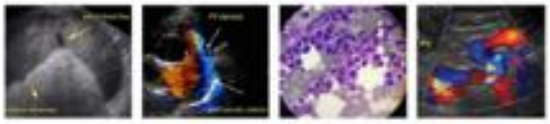


PATIENT

Gus Scott

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

7 years

WEIGHT

9.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Grass Valley VH

REFERRING VET

Dr Kristi Cortright

INVOICE

11328

DATE

8.4.22

PRESENTING CLINICAL SIGNS

History: History: ADR x 5 days. Not using litter box normally. Pacing. Seems depressed some days, other days totally himself per O. O started him on holistic OTC urinary treatment. Previous weight was 11.22# at For the Love of Pets

Abnormal PE/Chem/CBC/UA Results: Physical exam findings: BARH, BCS 4/9, CV-180, no murmurs, Resp-eupneic, lungs clear. GI bit gassy, bladder small, soft. Abnormal CBC values: b/w unremarkable Abnormal Chemistry Values: b/w unremarkable (calcium high but no PU/PD, likely artifact, r/o neoplasia) Abnormal UA Values: b/w unremarkable (u/s for cysto showed normal appearing bladder) Radiograph Findings (email radiographs if available): N/A Reason for Ultrasound: Rec u/s to identify cause of ADR. O is financially constrained, tried diet trial first but only for a week or so as he's still not doing well.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A scant amount of suspended, echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1-2 cm, are normal.

The **left kidney** is normal size (3.94 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is s normal size (3.79 cm); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 size (0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (0.47 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

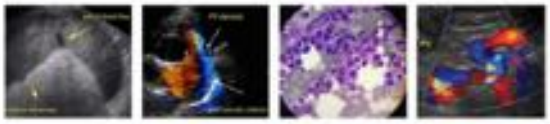
Spleen

The **spleen** is normal in size (0.85 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. A small amount of gravity dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts



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are normal. The duodenal papilla is also normal, measuring 0.38 cm in width. A few, prominent mesenteric lymph nodes are also seen, the largest measuring 0.81 cm in length.

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 thickness is normal with a normal layering pattern and appropriate mural detail. There is subjective mild thickening of the submucosal layer in some regions. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right 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. A few prominent sublumbar **lymph nodes** are visualized, the largest measuring 1. 42 cm in length. The nodes are normal in size and echogenicity. A 0.52 cm gastric lymph node is also seen.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

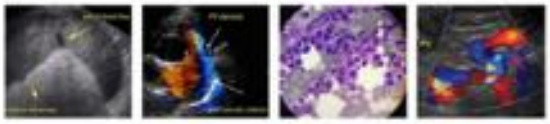
- The bowel changes are suggestive of inflammatory bowel disease. However, they may be a normal variant for this patient.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

*It is unclear whether the sonographic changes are the cause for the patient's clinical signs. Possible differentials include inflammatory bowel disease, chronic pancreatitis, occult neoplasia, orthopedic or neuromuscular disease, infection, metabolic disesase, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If possible, consider the following diagnostics:

1. Three-view thoracic radiographs are recommended to evaluate for occult neoplasia in the chest
2. Malabsorption panel, including serum cobalamin and folate, TLI and PLI to further evaluate for maldigestion/malabsorption and pancreatic disease



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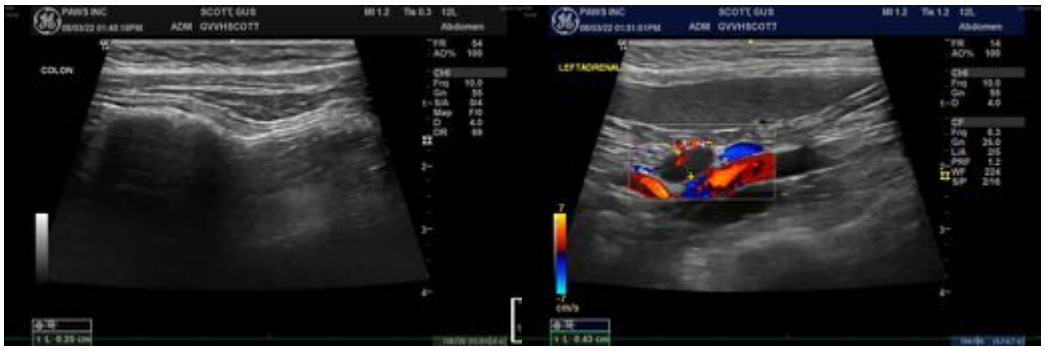
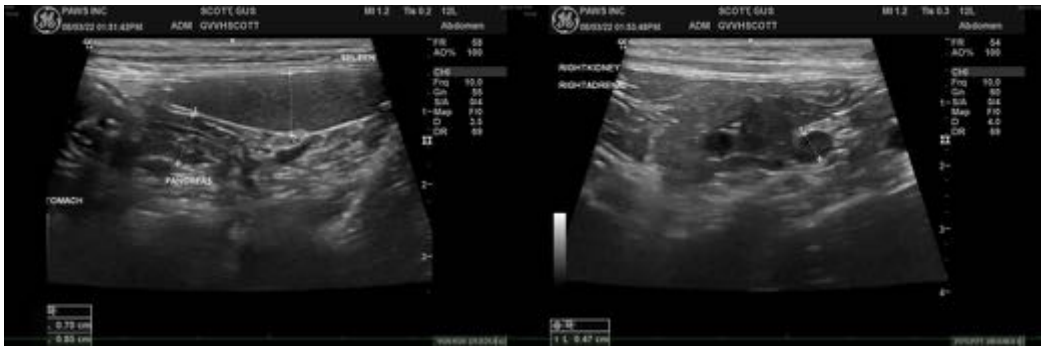
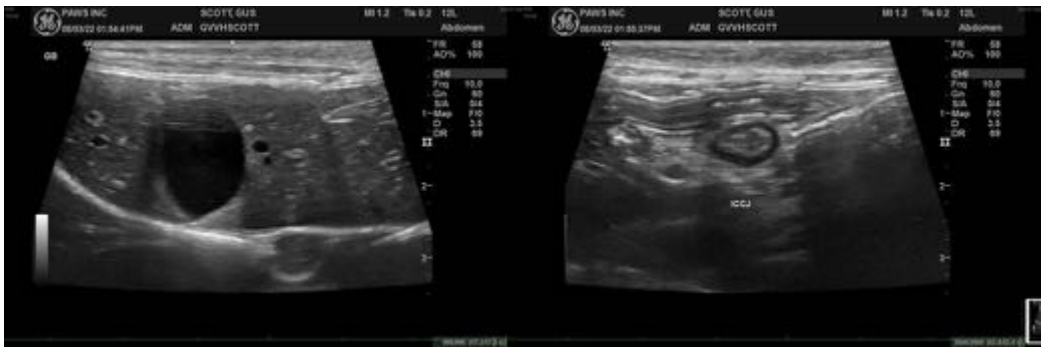
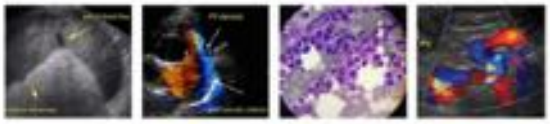
3. Thorough orthopedic and neurologic examination are also recommended to assess for nonmetabolic cause for the patient's clinical signs.







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



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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)
info@SonoPath.com