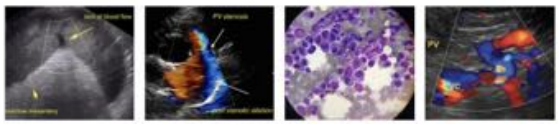


PATIENT

Oliver Ohman

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

13 yrs

WEIGHT

8.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Cats Only AH

REFERRING VET

Dr. Ben Fuller

INVOICE

12747

DATE

12/21/21

PRESENTING CLINICAL SIGNS

History: P was seen on 12/13/21 for sudden weight loss
Abnormal PE/Chem/CBC/UA Results: Lab results (see attached): CBC- no significant abnormalities; Chem- SDMA 42 (ref 0-14), CREA 3.0 (ref 0.9-2.3), BUN 40 (ref 16-37), TP 5.8 (ref 6.3-8.8), ALB 2.5 (ref 2.6-3.9), remainder within normal limits; TT4- within normal limits A: CKD, R/O protein-losing nephropathy TTO- discussed CKD and management; discussed submitting U P/C

ULTRASONOGRAPHIC EXAMINATION OF THE

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended. A small amount of echogenic debris is suspended 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 (3.57 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Trace pyelectasia is present (0.15 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.42 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Trace pyelectasia is present (0.16 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

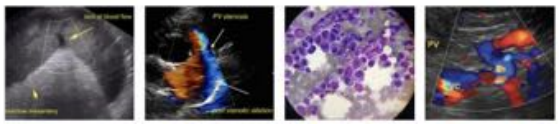
The right adrenal gland is normal in size (0.51 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.58 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 enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen. The gall bladder lumen is mildly distended. The wall is



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normal in thickness. A scant amount of echogenic debris is observed within the lumen. The cystic duct is dilated (0.41 cm in diameter). Luminal contents are anechoic. The common bile duct appears to be normal in diameter without evidence of intraluminal obstruction.

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 lumen of the proximal duodenum is mildly distended with chyme. An approximately 5 cm segment of small intestine is severely thickened (up to 0.97 cm) with a complete loss of the normal layering pattern. The remaining small intestinal segments are normal to moderately thickened with a prominent muscularis layer in most segments and thickening of the submucosal layer in at least one segment. In at least one additional small intestinal segment, there is loss of the normal layering pattern. A 2.7 cm irregular hypoechoic mass effect is observed in the region of the ileocecocolic junction. The remaining colonic wall is normal. No obstructive disease is noted.

Pancreas

The pancreas is diffusely enlarged with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is hyperechoic.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A few prominent lymph nodes are observed at the mesenteric root and in the cranial abdomen, the largest measuring 1.69 cm in length.

Other

The mesentery throughout the abdomen is hyperechoic. Trace free fluid is observed.

ULTRASONOGRAPHIC FINDINGS

- Bowel masses. Neoplasia (i.e., lymphoma) is considered likely with a low possibility of a severe inflammatory process (i.e., pyogranulomatous). The diffuse small intestinal wall changes are also concerning for emerging neoplasia (i.e., lymphoma).
- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. The dilation of the cystic duct is likely secondary to a functional obstruction (i.e., secondary to diffuse hepatopathy).
- The pancreatic changes are consistent with pancreatitis.
- The diffuse peritonitis is likely secondary to bowel pathology.

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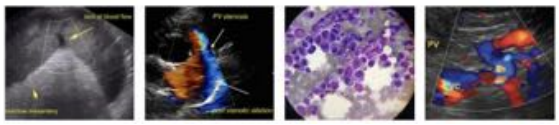

