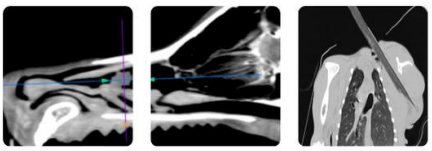

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PATIENT

Tupi Bochkov

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

17Y

WEIGHT

4.04kg

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Amanda Stuart

HOSPITAL NAME

Beatties Burlington

REFERRING VET

Al-Sultan

INVOICE

73375

DATE

1-20-26

PRESENTING CLINICAL SIGNS

History:

- P hx IBS, CKD, and pancreatitis (Dec 27th), Have diarrhea on and off for 2 month before initial appt
- Bloody diarrhea/ lethargic, and anorexia
- Medical management unsuccessful since Dec 27th, hospitalization for 3 days at beginning of Jan,
- Current Medications
- Buprenorphine, restorlax, mirtazapine, cerenia, Sc fluids, metronidazole

Abnormal PE/Chem/CBC/UA Results: BW: WNL but: SDMA 19 µg/dL 0 - 14 HIGH CREA 321 µmol/L 71 - 212 HIGH UREA 22.5 mmol/L 5.7 - 12.9 HIGH CHOL 5.99 mmol/L 1.68 - 5.81 HIGH Pancreatic Lipase 7.6 U/L 0.0 - 4.4 HIGH Radiographic Findings not done Primary Question to Be Answered in This Exam DDX: Inflammatory (Gastroenteritis, IBD, Pancreatitis) Organopathy (Liver/ Kidney) Neoplasia Metabolic disorder vs endocrine disease Motility (Ileus, GI hyper motility)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. (Left kidney 3.41cm, right kidney 3.85cm). A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. Mild to moderate pyelectasia is noted bilaterally. There is no evidence of mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.33 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.38 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

Primary:

- Chronic low grade smoldering pancreatitis is suspected.

Secondary:

- Age related kidney changes with mild to moderate pyelectasia noted bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

While chronic low grade smoldering pancreatitis is suspected, and could potentially be contributing to chronic gastrointestinal signs, further GI workup is warranted given the reported hematochezia.

Given the patient's reported azotemia, if not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

A routine fecal /giardia exam is recommended if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI

