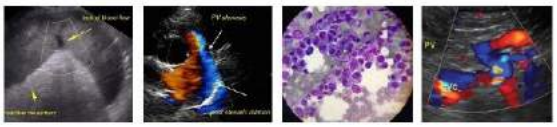


PATIENT
Snuggles Gesualdo

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Female Spayed

AGE
12 Years

WEIGHT
5.49 kgs.

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

IMAGING PERFORMED BY
Kelly Reshny, RVT

HOSPITAL NAME
Hamilton Region Emergency Veterinary Clinic

REFERRING VET
Dr. Gallienne

INVOICE
11680kk

DATE
8/20/21

PRESENTING CLINICAL SIGNS

History: Bloodwork: - moderate non-regenerative normocytic normochromic anemia (Hct 25%) - hyperglycemia (BG 23.93 mmol/L) - elevation in SDMA (18;RI 0-14) - electrolyte derangements (hyponatremia at 136 , severe hypokalemia at 2.2 mmol/L, hypochloremia at 13 mmol/L) - mild elevation in ALP (178; RI 14-111) - hyperbilirubinemia (40; RI 0-15) - hypercholesterolemia - metabolic acidosis (pH 7.02) 2. Urinalysis by ultrasound-guided cystocentesis: USG 1.024, pH 6.0, proteinuria, glucosuria, mild ketonuria (15 mg/dL), marked bacteriuria seen Urine culture pending 3. AFAST: liver appears subjectively enlarged, no peritoneal effusion at the DH, SR, HR or CC sites. Urinary bladder small, no abnormalities noted. No pericardial effusion or pleural effusion seen at DH site\ currently on: B12 250 mcg SQ, Cerenia 1 mg/kg, Pantoprazole 1 mg/kg, Buprenorphine 0.02 mg/kg IV, Ampicillin 22 mg/kg I, Insulin CRI (0.1 IU/kg/hour)

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 lumen is moderately distended with anechoic urine. 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 (4.30 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.33 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

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

Spleen

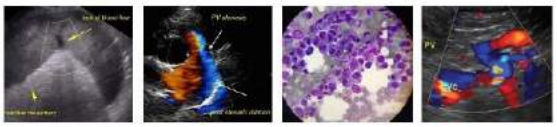
The spleen is subjectively prominent in size with slightly swollen peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

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 is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithsare observed. The cystic and common bile ducts are normal/not seen.

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



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thickness is normal with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. The lumen of the descending colon contains shadowing fecal material. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible/prominent with slightly irregular 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 hyperechoic.

Free Abdomen

The mesentery in the cranial abdomen is hyperechoic. A small amount of free fluid is visualized. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes are suggestive of mild acute pancreatitis with regional peritonitis.
- The hepatic parenchymal changes are most likely secondary to diabetes mellitus. However, other concurrent disease processes (i.e., inflammatory/immune-mediated disease, hepatic lipidosis, and infiltrative neoplasia (i.e., lymphoma)) cannot be excluded.
- The bilateral renal changes are consistent with diabetic nephropathy.
- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.

Secondary Findings:

- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Three-view thoracic radiographs are recommended to assess cardiopulmonary status if not already performed.
2. Aggressive supportive care for diabetic ketoacidosis/acute pancreatitis/urinary tract infection is recommended. Supplementation of the IV fluids with potassium is important, particularly after starting insulin therapy, which will drive insulin intracellularly. If the hypokalemia is refractory to potassium supplementation, magnesium supplementation may be warranted. Also consider supplementation with potassium phosphate to avoid hypophosphatemia and subsequent worsening anemia due to hemolysis. Nutritional support (i.e., via temporary feeding tube) is also strongly encouraged to help prevent/treat hepatic lipidosis.

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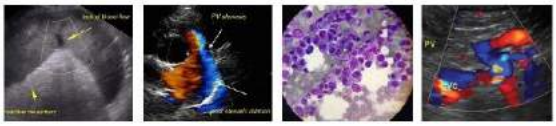

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

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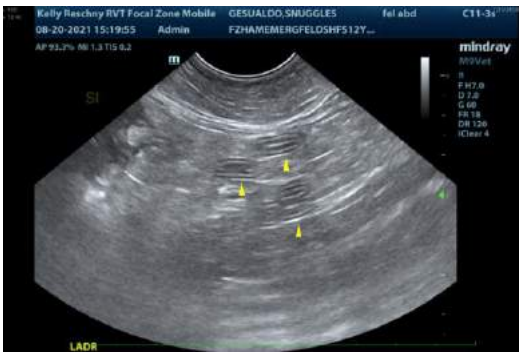

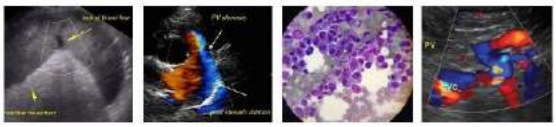

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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@sonopath.com