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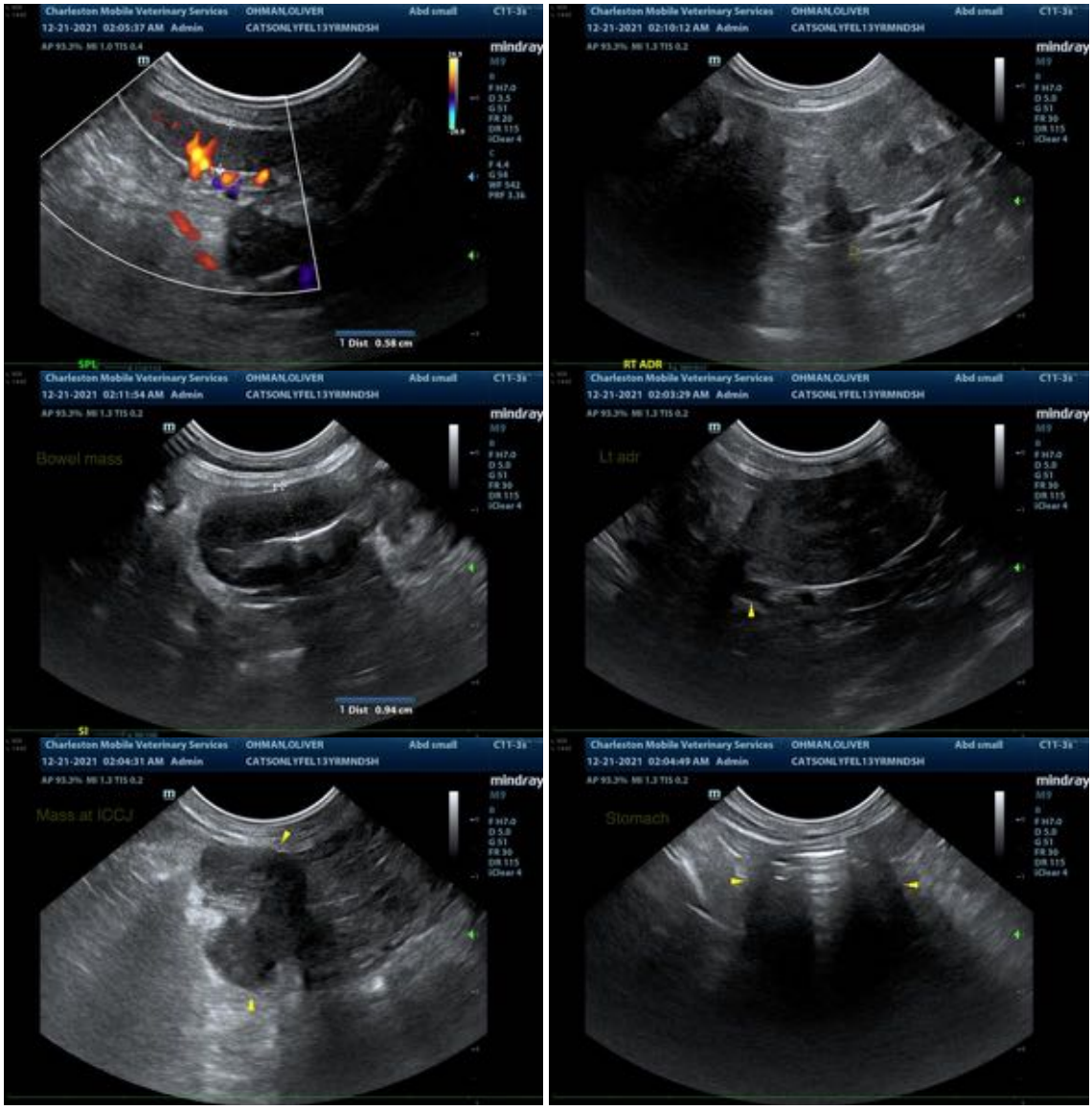
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess cardiopulmonary status.
- Fine needle aspirates of the bowel masses are recommended (if clotting status is appropriate). 25-gauge needles should be used.
- A GI panel (sent to Texas A&M) is also recommended.
- If aggressive diagnostics are not to be pursued, consider empirical treatment for inflammatory bowel disease with corticosteroids, as long as the client understands the risks of treatment without a definitive diagnosis.



