



PATIENT

Theo Gilbert

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male Neutered

AGE

11 Years

WEIGHT

4.2 kgs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Callihan

HOSPITAL NAME

Animal Emergency
Care

REFERRING VET

Dr. Noe/Chuckanut

INVOICE

11806kk

DATE
9/13/21

PRESENTING CLINICAL SIGNS

History: On 9/10/2021 Seen by primary care vet for diarrhea, salivating, inappetence, owner found philodendron leaf in stool. He had had diarrhea prior to this but got worse that day. Owner had been confining him to the bathroom due to the diarrhea, and that's where the plant was kept. He was febrile, with temp 103.9 and his physical exam revealed gassy thickened intestines. He was given SC fluids, a Vit B12 injection, and prescribed sucralfate due to the chemically irritating nature of philodendron, as well as metronidazole and Cerenia. Bloodwork was declined. Ultrasound was discussed. Owner last saw Theo eat on Thursday 9/9, has also not passed stool since; vomited yesterday. Presents on ER today due to no improvement in clinical signs.

Abnormal PE/Chem/CBC/UA Results: PE: Temp 102.8, HR 220/min, resp 42/min Wt 4.2kg QAR, really apprehensive, dehydrated 7-8%, mms pink sl icteric, CRT <2 sec EENT-Clean AU, clear OU, no nasal discharge, some tartar/gingivitis PLN- wnl HL-rate and rhythm normal, no murmur fair synchronous pulses, lungs clear Abd- tense, no masses palpated, gas and fluid-filled intestinal loops UG-wnl external appearance MSI-ambulatory x 4, good hair coat, BCS 5/9 Neuro-CN wnl, CPs wnl, no ataxia Rectal - not performed Admitted for IV fluids and supportive care overnight, bloodwork, abdominal ultrasound. I will call owner with bloodwork results and my preliminary impressions from the ultrasound, likely after midnight. If Theo perks up and begins to eat, consider sending home in the morning but did discuss transfer to Boundary Bay if not. CBC: Normal WBC count, bands suspected on automated and confirmed some present on manual; slight monocytosis Chem 17/lytes: -hyperglycemia 261 mg/dL -elev T Bili 3.1 -sl decrease Cl fPL: Abnormal Urine is concentrated at >1.050, negative for glucose, pos Ket, Bil; no bacteria Abdominal ultrasound performed, and images submitted to Sonopath, should have report no later than mid-morning.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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 2 cm, are normal.

The left kidney is normal size (4.56 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.

The right kidney is normal size (4.70 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.

Adrenal Glands

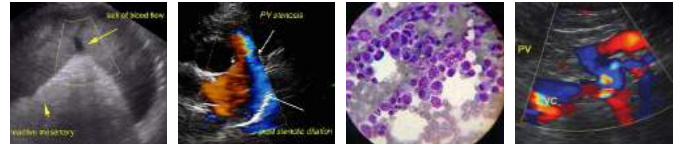
The region of the adrenal glands is evaluated. No obvious pathology is observed.

Spleen

The spleen is normal in size (0.69 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and diffusely homogeneous in appearance. No focal lesions are



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observed. There is a subtle increase in portal markings. Hepatic vasculature is of normal volume with no evidence of congestion. The gall bladder is distended. The wall is thickened (up to 0.33 cm), irregular, and hyperechoic. A moderate amount of gravity-dependent, echogenic debris is observed within the lumen. The cystic and common bile duct walls are slightly thickened. The ducts are dilated (up to 0.42 cm) and tortuous. The common bile duct can be followed to the level of the duodenal papilla. There is no obvious evidence of an intraluminal obstruction. Surrounding mesentery is hyperechoic.

Gastrointestinal

The gastric lumen is mildly distended with 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 segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. There is slight disruption in the normal 1:3 muscularis to mucosal ratio in most segments. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely visible with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated. Surrounding mesentery is mildly hyperechoic.

Free Abdomen

There is no evidence of free fluid. A few prominent lymph nodes are observed in the cranial and mid-abdominal cavity. The largest measures 0.57 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gall bladder/cystic/common bile duct changes are most consistent with cholecystitis/choolangitis.
- The hepatic changes are most consistent with inflammatory/immune-mediated disease. However, concurrent hepatic lipidosis cannot be completely excluded. Infiltrative neoplasia is possible but considered less likely.
- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The pancreatic changes are consistent with mild acute or chronic active pancreatitis.
- Cranial peritonitis, likely secondary to hepatobiliary/pancreatic/bowel pathology.

