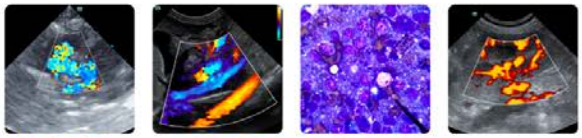

PATIENT

Gingy Shapiro

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

4.72 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Heatherlynn McFarlane, DVM (Internal Med)

INVOICE

72638

DATE

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PRESENTING CLINICAL SIGNS

AUS to further evaluate chronic constipation, vocalizing progressing despite soft stool (#4 on Purina Fecal Score). Previously diagnosed with chronic constipation and crystalluria ~5 years ago. Had been doing well with Cisapride 2.5mg PO q12hr, Lactulose 2mL q12hr, Miralax 1/8th tsp q12hr, and RC Fiber response dry with Purina EN wet though she would vocalize during the night (unknown if it was while she was posturing or in the litterbox). Over the past several months, the vocalizing is becoming more frequent and occurring during the day occassionally. Exam: very reactive/anticipatory with perianal/tail manipulation but unable to obtain a repeatable reaction or isolation change in reaction/behavior. Surgeon evaluated spinal/HL/tail and agreed most likely anticipatory rather than true pain. Meds: cisapride 2.5mg q12hr, lactulose 2mL q12hr, and miralax 1/8th tsp q12hr, Gabapentin 50-75mg Diet: RC GI Fiber Response dry with Purina EN wet, plan to transition to Hill's GI Biome for wet

Abnormal PE/Chem/CBC/UA Results: 10/14/25 - CBC: WBC 10.9, Neut 5.8K, Lymph 4.2K, Eos 0.54K, HCT 55% (H), PLT 183K (L, est adequate, clumping seen) - Chem: TP 7.5, Alb 3.9, Glob 3.6, Creat 1.3, BUN 22, ALT 42, ALP 30, GGT 3, TBil 0.1, Chol 311 (H), Na 159 (H), K 4.8, Cl 122, Ca 10.1, Phos 4.9 - T4: 2.4

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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 bilaterally small, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left measured 3.63 cm. Right measured 3.78 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.36 cm at cranial pole and 0.22 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.18 cm at cranial pole and 0.22 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

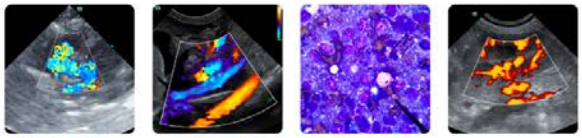
Spleen

The 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

The 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.

The 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.



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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 intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is subjectively mildly distended with firm, hard shadowing stool.

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. *See other.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

Medial and caudal to the spleen there is a small, hypoechoic density measuring 0.50 cm x 0.70 cm in size that upon later imaging with the linear probe I believe represents part of the prominent pancreas. Having said that, given the location, while thought less likely, a left ovarian remnant can't be definitively ruled out.

In the caudal abdomen, dorsal to the urinary bladder, between the trigone and the colon, is an approximately 1.0 cm x 1.2 cm in size anechoic density that could represent a fluid filled uterine stump versus other.

ULTRASONOGRAPHIC FINDINGS

- The fluid density in the caudal abdomen could represent a fluid filled uterine stump, as could be seen with a stump hydrometra or stump pyometra, although definitive uterine involvement can't be diagnosed, and a cystic structure not involving the uterine tissue such as a cyst, hematoma, abscess versus other can't be ruled out.
- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Mild inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling. *This change is mild/subtle and could be in part normal patient variant in a senior cat.
- Mild to moderate chronic kidney disease, most significant visibly in the right kidney.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

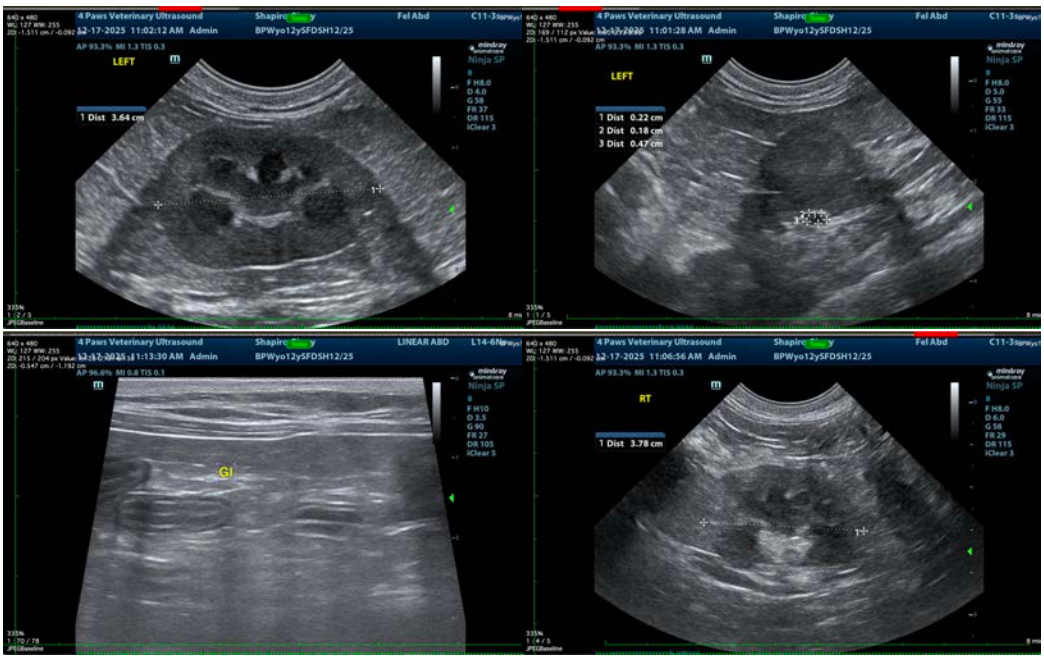
Based on imaging, it is possible that this patient has an ovarian remnant and a resultant stump hydro- or pyometra. However, upon further investigation, what I initially thought could be an ovarian remnant I believe is actually prominent pancreatic tissue, and the reproductive tract differentials may be completely unrelated or red herring, with patient's ultimate clinical signs being secondary to urinary disease, constipation, and/or even chronic low-grade smoldering pancreatitis. Therefore, if not recently evaluated, a 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 ratio is recommended.

