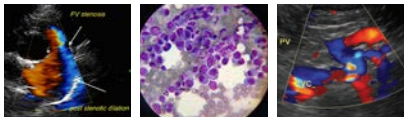
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

2/16/23

PATIENT

Oscar Durastanti

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

2/1/16

WEIGHT

7 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Durastanti

INVOICE

45321

PRESENTING CLINICAL SIGNS

Long term history of frequent vomiting/hairballs which has been well controlled on hydrolyzed protein diet. Over the past 6 months P has become incessantly vocal, constantly howling for food, but then unmotivated to eat when food is presented to him. He is at low BCS (3/9). There are no other concurrent GI signs. Full BW including T4 was performed and had no significant findings.

Current Medications: None; Pet will be given Gabapentin to facilitate ultrasound.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Gabapentin to facilitate scan.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are normal in size with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. There is a normal 1:3 cortex to medulla ratio. The medulla and cortices are uniform in texture with some mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Infiltrative disease (infectious, neoplastic, etc.) or nephritis cannot be ruled out but is considered less likely. The left kidney measures 3.27 cm. The right kidney measures 3.22 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.35 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.34 cm), shape and contour. Corticomedullary structure is unremarkable. 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.

Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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. Pancreatic duct dilation is noted.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Chronic active pancreatitis

SECONDARY FINDINGS

- Urinary bladder debris
- Age related kidney changes with incidental fat deposition

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

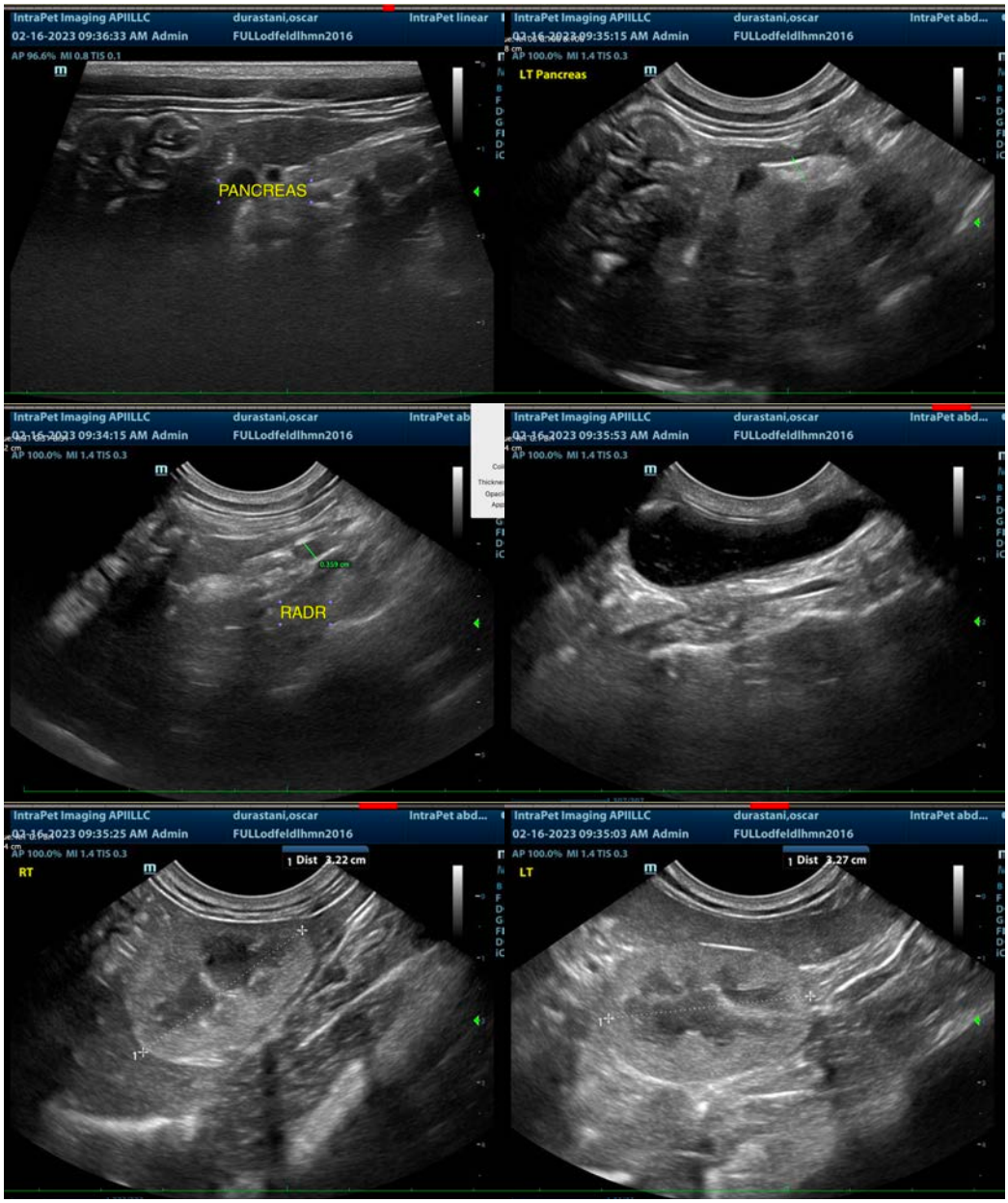
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

This patient may have some early infiltrative bowel disease not visible ultrasonographically, especially given the previous response to hydrolyzed protein diet, etc. Therefore, ultimately, especially if a malabsorption panel is consistent with malabsorption, biopsies of the GI tract may be necessary to definitively diagnose and therefore manage the disease, if present.

However, in the meantime, given this patient's reported desire for food but then reluctance to eat the food once introduced, further evaluation of other sources for decreased food intake including dental pain, TMJ pain, etc. should be considered.

In the meantime, empirical management with antiemetics and gastroprotectants may alleviate subclinical nauseas or gastritis, which may also improve ability to eat.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AP 100.0% MI 1.4 TIS 0.3
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1 Dist 3.27 cm

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
Beth.Johnson@sonopath.com