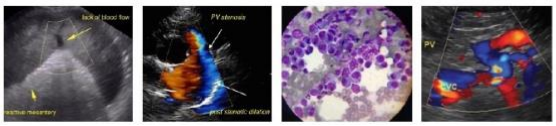


PATIENT

Maggie Van Huizen

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

15 Years

WEIGHT

2.8 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Beatties East Hamilton PH

REFERRING VET

Dr. Nanayakkara

INVOICE

21847

DATE

3/27/23

PRESENTING CLINICAL SIGNS

History: Vomiting and constipation noted. PE mm pale pink, slightly tacky, marked weight loss, some soft stool at anus. Assessment : 20% loss of body weight, straining(unsure if to pass BM or Urine), Dx: renal disease/ poorly regulated thyroid, other endocrine dz. Has been on Mirtazapine and Convenia. Abnormal PE/Chem/CBC/UA Results: BW-low thyroid, likely due to weight loss(dose too high) WBCs and Neuts marked increase, moderate increase in lymph and slight increase in monocytes. ALT marked increase and elevated renal values. U/A unable to collect due to size of bladder. Idexx consult suggested low thyroid based on weight loss likely exacerbating renal values, possibly contributing to ALT

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

Kidneys are bilaterally, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia (in the right kidney) noted and no mineral is observed. Mild pyelectasia is noted in the left kidney, measuring in the transverse view. The left kidney measured 2.8 cm. The right kidney measures 2.15 cm.

Adrenal Glands

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

Right adrenal gland is normal in size (0.36 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

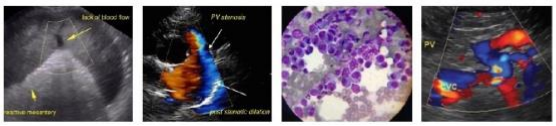
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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



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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 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 and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of peritoneal effusion. The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- Chronic Kidney Disease with mild left kidney pyelectasia – This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc. Differentials for left kidney pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.

- 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 aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

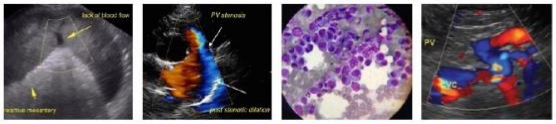
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

When it is possible to obtain a sample, 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.

This patients reported weight loss, especially if in the face of a normal appetite, could be secondary to infiltrative bowel disease, in which case 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.

Ultimately, biopsies of the GI tract may be necessary to definitively diagnose, and therefore, manage the weight loss. However, if decreased appetite is concurrently contributing to weight loss, kidney disease, etc., may be contributing, in which case empirical medical management of gastritis, potentially, even microulceration, nausea, etc., associated with the kidney disease, could be tried first, in the form



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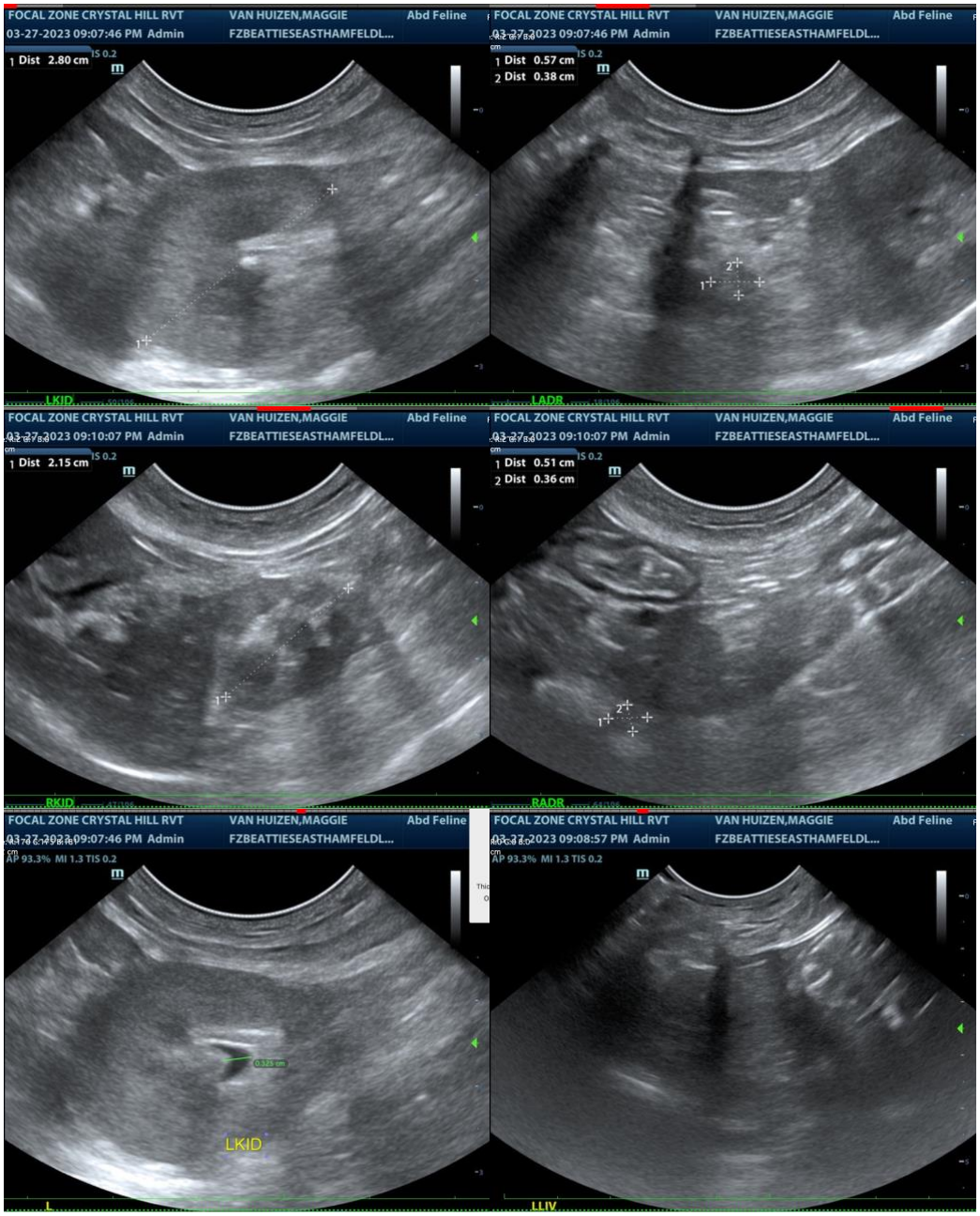
of anti-emetics, gastroprotectants and appetite stimulants. At the same time, decreasing or discontinuing methimazole, to allow the T4 to come back up to a normal limit, may help both appetite, as well as the progression of the chronic kidney disease.

