**PATIENT PRESENTING CLINICAL SIGNS**

Winston Cicalese History: Chronic diarrhea Poss IBD

SPECIES

Feline

Abnormal PE/Chem/CBC/UA Results: PE - unremarkable Bloodwork - hypercalcemia, hyperphosphemia, increased SDMA Fecal Dx - negative Malignancy Profile (see attached) - hypercalcemia (ionized), low Parathyroid Hormone, 0 Parathyroid Related Hormone Urinalysis - USG 1.014 Animal Biome testing - pending GI panel - Pending

BREED

DSH

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.

SEX

Neutered Male

Left kidney is normal in size (3.94 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

AGE

12 years

Right kidney is normal in size (4.18 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

WEIGHT

8.62 lbs

Adrenal Glands

Left adrenal gland is normal in size (0.42 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

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Amy Mayhew LVT

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. Multifocal discreet (<0.50 cm in diameter) hyperechoic nodules throughout the liver parenchyma are noted. Visible vasculature and biliary tree appear normal without distension or congestion.

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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.

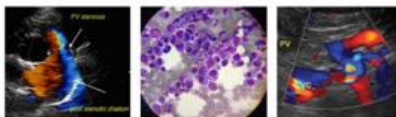
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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative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

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PATIENT The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas. Note soft stool.

Winston Cicalese

Pancreas

SPECIES

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.

Feline

Free Abdomen

BREED

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

DSH

ULTRASONOGRAPHIC FINDINGS

Findings

SEX

Neutered Male

- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.

AGE

12 years

- Liver nodules – Differentials for discrete liver nodules include primarily benign changes such as nodular hyperplasia, fibroses of old hematomas, granulomas, myelolipomas, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.

WEIGHT

8.62 lbs

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no definitive ultrasonographic evidence of neoplasia to further differentiate this patient's reported hypercalcemia as hypercalcemia of malignancy. Having said that, given the splenic changes, a fine-needle aspirate of the spleen is recommended (if the patient's coagulation status is appropriate) to more definitively rule out infiltrative round cell neoplasia. If round cell neoplasia is ruled out, the primary differential for this patient's hypercalcemia (given the malignancy panel results) is idiopathic hypercalcemia, and medical management should be considered.

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Further evaluation of this patient's chronic diarrhea is recommended as is reportedly already pending, with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory 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. In the meantime, empirical deworming with a 5-day course of Pancur is recommended, as is a probiotic such as Provable or Visbiome, and if tolerated, transitioning to a hydrolyzed protein diet. Some patient's respond better to one version or brand of hydrolyzed protein diet versus another, so several trials are often indicated.

