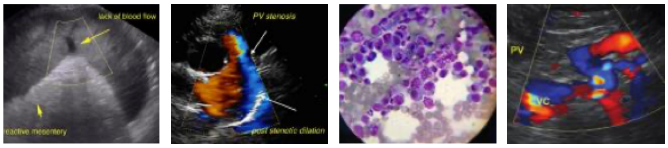
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Meka Williamson

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

13 years

WEIGHT

6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Aaron Deml, DVM

HOSPITAL NAME

Craig Road AH

REFERRING VET

Cameron Johnson, DVM

INVOICE

13781

DATE

7.21.23

PRESENTING CLINICAL SIGNS

History: Medical History: P is a 13yr old FS DSH presenting for vomiting, not eating and abnormal hiding behavior. Around 2 weeks ago, P started vomiting more often than usual. P was unable to keep food or water down. P also started experiencing hiding behavior and lethargy which is very abnormal for P. O states that P has always had a sensitive stomach, but recently, P has been vomiting more overall. Not E/D in the last 24 hours. No C/S/D. No current medications. Indoor only. P is the only cat within the household. Current medications: None Physical Exam: T - 103.0F rectal P - 240bpm R - 55brpm

ATTITUDE- quiet, alert, responsive BW - 6.0lbs BCS - 4/9 MM - pink, slightly tacky, CRT <2 sec, ~5-7% dehydrated
EENT- no nasal or ocular discharge OU; fundic exam not performed; no inflammation, erythema or discharge
AU; TM not assessed AU; no other significant findings ORAL- evidence of moderate dental calculus; 104 missing with possible oronasal fistula present PLNS - peripheral LNs are normal in size and not firm or painful H/L - normal sinus rhythm, no murmurs auscultated, eupneic; no evidence of increased respiratory rate or effort, bronchovesicular sounds are normal; no crackles or wheezes auscultated
ABD - Tense, non-painful, nondiagnostic UG - moderate sized bladder; no discharge or irritation; MSI - ambulatory x 4; no evidence of lameness; complete orthopedic exam not performed INT - nice hair coat, no evidence of ectoparasites, no abnormal findings
NEURO - normal gait and mentation, CPs intact x 4; CNs normal; no obvious deficits; full neurologic exam not performed Pain Score (0-4) - 0

Abnormal PE/Chem/CBC/UA Results: Hypocalcemia (iCa): 1.18 Hyperglycemia: 299

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 mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.30 cm in length) with a normal shape, architecture and smooth peripheral margins. 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 appears normal.

The right kidney is normal in size (3.50 cm in length) with a normal shape, architecture and smooth peripheral margins. 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 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 (0.63 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 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.

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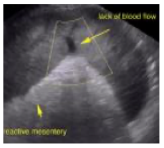
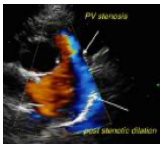
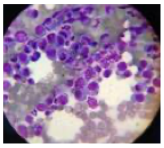
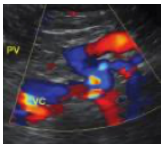

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The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 normal to borderline thickened (up to 0.27 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio, with a 1:1 ratio in many segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The mesentery in the region of the right limb is hyperechoic. The pancreas itself is otherwise largely isoechoic relative to surrounding omental fat.

Free Abdomen

The mesentery in the cranial abdomen is hyperechoic. There is no obvious evidence of free fluid. Two-to-three prominent lymph nodes are observed in the cranial abdomen, the largest measuring 0. 36 cm in diameter. Surrounding mesentery is mildly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern consistent with inflammatory bowel disease or emerging lymphoma.
- Cranial peritonitis, possibly secondary to bowel pathology, and/or mild pancreatitis.

Secondary Findings

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Bilateral chronic age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a Texas GI panel including serum cobalamin and folate, TLI and PLI to further evaluate for maldigestion/malabsorption and pancreatitis.
- A fecal evaluation for internal parasites is also recommended.
- Consider three-view thoracic radiographs to assess for occult esophageal disease.
- Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis.
- In the meantime, symptomatic care is recommended, including a probiotic.

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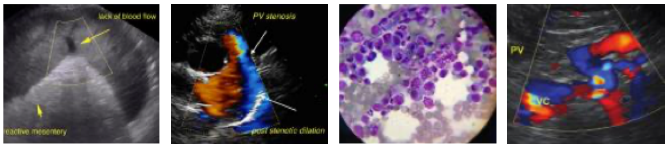

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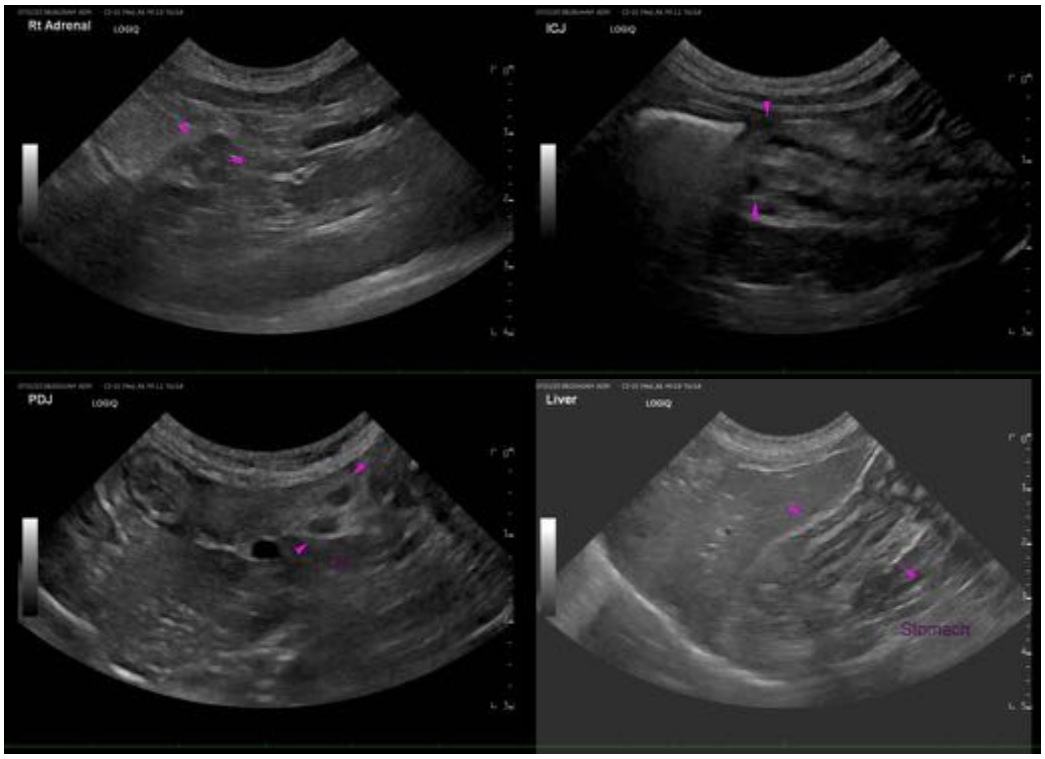

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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