A suspicion is the increased liver enzymes are secondary to decreased appetite and hepatic lipidosis, however, without a history of decreased appetite, infiltrative disease is also possible. Therefore options include either treating, improving appetite and monitoring the ALT, while concurrently administering hepatic nutraceuticals, etc., or sampling the liver beginning with a fine needle aspirate, if patients coagulation status is appropriate.



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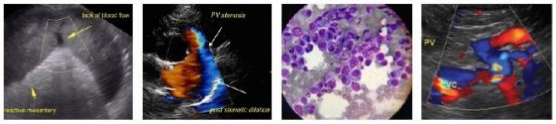

THE FOCAL ZONE
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289-808-2608 info@thefocalzone.com

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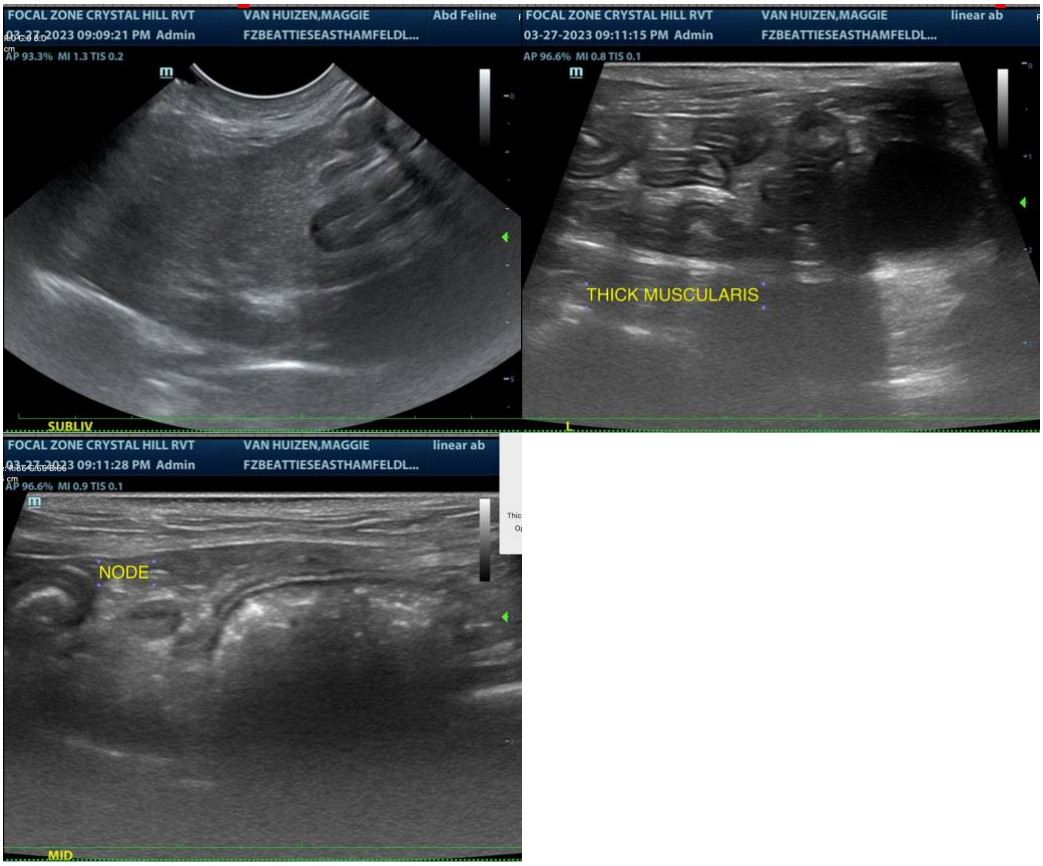

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com