



PATIENT

TJ Stuit

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

13 years

WEIGHT

13.3 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Sheldon

HOSPITAL NAME

Advanced PetCare of
Oakland

REFERRING VET

Dr. Sheldon

INVOICE

42755

DATE

2/13/23

PRESENTING CLINICAL SIGNS

History: Pet has a history of diabetes, constipation, dental disease, pancreatitis. For the past month he has had a decreased appetite and weight loss. Currently on cerenia and mirtazapine and does seem to be feeling better on meds. Spec fPLI is pending.

Abnormal PE/Chem/CBC/UA Results: fPLI- abnormal cbc- hi monocytes, rest wnl chems- normal glu 123, elevated sdma 22, rest wnl t4 4.0-borderline but wnl ua ph 6.5, wnl

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 have an irregular capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Left renal pelvis is moderately dilated measuring 0.48 cm. Ureter is non-dilated. Right renal pelvis is normal. The left kidney measured 3.85 cm and the right kidney measured 4.16 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 1.1 cm in length and 0.48 cm at the cranial pole and 0.51 cm at the caudal pole. The right adrenal gland measured 0.85 cm and 0.54 cm at the cranial pole and 0.43 cm at the caudal pole.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and 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

Liver contains a 1.4x1.3cm irregular to ovoid hyperechoic nodule as well as a 0.7x1.cmcmm ovoid hypoechoic nodule. The liver is otherwise subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally



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Gastrointestinal

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The stomach contains minimal luminal contents. 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 and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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Multiple loops of jejunum were thickened with a prominent muscularis layering. Bowel loops follow a curvilinear path with distinct wall layering. 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.

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Pancreas

Body of pancreas is visualized and is hyperechoic and slightly irregular with slight enlargement, no fluid accumulations and hyperechoic surrounding mesentery suggestive of focal inflammation.

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Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

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Free Abdomen

No masses or free fluid were noted.

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ULTRASONOGRAPHIC FINDINGS

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Primary Findings

1. Small intestinal thickening with prominent muscularis
2. Pancreatitis
3. Liver nodules
4. Left pyelectasia
5. Degenerative renal changes

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Small intestinal changes are most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or GI lymphoma being the top differentials. No overt neoplastic criteria present in the bowel given that curvilinear layering is still intact which would suggest inflammatory bowel as opposed to round cell neoplasia (LSA, MCT and similar). Intraoperative US-guided bx would be optimal in this patient to obtain the most representative samples in the GI tract. I cannot rule out a preneoplastic (LSA) state however and follow-up sonograms recommended especially if the patient is not responding to empirical efforts. Endoscopic biopsy is less invasive but may miss lesions due to inability to sample more than top 1-2 layers of GI tract and inability to obtain samples from all sections of the GI tract. Surgical biopsies are more likely to be diagnostic but are more invasive. A GI panel (PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation.

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Pancreatic changes are relatively mild but likely reflect acute pancreatitis. Sonographic appearance of the pancreas does not always reflect the degree of inflammation and the Spec PLI will be of help in determining the degree of pancreatic inflammation present. In the face of small intestinal changes, a variation of feline triaditis (IBD, pancreatitis, cholangiohepatitis) may be present in this patient, with cholangiohepatitis not being a feature in this patient's case at this time.

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Empiric treatment for IBD/pancreatitis complex includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, GI support as needed (fluid therapy, anti-nausea, appetite stimulant, enteral nutrition if needed). Antibiotics are generally not warranted for acute pancreatitis as it is generally sterile. Treatment with steroids (budesonide vs prednisolone) is often required – biopsies should be acquired prior to treatment with steroids. Steroids may ultimately be tapered to the lowest effective dose or discontinued in some cases.

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Liver nodules are a common change in older pets and may represent benign regenerative, reactive or inflammatory nodules. Early neoplastic lesions (hemangiosarcoma, biliary adenoma or adenocarcinoma, hepatic carcinoma, lymphoma, MCT or less aggressive hepatocellular carcinoma or hepatoma, other) cannot be ruled out. Fine needle aspirate of the abnormal areas is recommended to further characterize parenchymal changes.