Ultrasound is not the most specific test to diagnose constipation. Therefore, if constipation is clinically or radiographically supported, more aggressive constipation management or inteverntion, including potentially antibiotics, de-obstipation, etc. may be warranted. It would be helpful to visualize patient's activity during the vocalizing episodes, potentially with cameras or other methods, given the reported occurrence during the night.

Finally, if a metabolic i.e., urinary, gastric, other diagnosis is not made, further orthopedic and/or neurologic workup could be considered, and/or ultimately behavioral changes could result in nighttime crying, again noting what patient is doing during episodes would be helpful.

In the meantime, given the changes noted above, as the fluid filled structure in the caudal abdomen could be contributing, sampling of it via fine needle aspirate could be considered if patient's coagulation status is appropriate, or advanced imaging such as an abdominal contrast CT scan could be considered.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.



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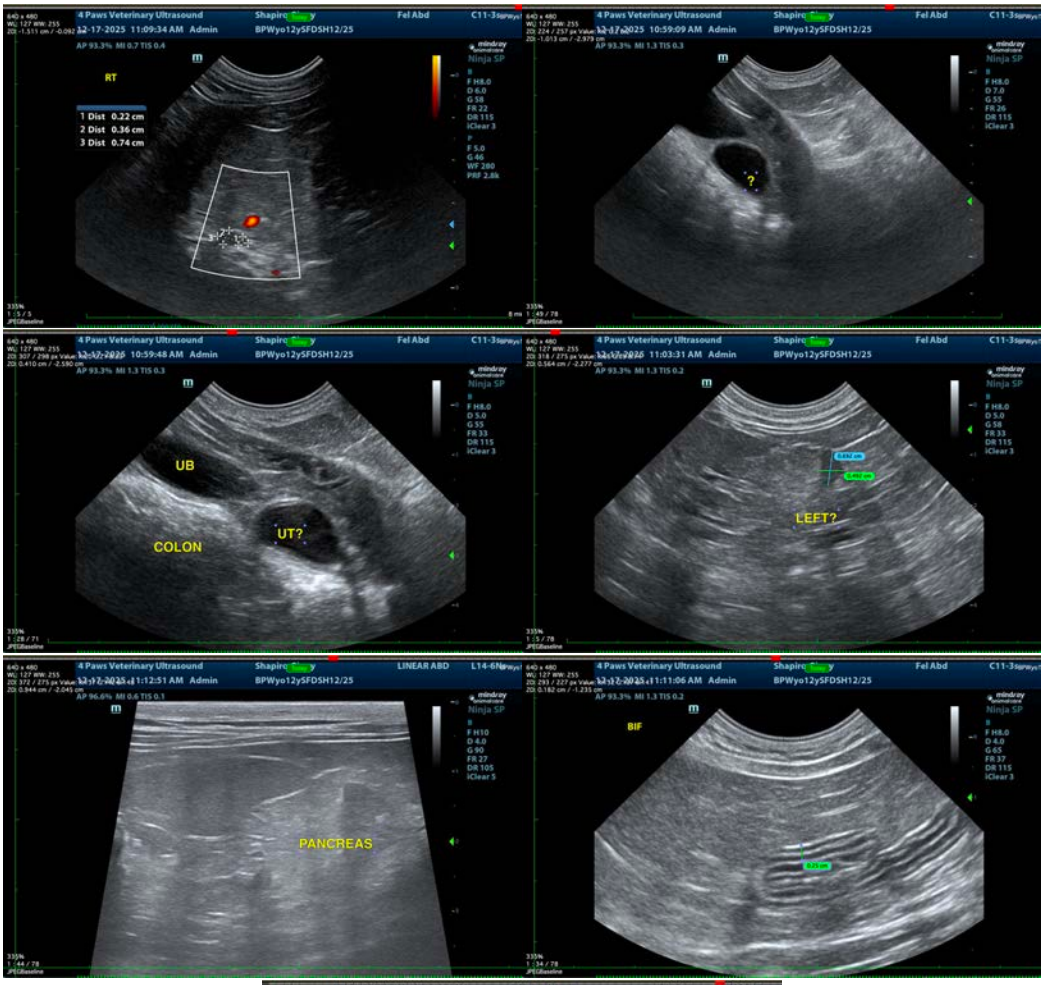

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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