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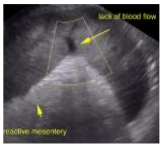

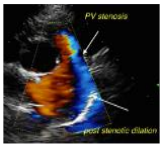

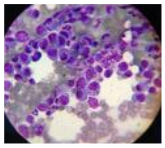
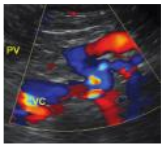

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Roger Horsley

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 years

WEIGHT

13.32 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Goodman

HOSPITAL NAME

Evandale-Blue Ash PH

REFERRING VET

Dr. Wehmer

INVOICE

14193

DATE

8.21.23

PRESENTING CLINICAL SIGNS

History: Patient presented 8/16 for possible urethral obstruction based on owner history. Vomited clear fluid the previous night, inappetence, and vocalizing in the litterbox followed by bloody liquid (owner suspected diarrhea). Abdominal rads showed good serosal detail, diffuse fluid and gas pattern throughout small intestines and colon, no formed stool in colon, urinary bladder moderate in size with no radioopaque stones, possible plump right kidney. Performed full bloodwork that showed mild inflammatory response and stress hyperglycemia. Since patient was stable otherwise, administered Cerenia, sent home metronidazole and bland food options. Patient returned 8/17 for continued hospitalization and had a TAMU GI panel sent out (results pending). Had diarrhea without blood present overnight and did not eat. Started on IVFT with ondansetron, mirtazapine and Buprenex for any discomfort. Continued hospitalization on 8/18 where owner reports he is now excessively drinking water, still not eating and still having diarrhea without any blood present. Patient remains BAR and talkative/purring while hospitalized and belly remains soft and non-painful. Returned to the emergency room over the weekend for continued in appetence. Presented today for recheck evaluation as his symptoms haven't worsened, but they aren't improving either. still not really interested in eating, still having diarrhea as well. Patient did begin coughing while in the clinic, performed 3 view chest rads and sent out for rad consult (report attached). He has coughed intermittently since being here and has been tachypneic.

Abnormal PE/Chem/CBC/UA Results: BW and rad report attached still waiting on TAMU GI results We have not seen this patient prior to 8/16. USG 1.034. Some proteinuria, inactive sediment. Mild cardiomegaly and increased opacity in the perihilar region on chest x-rays.

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 and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.15 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Mild pyelectasia is present (0.25 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal in size (4.27 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A cortical infarct is suspected at the caudolateral aspect. There is no evidence of pyelectasia, nephroliths, or hydroureter.

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 (0.91 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.

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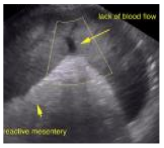

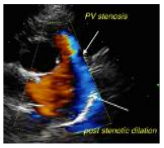

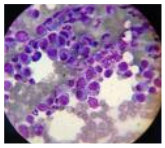
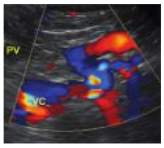

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Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen and is homogenous in appearance. Intrahepatic biliary tracts are dilated. Hepatic vasculature is of normal volume with no evidence of congestion. 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. A small amount of gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with fluid, gas and chyme (mild). The small intestinal wall is normal in thickness with a normal layering pattern. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The lumen of the descending colon contains liquid-appearing fecal material. There is no obvious 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

There is no obvious evidence of free fluid. Several prominent, rounded, hypoechoic lymph nodes are observed in the mid-to caudal abdomen (the largest measuring 1.36 cm in its longest dimension). Surrounding mesentery is hyperechoic.

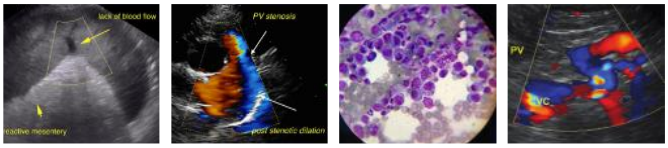
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The bowel changes are most consistent with gastroenteritis/colitis. Etiologies could include dietary indiscretion, dysbiosis, food allergy/intolerance, inflammatory bowel disease, partial obstruction (less likely), underlying metabolic issue, other.
- The abdominal lymphadenopathy could be consistent with lymphoid hyperplasia, reactive lymphadenitis or emerging neoplasia (i.e., lymphoma). Adjacent peritonitis is present.

Secondary Findings

- Bilateral chronic renal changes. The left pyelectasia may be secondary to pyelonephritis, age-related remodeling, fluid therapy (if applicable), or some combination thereof.



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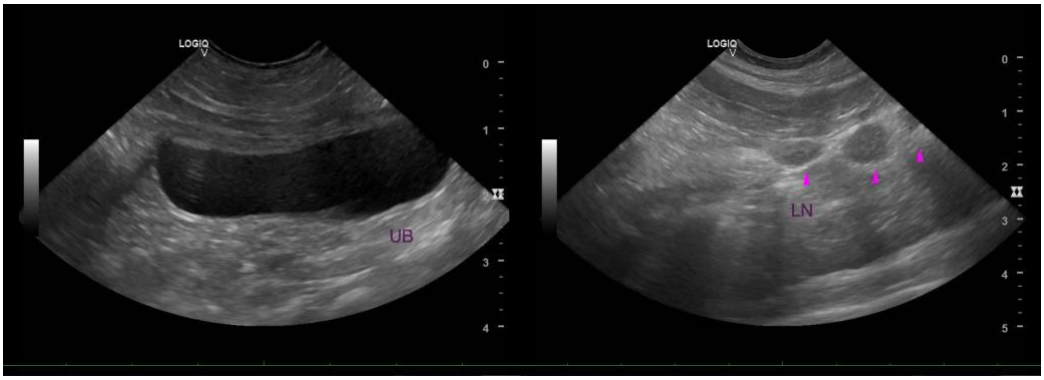
- The hepatic changes are suggestive cholangitis +/- concurrent bacterial cholangiohepatitis, hepatic lipidosis or emerging neoplasia (less likely). Cytology or histopathology would be necessary to get a definitive diagnosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for internal parasites is recommended (if not already performed).
- Consider prophylactic deworming with Fenbendazole, as well as initiation of a probiotic and fiber supplement (i.e., psyllium).
- If accessible, consider fine-needle aspiration of the prominent abdominal lymph nodes (if clotting status is normal). Twenty-five gauge-needles should be used.
- A T4 +/- free T4 by equilibrium dialysis is recommended to evaluate for hyperthyroidism as a possible cause for diarrhea.
- Depending on the results of the above diagnostics as well as the Texas GI panel, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis.
- Regarding the thoracic radiograph results, consider an echocardiogram, baseline blood pressure measurement, and ECG.



