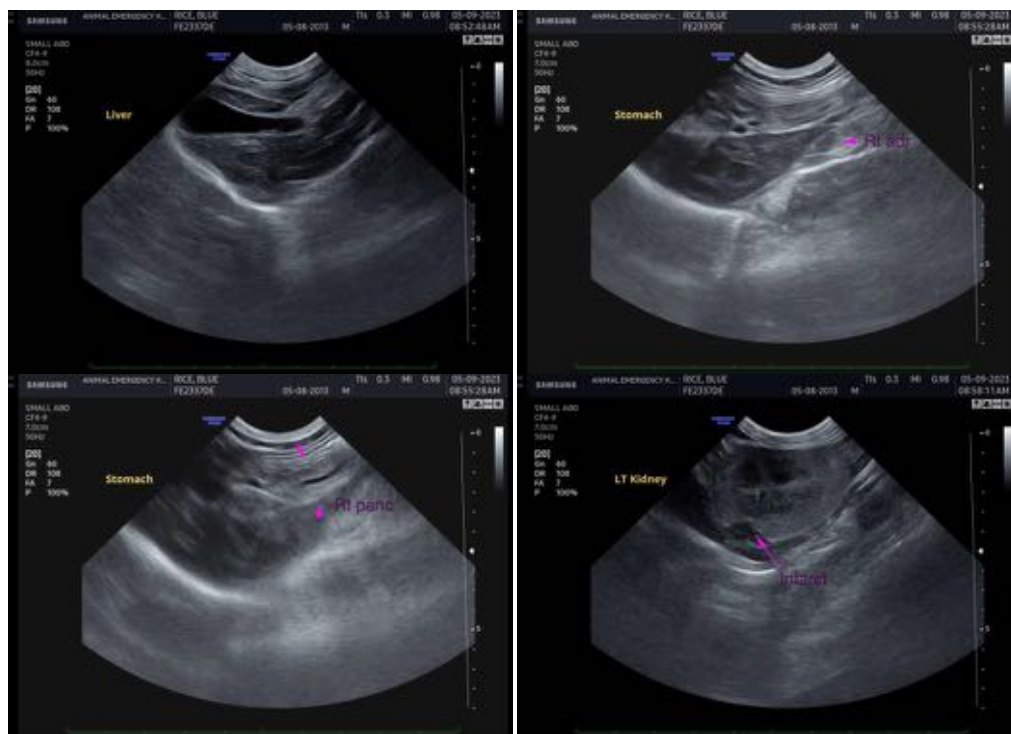
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5. fPLI +/- a full GI panel (Texas A&M) including serum cobalamin, folate, TLI and PLI to assess for pancreatic disease and maldigestion/malabsorption), if not already performed
6. While awaiting test results, empirical treatment for bacterial cholangiohepatitis is recommended including broad spectrum antibiotics, hepatic antioxidants and other supportive measures. Nutritional support (i.e., via temporary feeding tube) is also recommended to help prevent/treat hepatic lipidosis.
7. Given the frequency of vomiting, also consider thoracic radiographs to assess for occult aspiration pneumonia.
 - Regarding the bilateral renal changes and urinalysis findings, the following should be considered:
 1. Urine culture and sensitivity
 2. UPC if proteinuria persists in the absence of infection
 3. Baseline blood pressure measurement





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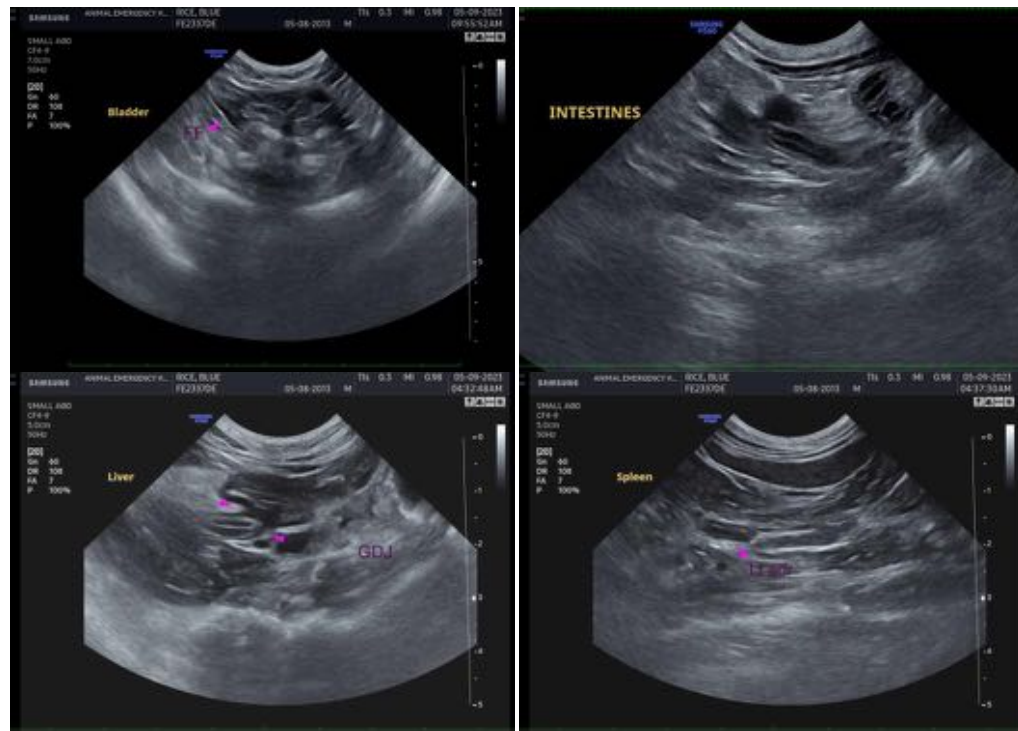
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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