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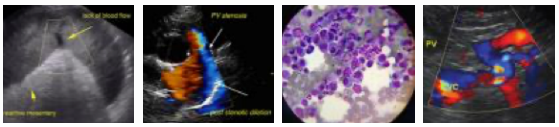


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT
Linus Hensley

SPECIES
Feline

BREED
Domestic shorthair

SEX
Male, neutered

AGE
14 Yrs.

WEIGHT
12 lbs.

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

IMAGING PERFORMED BY
Sara Hansen

HOSPITAL NAME
Q Street AH

REFERRING VET
Dr. Cone

DATE
1/24/23

INVOICE
14509

PRESENTING CLINICAL SIGNS

History: - Presented for sudden onset vomiting for 24 hours. Unable to keep food or water down but interested in eating and drinking. No urine or feces in litter box since yesterday; spending more time sitting in litter box. Indoor only. Started Methimazole for hyperthyroidism 3 weeks ago. - Physical exam: weight loss (0.6 lb since hyperthyroidism diagnosis), quiet demeanor, dehydration, small soft urinary bladder.
Abnormal PE/Chem/CBC/UA Results: Labwork 3 weeks ago was normal except for elevated TT4 (5.4, n=0.8-4.0). Repeat labwork is pending. Current Medications Cerenia, Methimazole Radiographic Findings Soft tissue opacity cranial to kidneys. Possible stone in urethra.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is mildly to moderately distended. A small 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 in size (4.09 cm in length) with a slightly irregular shape. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A cortical infarct is observed at the cranial pole. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.30 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.44 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

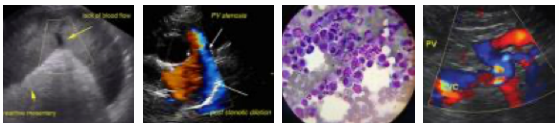
The right adrenal gland is normal in size (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent in size (1.05 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is of appropriate echogenicity and echotexture. Several small, ill-defined hyperechoic nodules/areas are observed throughout the organ. 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 portal vein: caudal vena cava



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ratio is approximately 1:1. 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.

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 0.33 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in some segments. In addition, the submucosal layer is mildly thickened in some regions. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The tip of the left limb is visible with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.12 cm in diameter). Surrounding mesentery is slightly hyperechoic.

Free Abdomen

Trace free fluid is observed. A few prominent mesenteric lymph nodes are visualized, the largest measuring 0.80 cm in length. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Bowel pattern suggestive of inflammatory bowel disease with some potential for emerging lymphoma
- The pancreatic changes at the tip of the left limb are suggestive of mild pancreatitis (rule out acute vs chronic, active).
- Trace ascites.

Secondary Findings:

- The mesenteric lymphadenopathy could be consistent with reactive change or less likely, emerging neoplasia.
- Bilateral, chronic age-related renal changes with dystrophic mineralization and a left cortical infarct.
- The mild splenomegaly with the hyperechoic parenchymal changes could be consistent with a benign process (i.e., lymphoid hyperplasia or similar). Alternatively, emerging neoplasia (i.e., round cell tumor) is possible.

*It is unclear whether the patient's vomiting is secondary to pancreatitis, inflammatory bowel disease, drug reaction (Methimazole), or other underlying issue.

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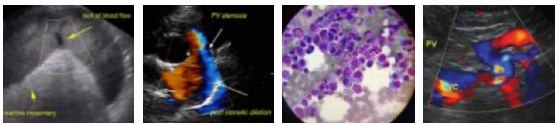

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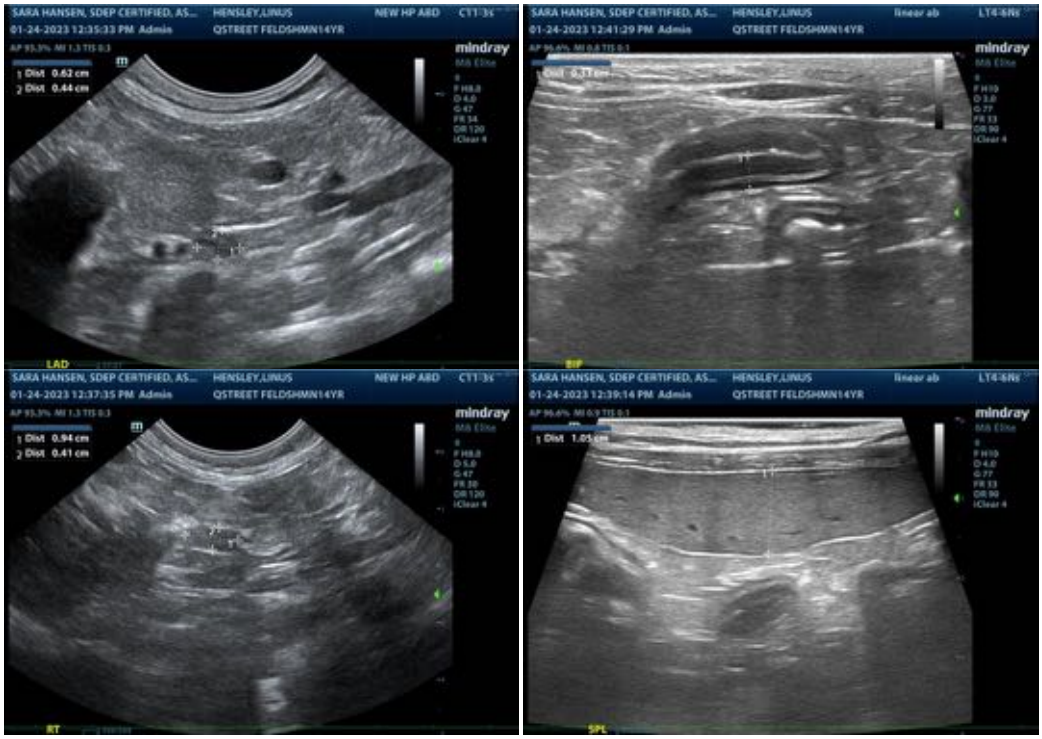
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider temporary discontinuation of the Methimazole to determine if a drug reaction is causing the vomiting.
- A fecal evaluation for ova/Giardia.
- GI panel including serum cobalamin, folate, TLI and PLI to further assess for maldigestion/malabsorption and underlying pancreatic disease.
- Consider three-view thoracic radiographs to assess for occult esophageal disease.
- Depending on the results of the above diagnostics, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis.
- While awaiting test results, symptomatic care is recommended.
- Once the patient is eating again, consider supplementation with a probiotic.