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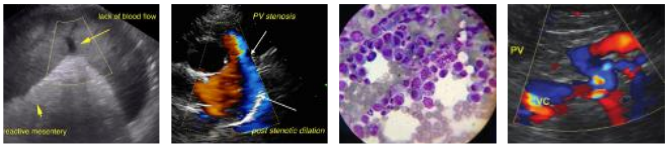

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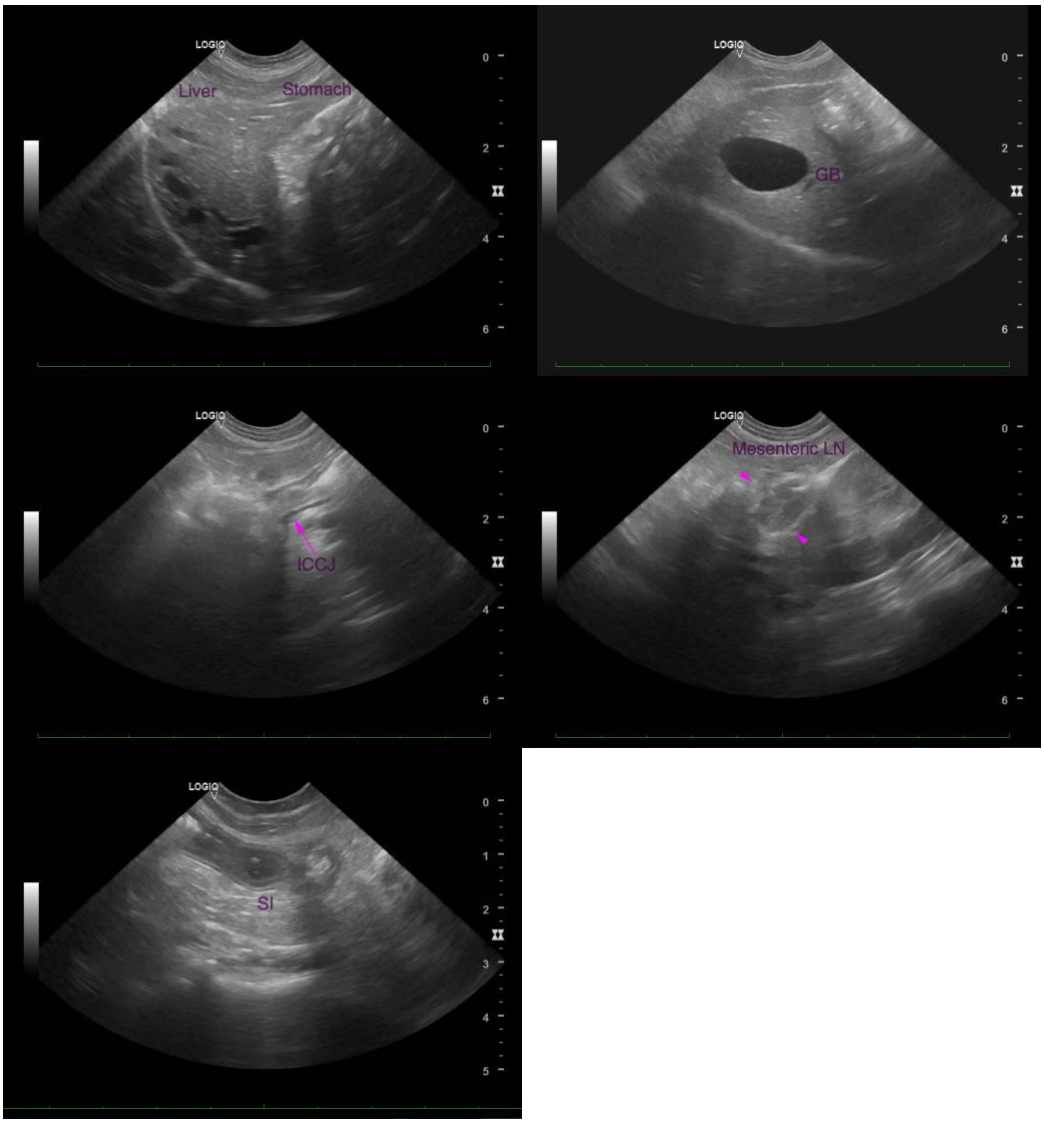

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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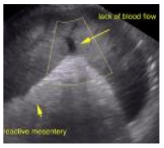

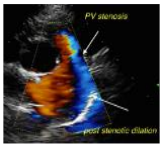

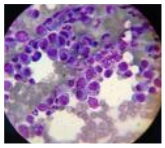
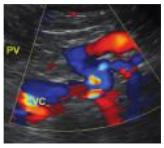

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