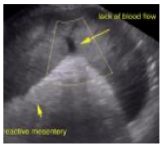
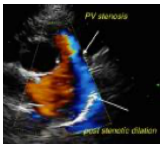
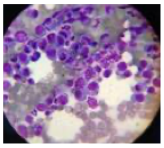
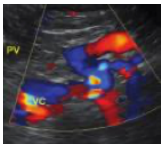
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Oscar Eiseler

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 years

WEIGHT

13.9 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Laurel Logas

HOSPITAL NAME

Bradentown VH

REFERRING VET

Laurel Logas

INVOICE

11430

DATE

8.17.22

PRESENTING CLINICAL SIGNS

History: Feral cat adopted 6 years ago as an adult. Has been a house cat ever since. He is on Revolution Plus monthly. Owners feed Friskies dry and canned food. Presented 8/8/22 ADR on and off for 2 weeks. He had diarrhea on and off and not eating and then would be fine a few days later. Treated symptomatically. See Px and work-up below. 8/15 He presented again not much better. He was defecating small amounts of stool and crying for defecation. Owners had not seen urine for 1.5 days. He was eating a little of the Friskies. Repeat blood work was the same and UA WNL. Rads showed colon full of stool but not distended, firm but not hard on rectal exam. bladder large. He later emptied his bladder in the hospital cage. His rectum was very ulcerated and painful. There was no stricture. He was scheduled for ultrasound today. Enema was repeated yesterday and today. Dx. of proctitis, cause unknown.

Abnormal PE/Chem/CBC/UA Results: 8/8/22 Normal exam. grey feces aroun the rectum. T 101 P 160 R40 Profile glob 5.4, alb 2.6 the rest -N CBC WNL. Feleuk/FIV neg. Treatment with cerenia, profender, SQ fluids, Proviable, Royal Canin GI food. 8/15/22 rectum very ulcerated and painful. firm/soft stool in colon, Repeat blood work the same results. UA WNL. rads show stool in colon but not distended. Treatment with enema, Convenia, oral buprenex, topical mupirocin on rectum, miratraz for appetite. ultrasound scheduled for today. Enema repeated yesterday and today. Today pet is eating better but has only produced a little stool. Still straining and crying. Bladder is again large but no history of straining to urinate. Diagnosis Proctitis cause UK

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is distended with anechoic urine. 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 (4.35 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. The cortex is hyperechoic. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The **right kidney** is normal size (4.95 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. The cortex is hyperechoic. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The **left adrenal gland** is normal size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The region of the **right adrenal gland** is evaluated. No obvious pathology is observed.

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 **gall bladder** lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is mildly distended with ingesta. The gastric wall is normal in thickness with a normal layering pattern. 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. There is no evidence of an obstructive pattern.

Pancreas

The region of the **pancreas** is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

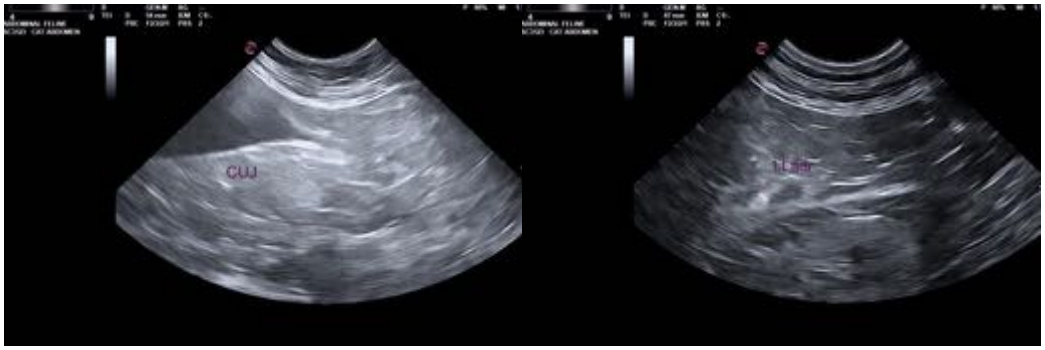
- Bilateral age-related degenerative renal changes
- *An obvious cause for the patient's clinical signs is not identified in this study.

