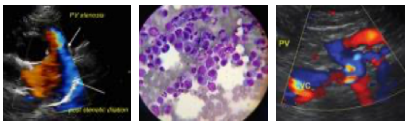
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

8/7/23

PATIENT

Milo Scrandis

SPECIES

Feline

BREED

Domestic longhair

SEX

Male, neutered

AGE

5/29/2013

WEIGHT

8.69 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Everhart VH

REFERRING VET

Dr. Kerr

INVOICE

15178

PRESENTING CLINICAL SIGNS

Milo presents for intermittent vomiting for ~3 months, but has otherwise been eating, drinking, and using the bathroom normally. PE largely within normal limits, but a new heart murmur was diagnosed during visit in early July. Murmur 3/6. Comments: Systolic murmur, PMI L apex.

Current Medications: Cerenia 16mg tablet 7/14/23.
Lab Results: Blood pressure 130 mmHg. BUN 39, WBC 26.4 (3.5 - 16.4), Neutrophils 22176, Lymphocytes 1056, Monocytes 792, Eosinophils 2376.
Glucose 357, precision PSL 31, eosinophilia, USG 1.065, 3+ proteinuria, inactive sediment, T4 normal
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

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 the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (3.95 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic relative to the spleen. The cortex is mildly thickened and there is mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (4.05 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic relative to the spleen. The cortex is mildly thickened and there is mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

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

The right adrenal gland is normal in size (0.30 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is overall normal in size (0.86 cm in width at the level of the hilus). At the medial aspect, a 1.69 x 0.52 cm isoechoic swelling is observed. The remaining peripheral margins are curvilinear. The parenchyma is homogeneous. Splenic vasculature is normal with no evidence of thrombosis.

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. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen contains a 2.21 cm irregular shadowing structure and a small amount of ingesta. 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 0.30 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal.

Pancreas

The left limb of the pancreas is normal in size 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 obvious evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.39 x 0.77.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma. The shadowing structure within the gastric lumen likely represents foreign material. It does not appear to be causing a gastric outflow tract obstruction at the time of the study.

Secondary Findings:

- The bilateral renal changes are most consistent with chronic interstitial nephrosis/nephritis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Minor age-related pancreatic remodeling.
- The splenic swelling could be consistent with a normal variation, a benign focus (i.e., lymphoid hyperplasia or similar), or an emerging tumor.

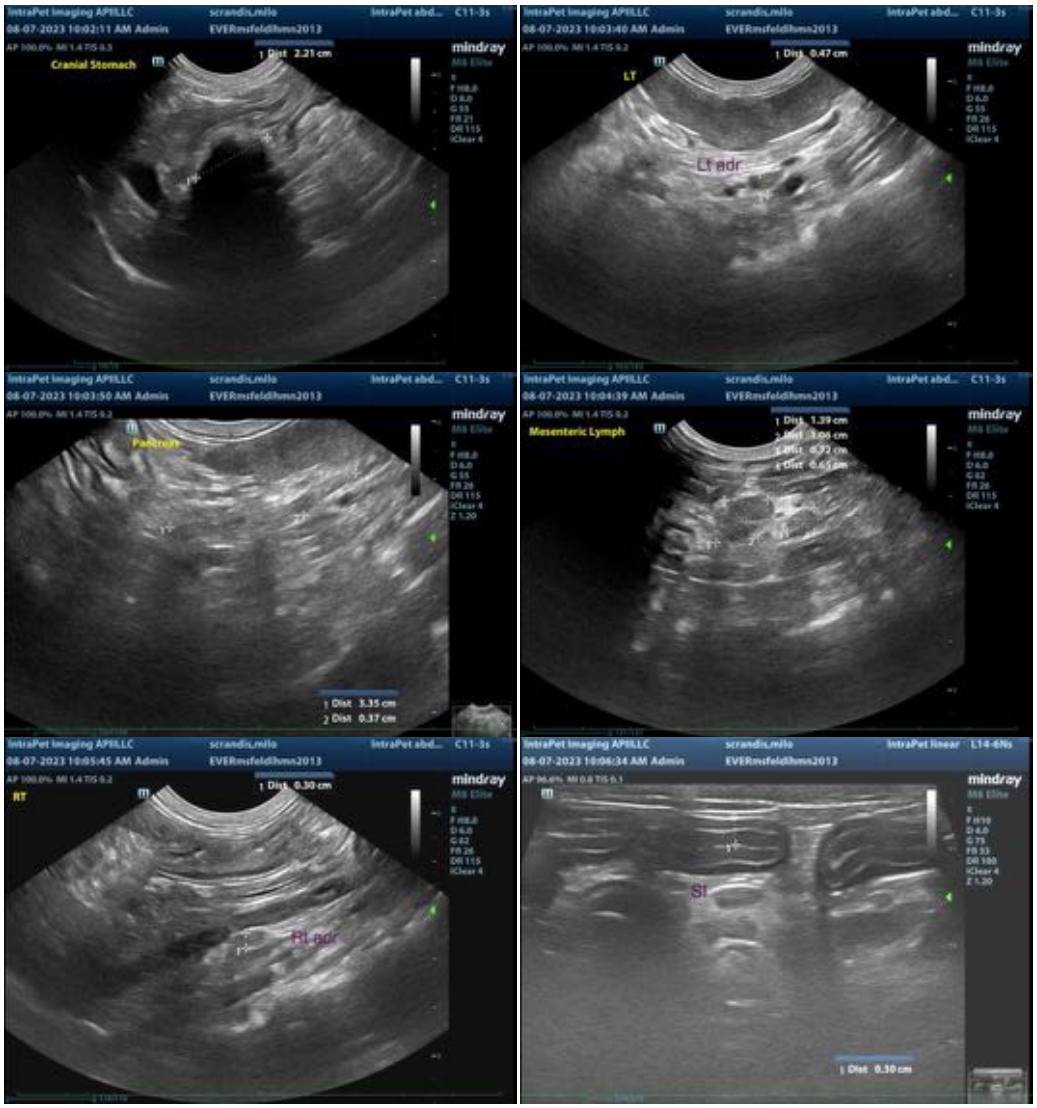
*It is unclear whether the patient's clinical signs are secondary to bowel disease, gastric foreign material, pancreatic disease or some combination thereof.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the eosinophilia and the patient's clinical signs, a fecal evaluation for ova and Giardia is recommended.
- Also consider prophylactic deworming with Fenbendazole.
- A Texas GI panel including serum cobalamin, folate, TLI and PLI should also be considered.
- A 6-week limited antigen diet trial to assess for food allergies.
- Consider initiation of a probiotic with a high colony count.

- Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis. An upper GI endoscopy may be preferred in that the stomach can be evaluated for foreign material. If found, it can be potentially be retrieved during the procedure while also obtaining GI biopsies.

- Regarding the splenic swelling, fine needle aspiration should be considered (if clotting status is appropriate). A 25 gauge needle should be used.



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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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