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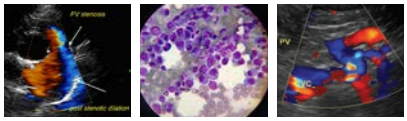

SonoPath

Clinical Sonography & Telecytology

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DATE

9/22/22

PATIENT

Daisy Brocato

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9/19/11

WEIGHT

10.5 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Stephanie Warga RDCS, RVT

HOSPITAL NAME

Everhart Vet Hospital

REFERRING VET

Dr. Kerr

INVOICE

41569

PRESENTING CLINICAL SIGNS

Hx from ER visit 9/10/22: Daisy is a 11 years and 0 months FS DSH / Domestic Shorthair that presents for severe diarrhea and lethargy. She was a feral cat and often hides and doesn't often allow herself to be picked up or held. Two weeks ago one of O's other cats Daisy was close to was euthanized d/t cancer. She has been more reclusive, not eating as well, since then - O thought behavioral. This morning she was mobile and seemed to be fairly normal, however, O's son came home at 4pm and
by the time O came home at 12am he said she had not moved at all and was very lethargic. O found her on O's bed covered in liquid diarrhea and very limp. Daisy presented to EVH on 9/19/22 for purulent nasal discharge from both nostrils along with severe congestion. Over the week between the ER visit and presenting to EVH, Daisy also went from 12.1 lbs. to 10.2 lbs. Physical exam reveals severe gingivitis and oral ulceration, severe purulent nasal discharge with upper respiratory congestion, and generalized loss of weight loss.

Current Medications: Baytril 22.7mg/mL - 22.7mg [1mL] SID, Cerenia 10mg/mL - 4.7mg [0.47mLs] IV SID, Mirtazapine Transdermal on pinna SID. Transitioning to outpatient care with: Intra-nasal Cerenia (1ml Cerenia w/9mLs Saline) 1 drop each nostril x 3d then EOD x 3d
Clavamox drops 1 mL PO BID until gone
Lab Results: HCT 27.4 (29.7 - 44.5), RETIC * 50.3 (3.0 - 50.0) K/µL, WBC * 48.89 (5.50 - 19.50) K/µL, NEU * 44.66 (2.50 - 12.50) K/µL, MONO * 2.26 (0.15 - 1.70) K/µL, EOS * 1.01 (0.10 - 0.79) K/µL, BASO * 0.31 (0.00 - 0.10) K/µL, GLU 224 (71 - 159)mg/dL, CREA (0.4 0.8 - 2.4) mg/dL, BUN 6 (16 - 36) mg/dL, GLOB 6.2 (2.8 - 5.1)g/dL.
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

The urinary bladder is moderately 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.

The right kidney is normal in size (4.6 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 (4.05 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 (0.43 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.33 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. A tortuous but not pathologically dilated common bile duct is noted, which can be a normal anatomic variant.

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 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 is empty with no evidence of obstruction or foreign material.

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.

ULTRASONOGRAPHIC FINDINGS

- **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.

- Chronic active pancreatitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

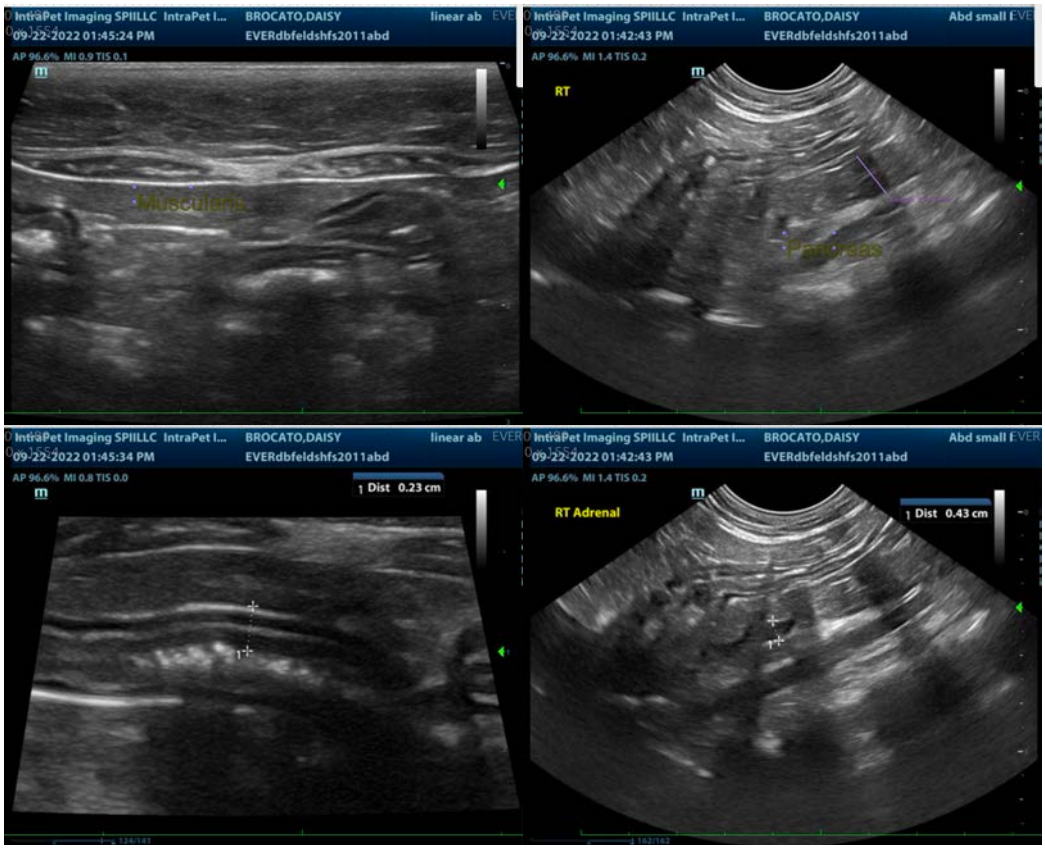
Given this patient's history, some of the weight loss is likely secondary to decreased appetite owing to severe reported respiratory disease, and an upper respiratory workup may be indicated to help diagnose and manage infectious versus neoplastic upper respiratory disease.