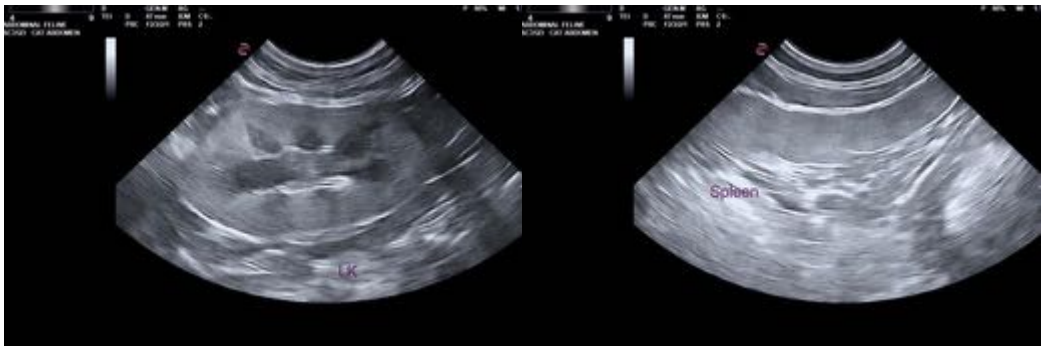
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

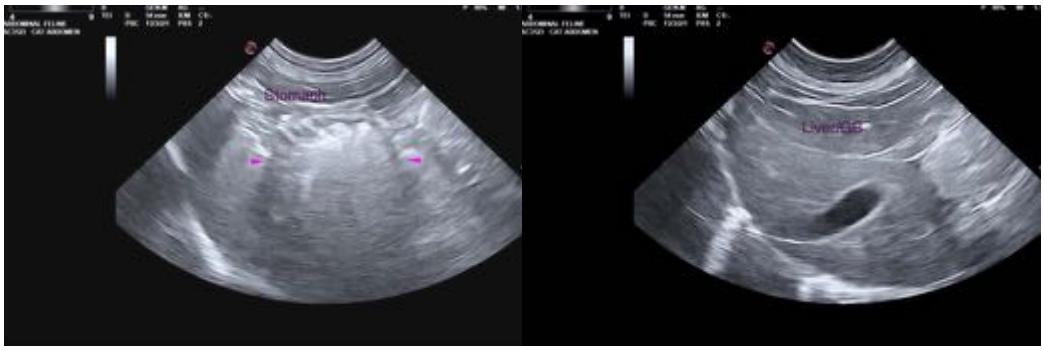
Regarding the diarrhea, consider the following:

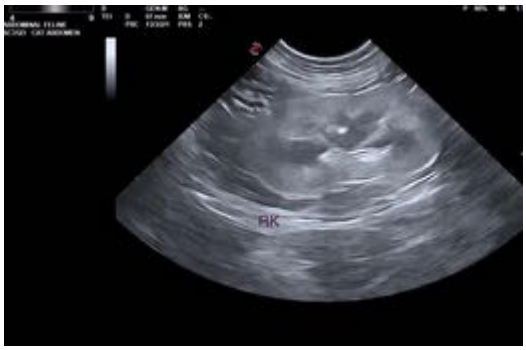
1. A fecal evaluation for ova and Giardia is recommended, if not already performed.
2. Prophylactic deworming with Fenbendazole is also recommended.
3. Consider a malabsorption panel (including serum cobalamin and folate, TLI and PLI).
4. Consider transitioning to a low-fat or a novel protein diet.
5. Ultimately, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. Endoscopic biopsies of the colon may be preferred in that mucosal lesions (i.e., structures, polyps, tumors) can be visualized and sampled. Three-view thoracic radiographs should be performed prior to anesthesia.

Regarding the perianal lesion, consider a biopsy to rule out neoplasia.









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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