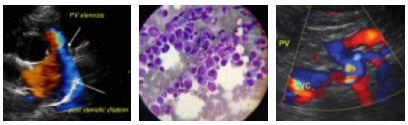
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

8/18/21

PATIENT

Guillo Davison

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

9/8/2009

WEIGHT

15 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Paradise Animal Hospital

REFERRING VET

Dr. Twardzik

INVOICE

11905

PRESENTING CLINICAL SIGNS

History: Brought him up three years ago from Colombia, S.A. Since coming to the states, has vomited periodically. This past week, vomiting 5-6 times a day, having diarrhea and not eating. Only vomiting 1-2 times a day last day or two. Owner changed his food 2-3 weeks ago as they couldn't find his normal diet (Senior diet from Merrick). Owner had changed food a few months ago and he vomited frequently then, as well. Owner started Fortiflora, no other meds. Decreased drinking and urination, more lethargic. Strictly indoors. On exam, patient had lost 1.5 lbs since the previous visit and had moderate gingivitis.

Current Medications: Started Fortiflora prior to visit. On 8/13, started: Cerenia 16 mg -- 1/2 tab PO SID (box). Miratаz -- 1.5" strip to inside of ear Q 24 hours, PRN for appetite stimulation.
Lab Results: CBC: WNL. Chem: Elevated Creat 2.9 mg/dL, Elevated GGT 6 U/L, Decreased K+ 3.3 mmol/L, T4: 2.3 mg/dL.
Radiographs: No obvious FB or obstructive pattern noted.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not needed.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (3.75 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.88 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild 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 in size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

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. A 0.51 x 0.31 cm hyperechoic nodule is observed at the cranial lateral aspect. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic 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 gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen. 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 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 to mildly thickened (up to 0.38 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio with a 1:1 ratio in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

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 visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. 1-2 prominent mesenteric lymph nodes are visualized, the largest measuring 0.77 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The prominent mesenteric lymph nodes are most likely reactive.
- 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.
- In light of the patient's history, the hepatic parenchymal changes are most consistent with hepatic lipidosis; however, concurrent inflammatory disease or infiltrative neoplasia (less likely) are also considerations.

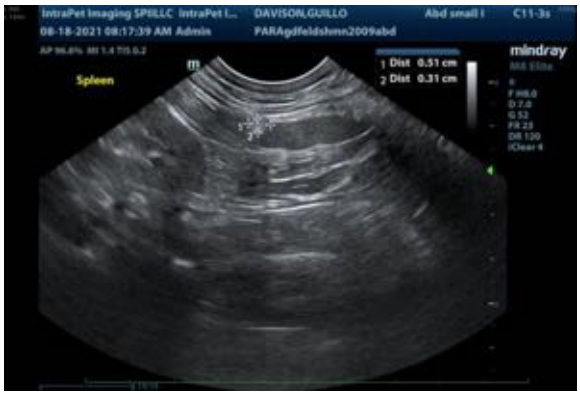
Secondary Findings:

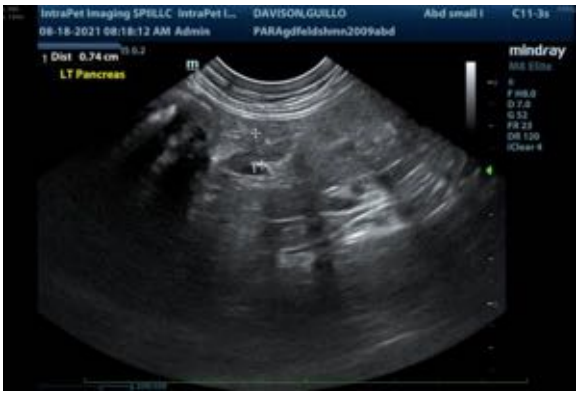
- The hyperechoic lesions adjacent to the splenic vessels are most consistent with myelolipomas. Although a neoplastic process within the spleen cannot be excluded, it is considered unlikely in this patient.
- Non-specific, age-related renal pathology.

