

**DATE PRESENTING CLINICAL SIGNS**

8/16/22

PATIENT

Smokey Rogers

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8/13/14

WEIGHT

8.3 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Rachel Brilhart RDMS

HOSPITAL NAMEAnimal Emergency
Hospital**REFERRING VET**

Dr. Kalwa

INVOICE

40510

Chronic weight loss - 10 lbs over 8 months - Vomiting- severe over past few days ~5 x / day - Very hungry/ over-eating ATO- - Owned since <6 months old - Indoor only - Initially when younger gained weight was up to 17.5 lbs - 6-10 months ago started losing weight- has lost over 10 lbs - First took to vet in February- thought thyroid? Cancer? Had diet change- nothing was conclusive. O states he had chest xrays ~ 30-45 days ago, Ultrasound march 8-9th, GI panel, bloodwork, thyroid test - Thyroid came back in the "grey zone" started treating for 3-4 weeks - Dont think the vomiting is from the medication due to time period. - Diet- O tried hydrolyzed diet- now back to purina one. Date: 08-13-2022 Notes: rDVM records: - Treating for hyperthyroidism- methimazole- Free t4 little high - Anemic - BW- rest nsf - GI panel Texas A and M - AUS - Radiographs Unremarkable Concern for occult neoplasia Discussed case with internal medicine specialist Discussed biopsies Discussed internal medicine referral

Current Medications: Omeprazole, Cerenia, Metronidazole, Gabapentin.

Lab Results: See attached.

Radiographs: Decreased serosal detail in abdomen muscle wasting/ cachexia gas dilated colon

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

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.

The right 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.

The left kidney is normal in size (4.03 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.

Adrenal Glands

The right adrenal gland is normal in size (0.36 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 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 visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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.

From stomach to colon, the bowel is markedly distended with what appears to be normal ingesta/chyma, so the assumption is that this is a post-prandial study.

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is scant amount of anechoic free fluid noted.

There is no apparent lymphadenopathy noted in these images.

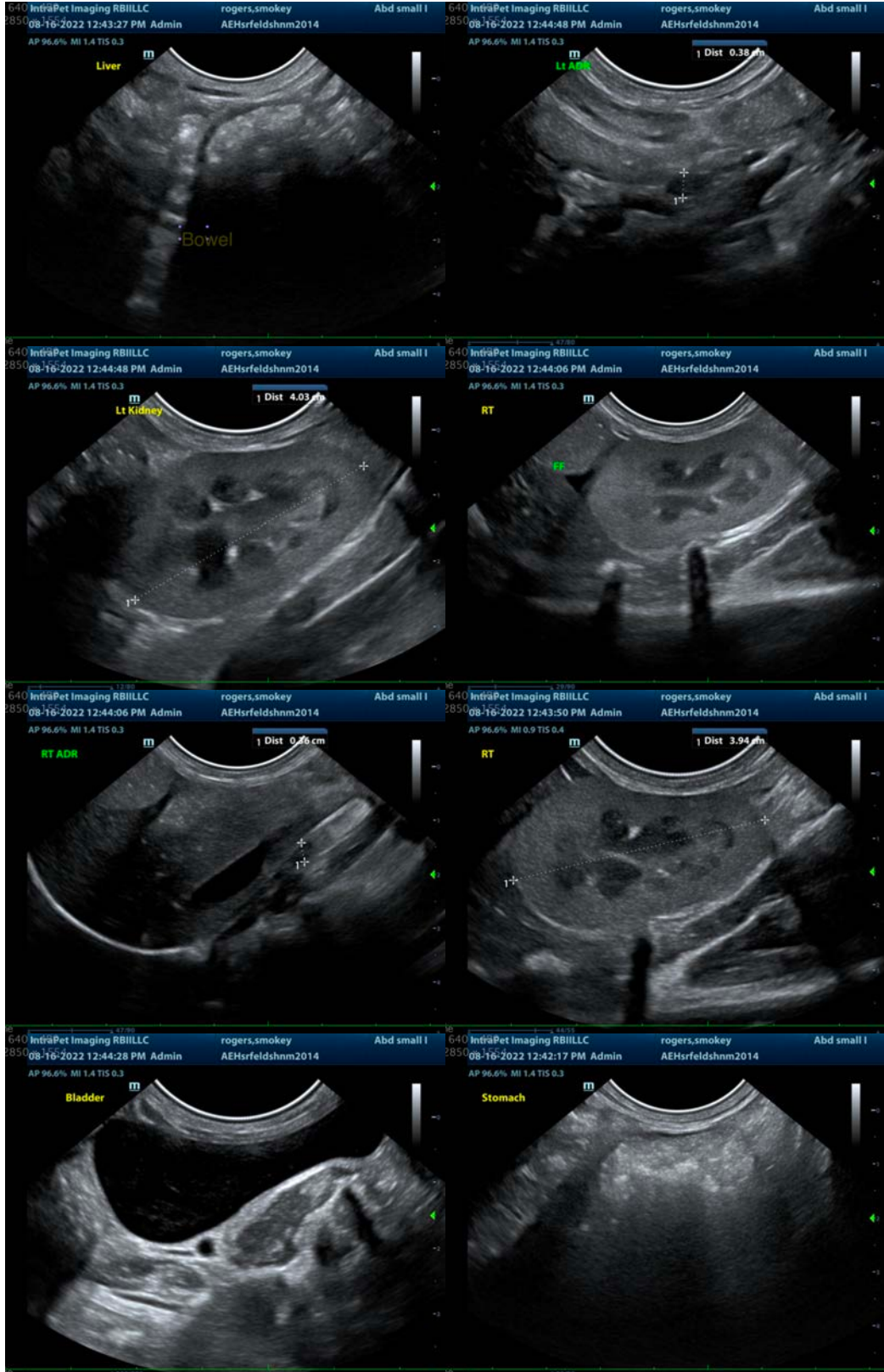
ULTRASONOGRAPHIC FINDINGS

- This appears to be a post-prandial study.
- Scant amount of anechoic free fluid
- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no obvious ultrasonographic explanation for this patient's weight loss, despite an increased appetite. Occult gastrointestinal disease, however, can be present and result in weight loss, despite a relatively normal ultrasound. Therefore, if managing the historically reported grey zone hyperthyroidism does not result in clinical signs, and a calorie deficit has been ruled out by double checking that the appropriate amount of calories is being offered, and that another pet, etc. is not consuming them, next steps may have to include biopsies of the gastrointestinal tract, being sure to include ileum if possible to further workup possible infiltrative bowel disease.

Prior to biopsies, or if biopsies cannot be obtained, other empirical therapies could include a new diet transition to a different novel or hydrolyzed protein diet, again being sure to ensure adequate caloric intake as the diet is changed, empirical deworming with a 5-day course of Panacur, and potentially a course of Prednisolone if not contraindicated based on patient contraindications, comorbidities, etc., with monitoring for improvement.



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.

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