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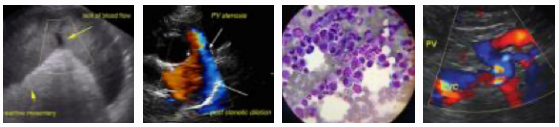

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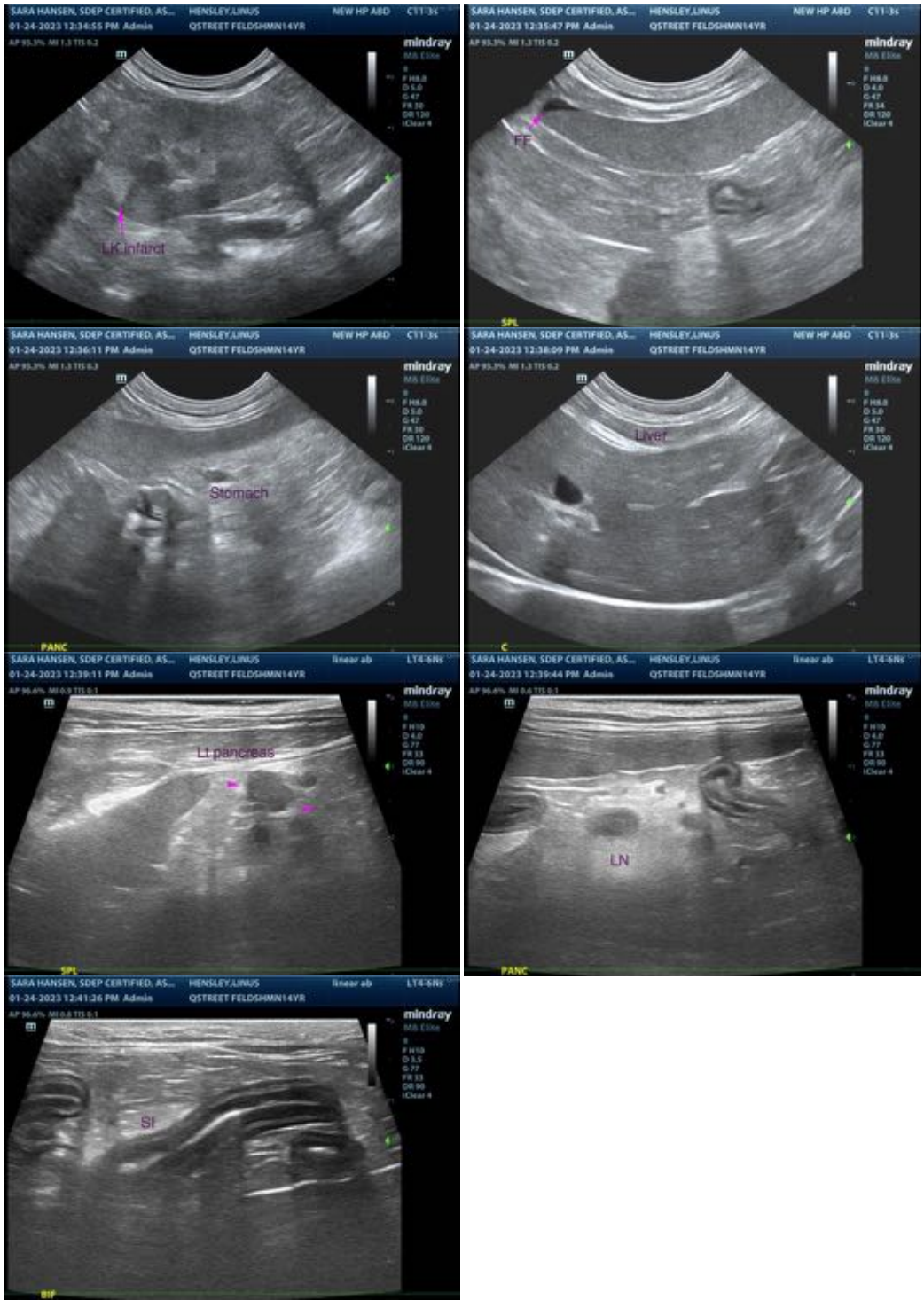
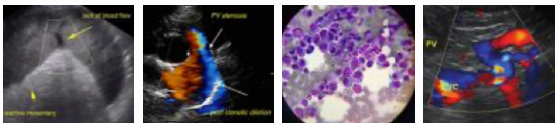


The information and recommendations provided are based on the images presented by the referring



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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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com