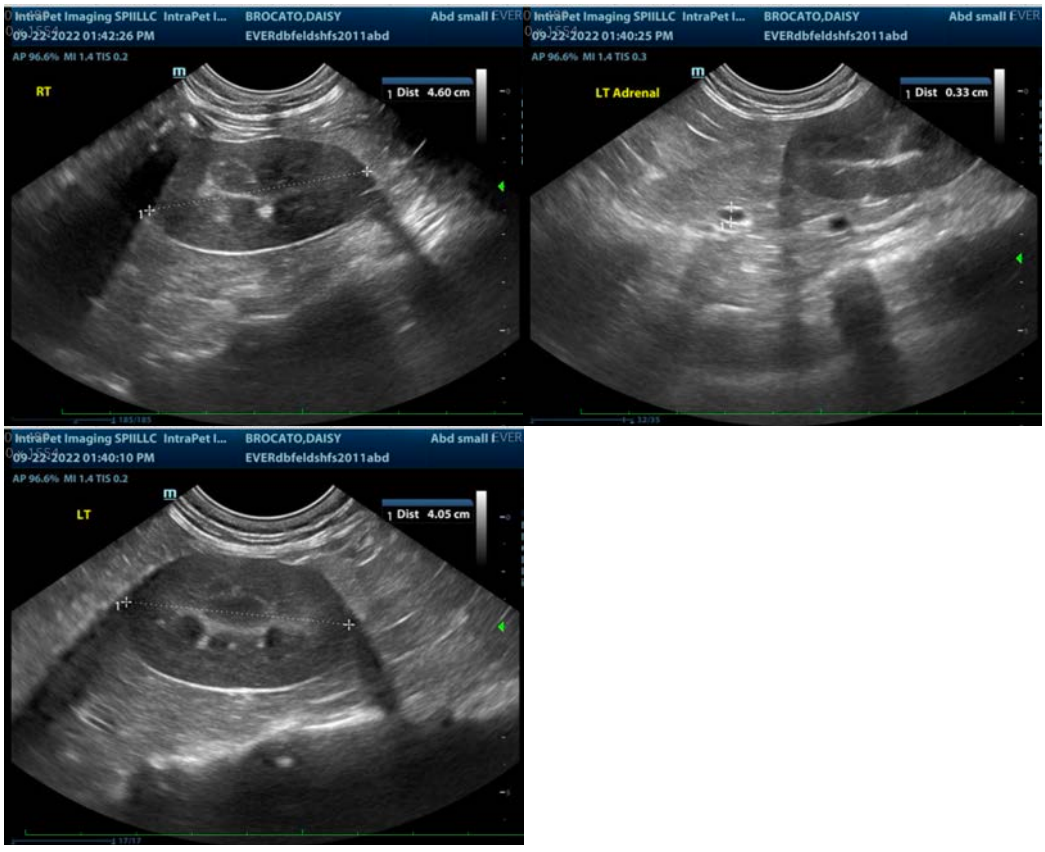
However, given the reported diarrhea and the ultrasound findings described above, concurrent infiltrative bowel disease is also possible, and recommendations include:

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.

Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.

If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Other supportive therapeutic considerations could include fiber supplementation, especially with large bowel diarrhea and/or a probiotic.





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