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Left pyelectasia is concerning acute pyelonephritis, though with normal kidney values and the unilateral nature of the dilation, a non-active, chronic change is also possible. It may represent obstructive ureterolithiasis, either present or resolved, or other acute on chronic or chronic insult - toxin exposure, recent stone passage, leptospirosis (rare but possible in cats), etc. Renal parenchymal changes are likely age-related degeneration. Correlate clinical significance of renal changes with blood work/urinalysis and urine culture findings and clinical signs.

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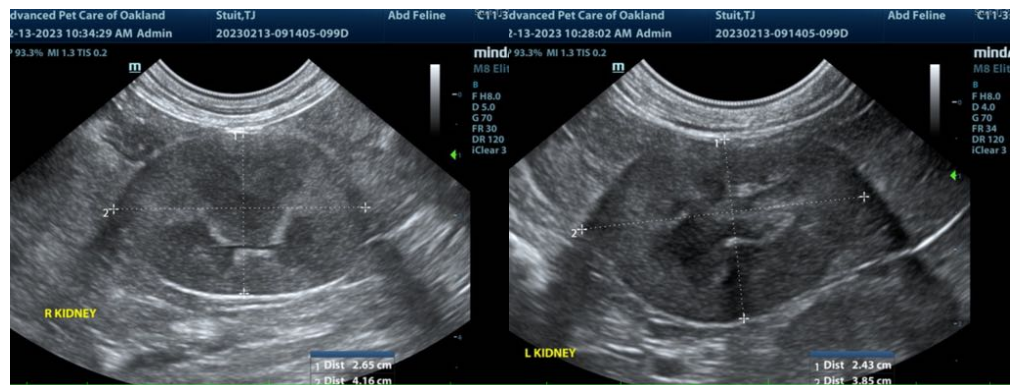
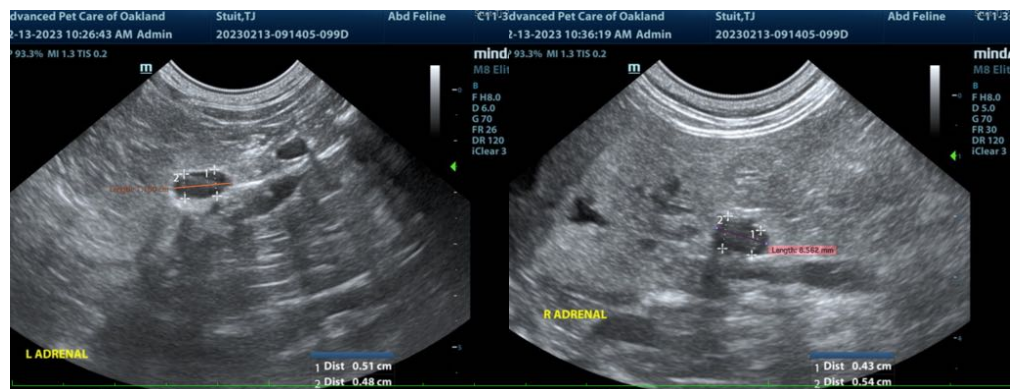
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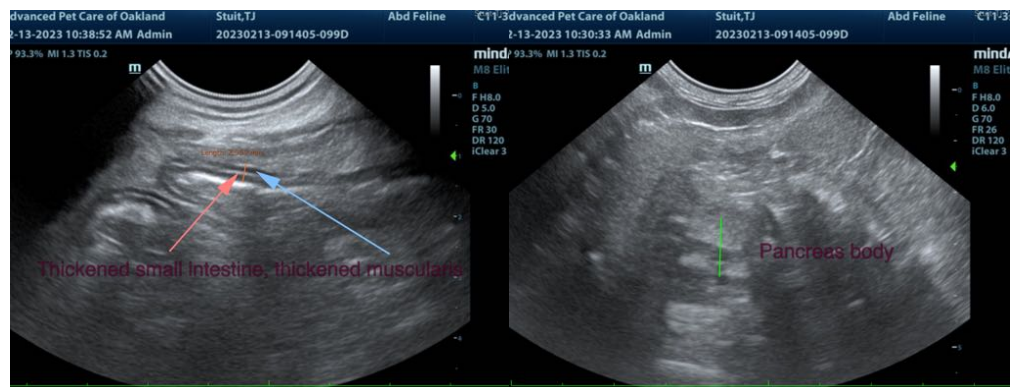
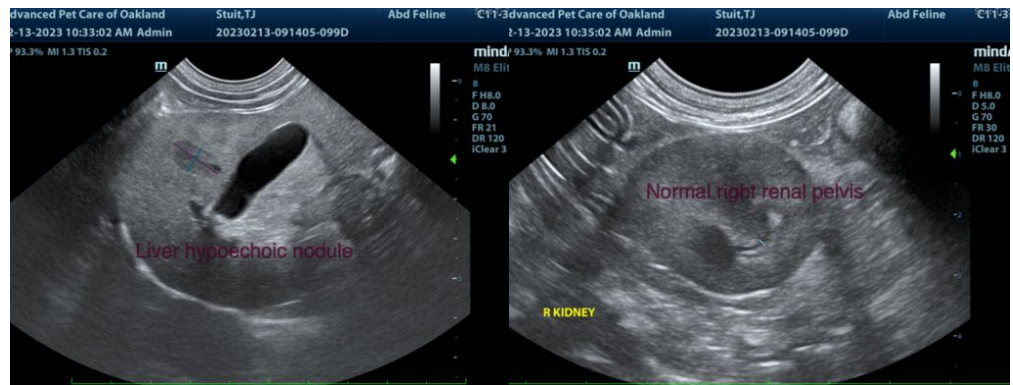
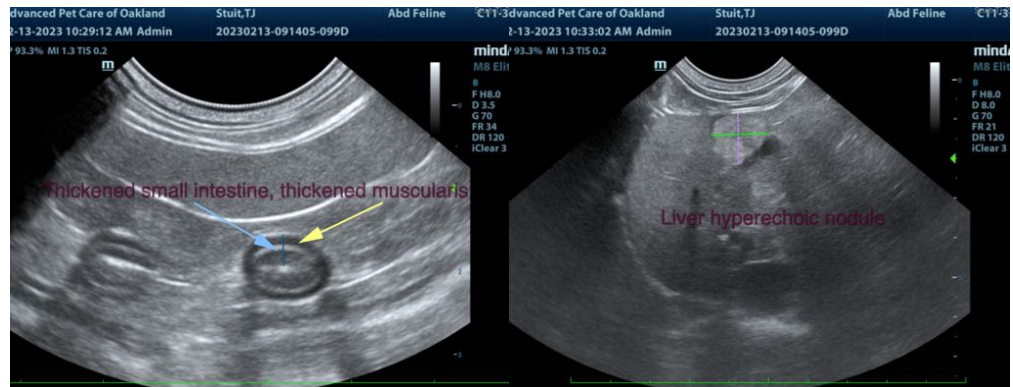
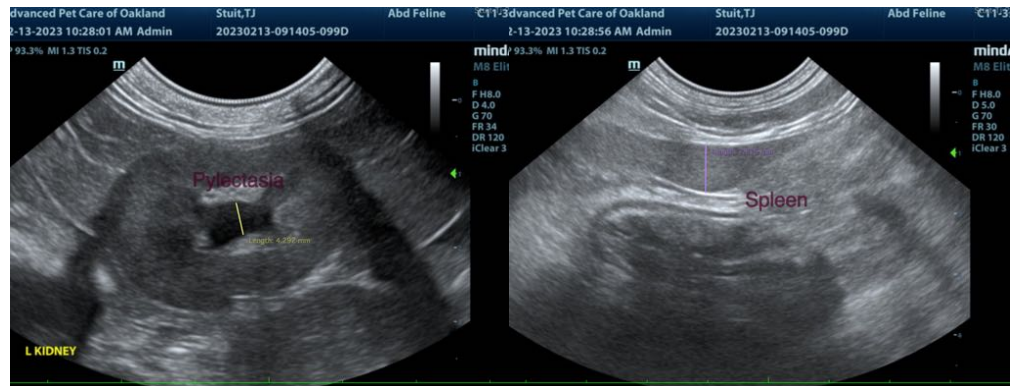
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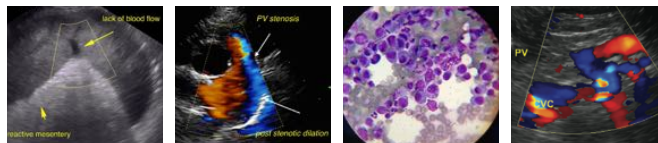
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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info@SonoPath.com

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