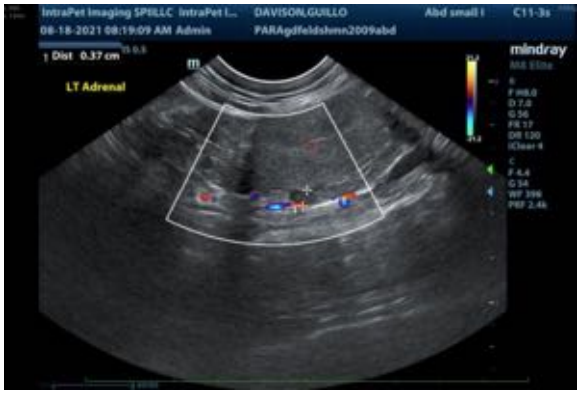
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

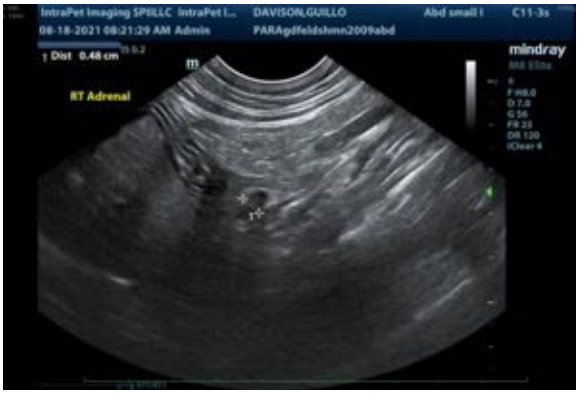
- If an aggressive approach is desired, endoscopic or surgical gastrointestinal biopsies can be considered along with less invasive diagnostics including a malabsorption panel, hypoallergenic diet trial and a fecal evaluation for ova and Giardia.
- Three-view thoracic radiographs are also recommended prior to anesthesia.

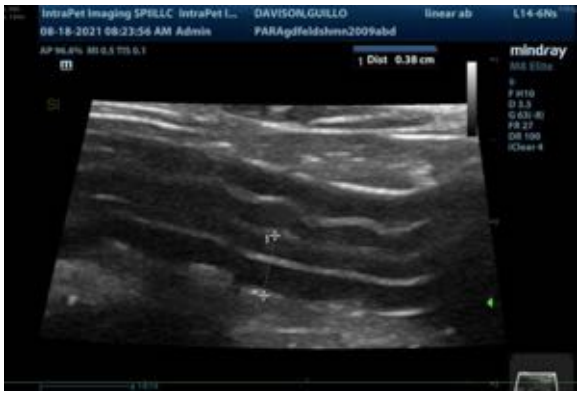
- Given the concern about the development of hepatic lipidosis, nutritional support (i.e., temporary feeding tube) is also strongly encouraged.