Secondary Findings:

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Minor age-related renal changes.

**Given the sonographic changes, "Triaditis" is a consideration in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Consider a fine needle aspirate of the liver (if clotting status is appropriate). A 25-gauge needle



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should be used. If cytologic evaluation is inconclusive and the patient does not respond to supportive care, a surgical liver biopsy with aerobic and anaerobic bile cultures along with gastrointestinal biopsies can be considered.

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2. Three-view thoracic radiographs should be performed prior to any anesthetic event.
3. While awaiting test results, consider empirical treatment for cholecystitis/cholangitis/pancreatitis.

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4. Other diagnostic considerations include:
 - a. Malabsorption panel including serum cobalamin, folate, PLI and TLI.
 - b. Fecal evaluation for ova/Giardia

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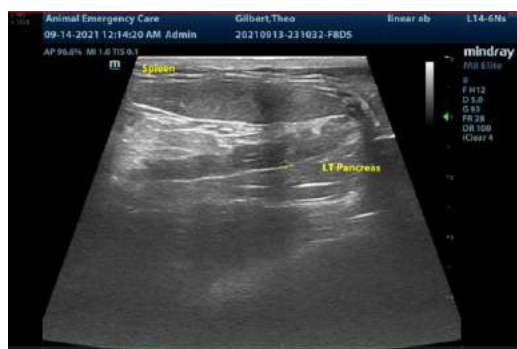
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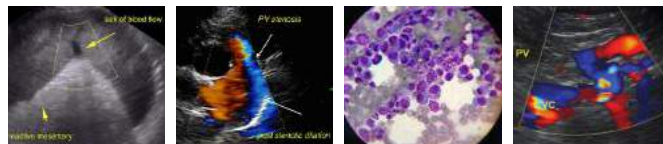
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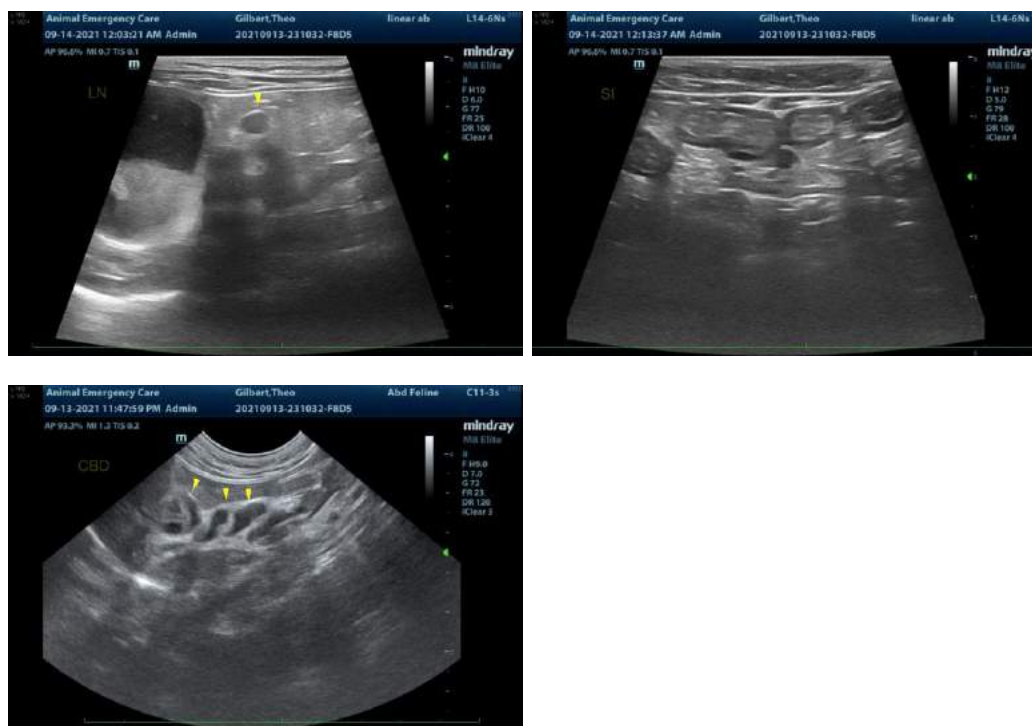
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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