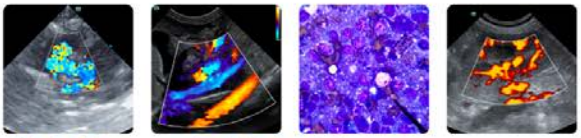


PATIENT

Milo Tiburzi

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

5 Years 5 Months

WEIGHT

7.7 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

VCA Northside Animal Hospital

REFERRING VET

Dr Fusselman

INVOICE

74720

DATE

4/23/26

PRESENTING CLINICAL SIGNS

Unregulated diabetes *Diabetic* FIV (+). Unkept feline. Dx diabetic in Feb. did not respond to Senvelgo- difficult time w Glargine as well. Current Medications: Glargine 4U bid (gabapentin)

Abnormal PE/Chem/CBC/UA Results: ALT-338; BUN-56; Crea-1.3; SDMA-19.7; Glucose-481; WBC-40.6; Neuts-37352; Mono-812; Eos-1218. UA: Glucose 3+; USG: 1.037

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys present normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. There is a hyperechoic band between the cortex and medulla bilaterally. Left kidney measures 4.5 cm. Right kidney measures 4.39 cm.

Adrenal Glands

The adrenal glands are bilaterally enlarged and hypoechoic with no specific masses or nodules seen. Left measures 0.61 cm in thickness. Right measures 0.52 cm in thickness.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

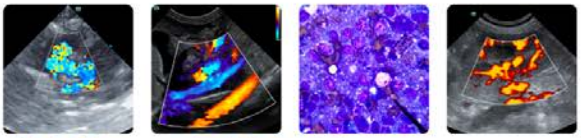
The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains shadowing material with complete acoustic dropout, concerning for possible foreign material. It does not appear obstructive. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.



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Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The right and left limbs of the pancreas are enlarged and hypoechoic with surrounding hyperechoic mesentery. No fluid accumulations visualized. No mass effect consistent with pancreatic neoplasia visualized.

Free Abdomen

Mesenteric and peripancreatic lymph node are enlarged with normal length to width ratio and normal echogenicity.

Scant free fluid is noted throughout the abdomen.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis with focal peritonitis.
- Scant free fluid.
- Mesenteric and peripancreatic lymphadenopathy.
- Bilateral adrenomegaly.
- Bilateral medullary rim sign.
- Shadowing material in the stomach – concerning for gastric foreign body.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pancreatic changes are consistent with severe pancreatitis. The prognosis of acute pancreatitis is largely dependent on the severity of clinical signs and response to treatment. Mortality is reported as high as 25% and secondary organ dysfunction and systemic inflammatory response syndrome can occur as inflammation progresses. Ultrasonographically, pancreatic inflammation is severe in this patient. Ultimately the need for hospitalization for treatment is based on the patient's cardiovascular stability, pain and appetite. Hydration and enteral nutrition are key factors in positive outcomes and if these cannot be achieved on an outpatient basis, hospitalization for 24 hour care is strongly recommended.

Treatment for pancreatitis is entirely supportive and involves fluid support, GI support - anti-nausea (ondansetron, cerenia 2mg/kg PO SID), appetite stimulation (mirtazapine, elura), analgesia (buprenorphine, gabapentin) and enteral nutrition as needed (syringe feeding, NG tube placement, etc). Antibiotics are generally not warranted for acute pancreatitis as it is usually sterile, however given the severity of inflammation I would use antibiotics (ex unasyn +/- fluoroquinolone) in this case. Intravenous antibiotics are preferred to ensure absorption and decrease GI side effects of oral antibiotics which can lower appetite compromising treatment and recovery. Anti-inflammatory steroids may be tried in an attempt to reduce inflammation if traditional supportive care is inadequate. Serial imaging is indicated to monitor response to treatment.

Abdominal fluid is scant and likely represents abdominal inflammation. Serial free fluid evaluations with attempt at abdominocentesis with plan for fluid analysis and cytology is recommended.

Lymphadenopathy also likely reflects inflammation. Lymph node FNA could be attempted to rule out round cell infiltration.