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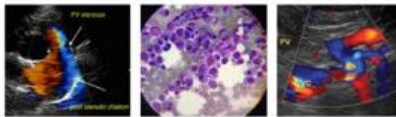
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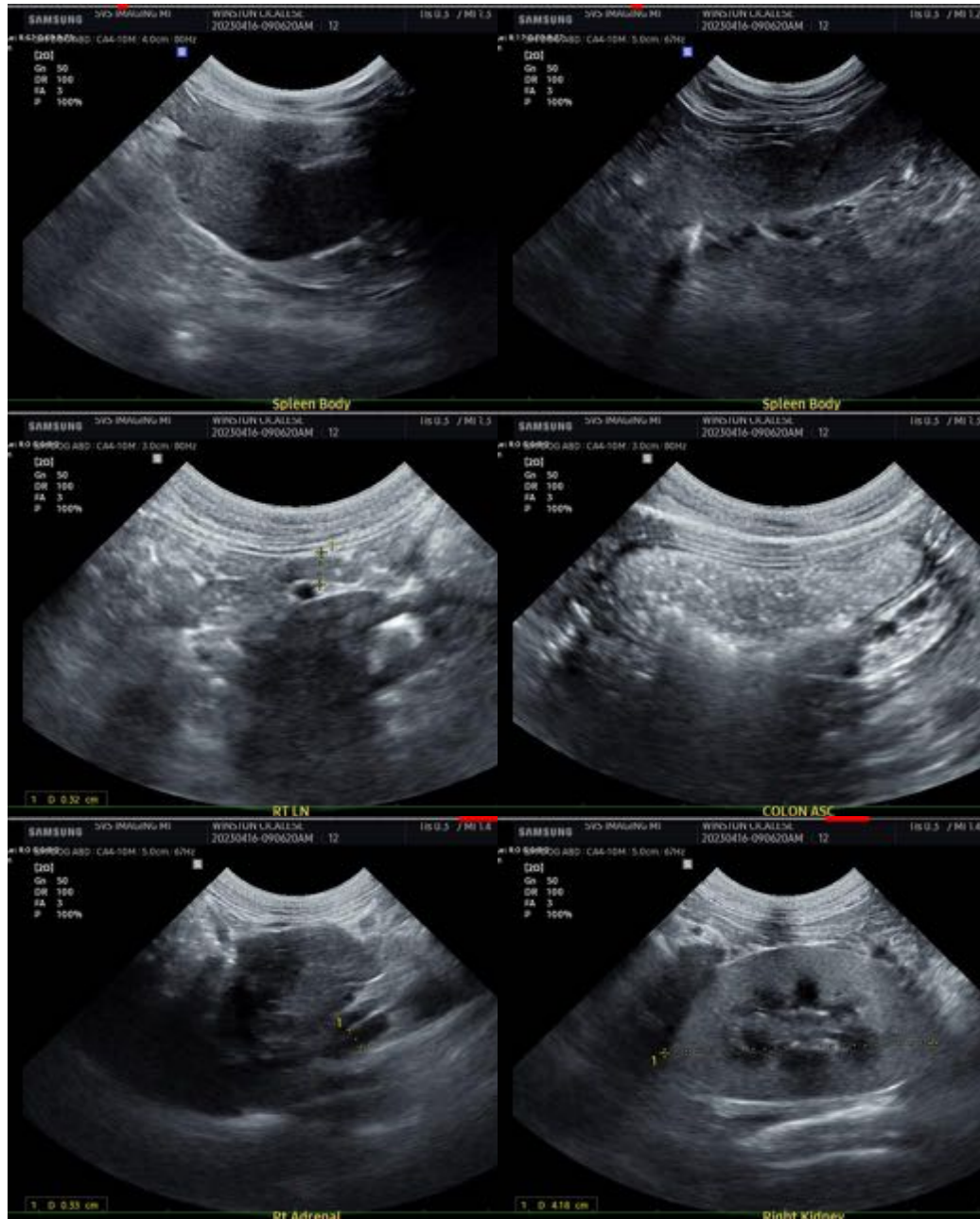
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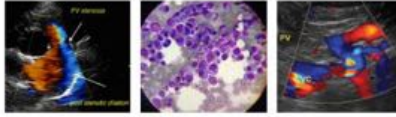
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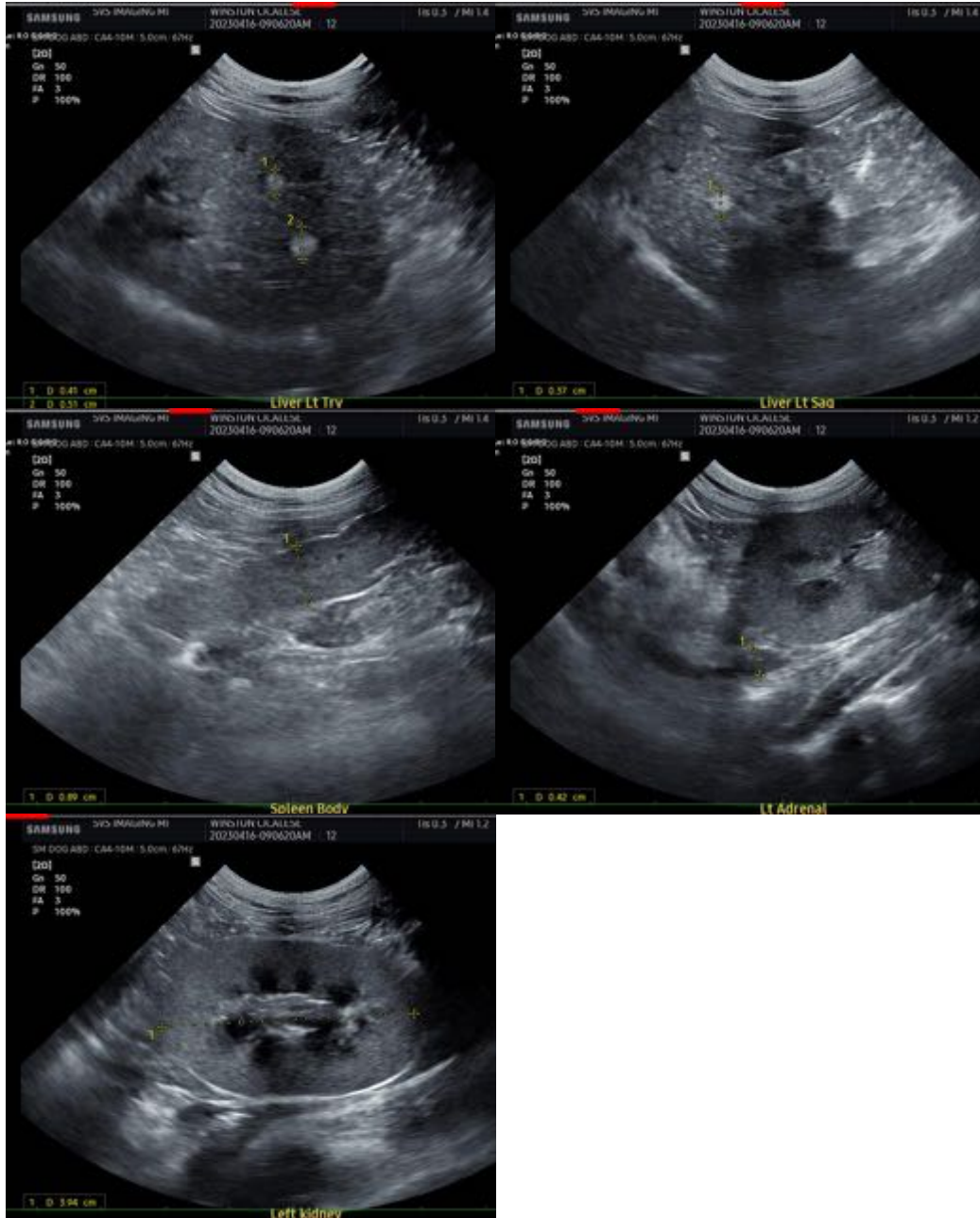
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

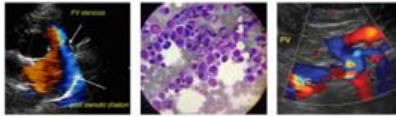
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Beth Johnson, DVM DACVIM

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