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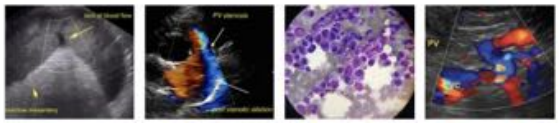

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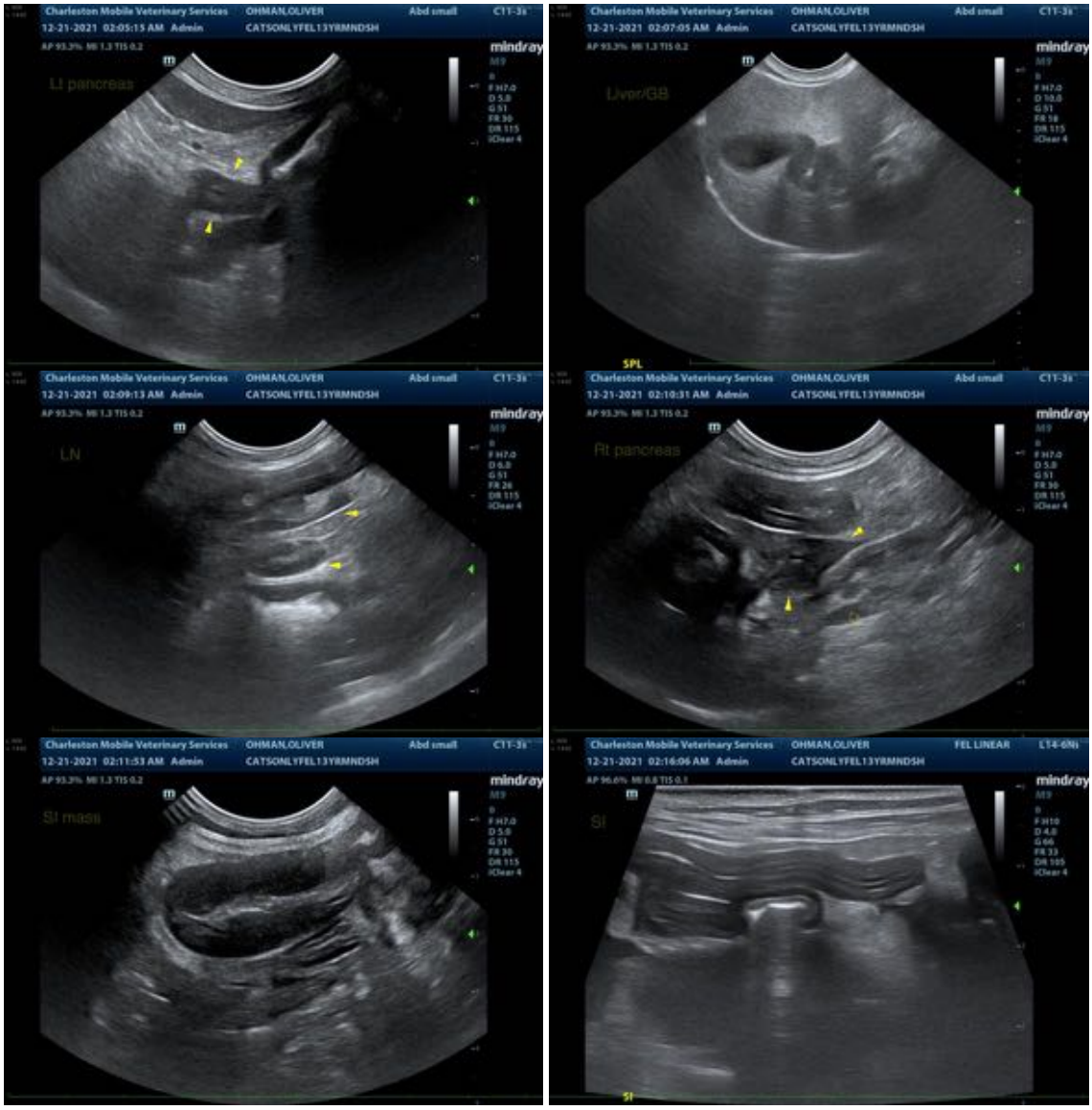

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

Andrea.Nicastro@CharlestonMobile.net