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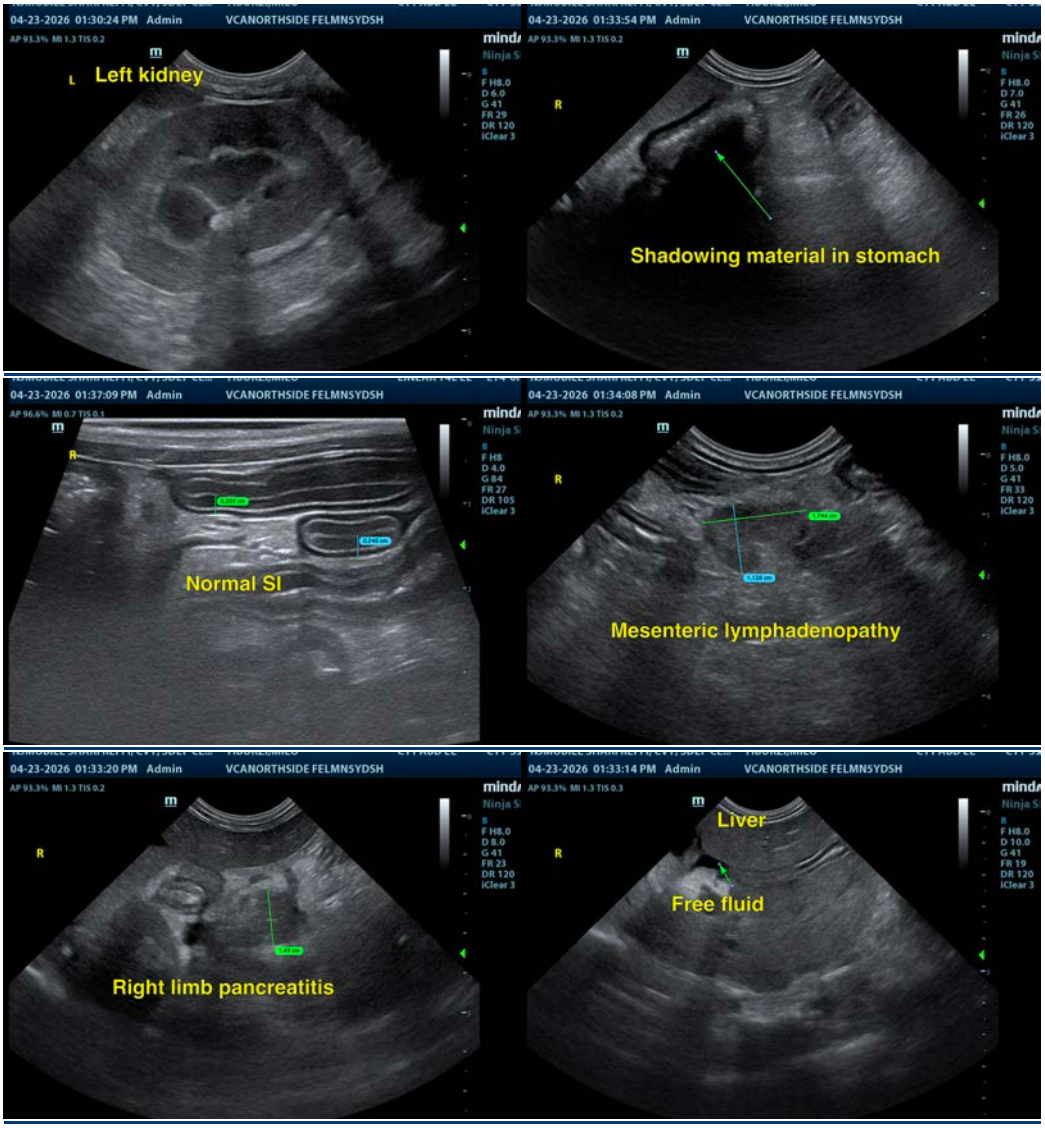
Hard shadowing in stomach likely represents non-food material. It is not currently obstructive, though gastric foreign bodies can be dynamic causing intermittent pyloric outflow obstruction and waxing and waning clinical signs. This shadowing could be a trichobezoar, foreign material, accumulation of plant debris, etc. Abdominal radiographs will be of benefit to further visualize gastric contents. If persistent foreign material is present, endoscopic visualization and retrieval should be considered. Abdominal exploratory surgery with plan for gastrostomy is an alternative.

I would proceed with caution if considering abdominal explore, given this patient's comorbidities.



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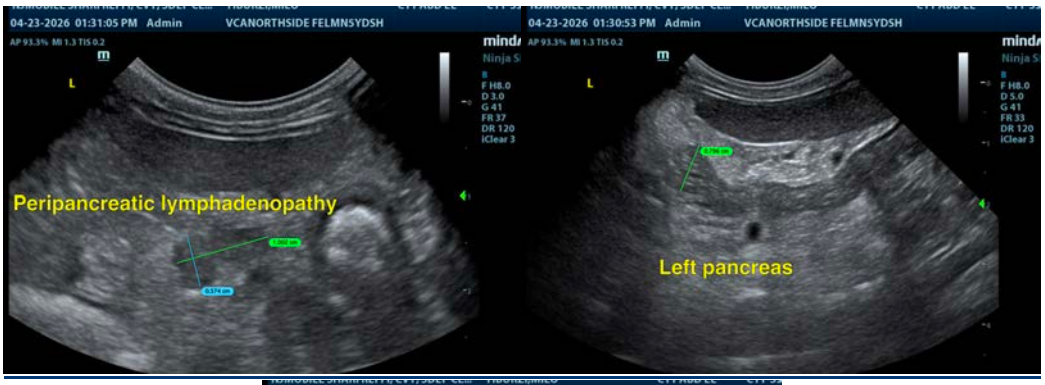

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com