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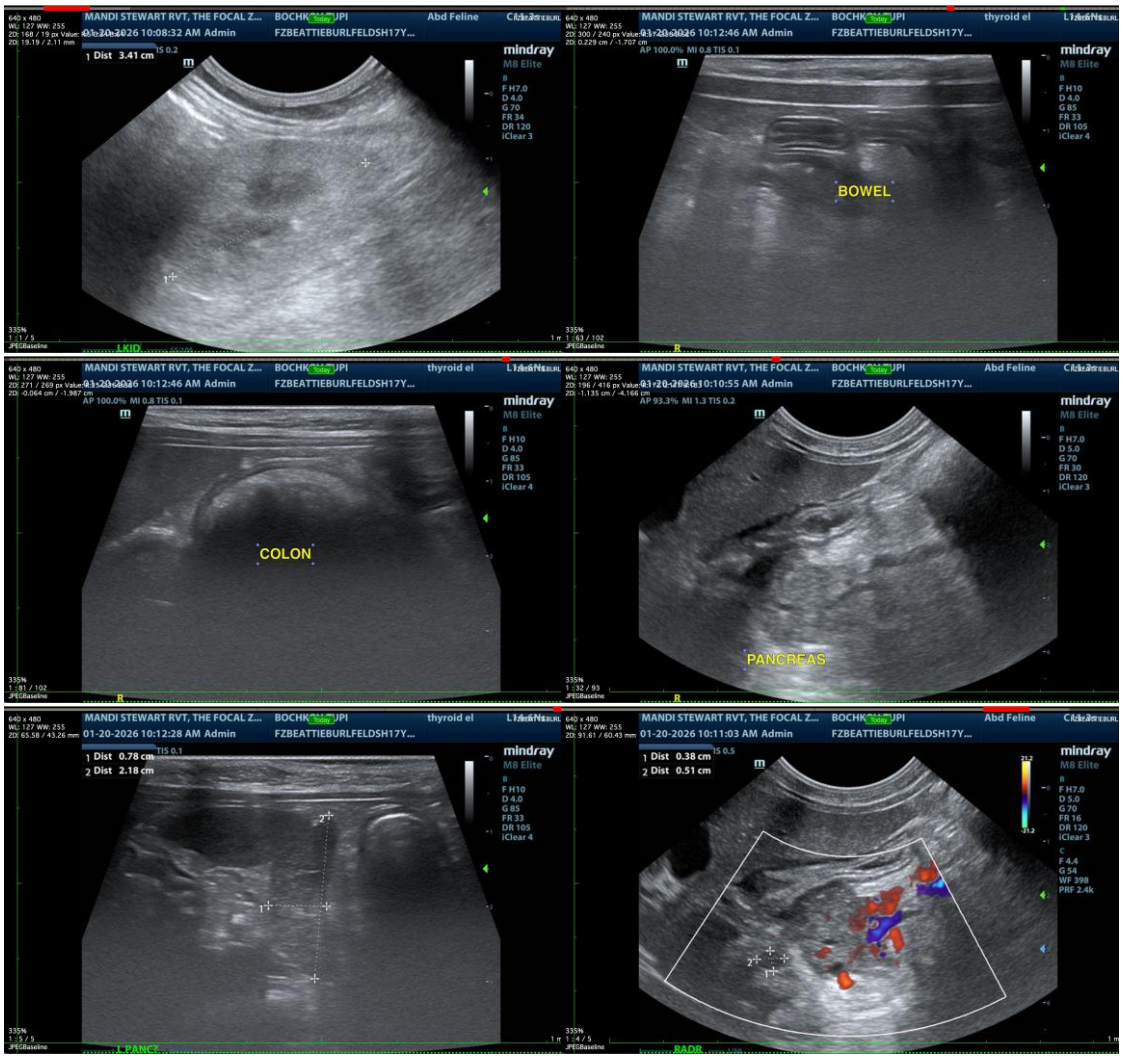
Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required. Additionally, fecal microbe transplant therapy could be considered.



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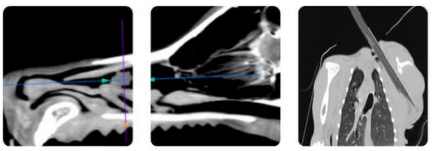

Teleradiology
Educational Teleconsultation Services™

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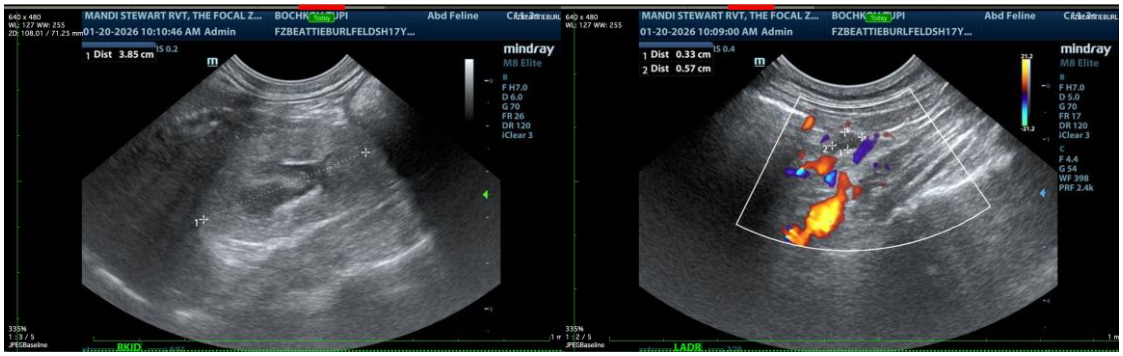

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

info@sonopath.com