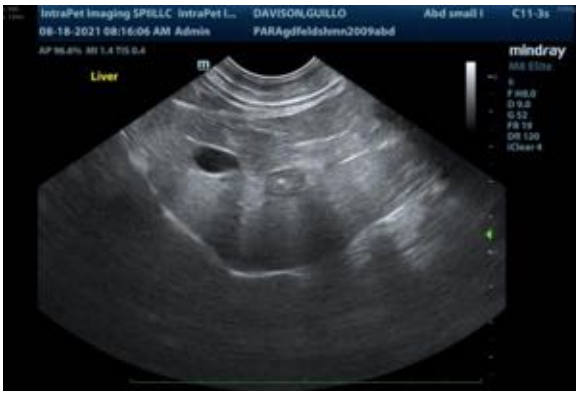


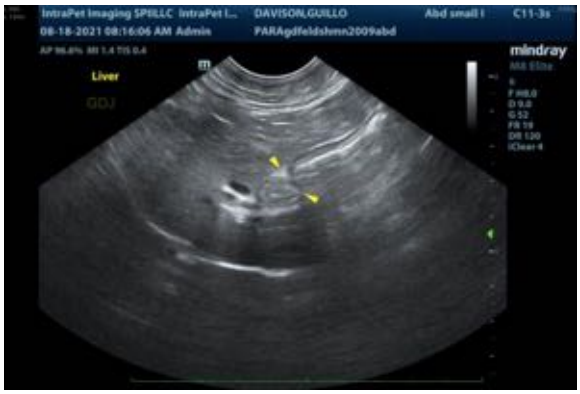


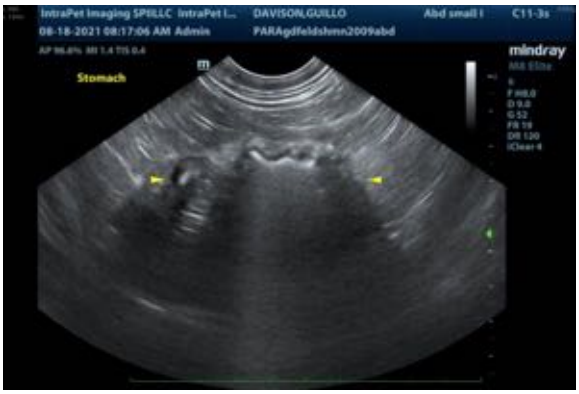


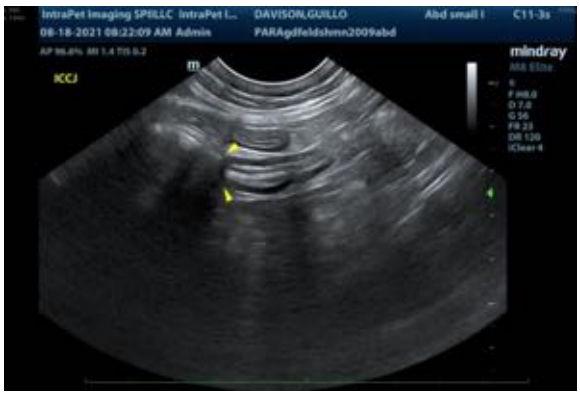


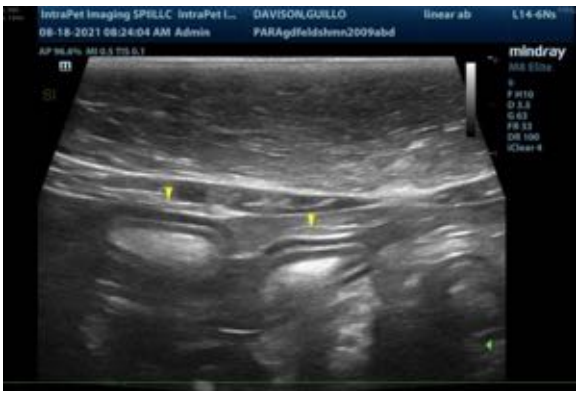


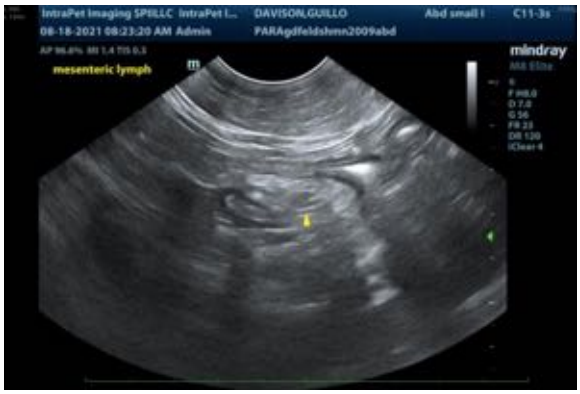












The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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