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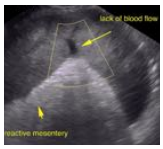

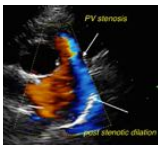

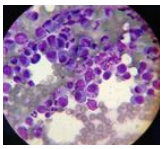
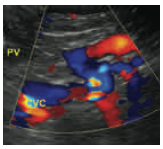

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1-800-838-4268 info@sonopath.com

PATIENT

Lucy Harry

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

14 years

WEIGHT

12.5 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Tranquility VC

REFERRING VET

Dr. Kurapati

INVOICE

95352

DATE

1/18/22

PRESENTING CLINICAL SIGNS

On and off soft pudding stools, defecating outside litterbox, consistent elevating ALT. Current meds: Metronidazole
Abnormal PE/Chem/CBC/UA Results: 2/2021-ALT 277(H158) high end normal T4 3.1(H4.7) ;10/2021 Free T4 3.2(H2.6); ALT 406(H158) ,T4 4.7(H4.7) 1/5/2022- ALT 138(H100), Calcium 10.9(H10.8); Gluc 175 (170); T4 3.9 (0.8-4.0). USG 1.030, Prot 1+

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 3.78 cm. The right kidney measured 3.69 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.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

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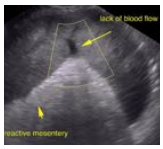

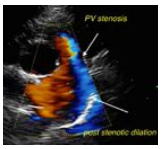

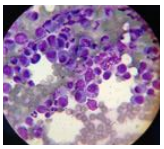
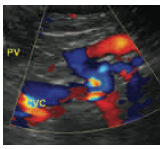

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Gastrointestinal

The **gastrointestinal tract** revealed minor variable thickening and echogenic submucosal changes most consistent with low grade end result of chronic GI disease such as IBD and may be related to malassimilation of nutrients if any weight loss is present. No obvious neoplastic patterns were noted and luminal content as unremarkable.

Pancreas

The **pancreas** revealed mixed, hypoechoic, irregular parenchyma with enhanced surrounding mesentery. The region measured 1.5 cm at the right base.

ULTRASONOGRAPHIC FINDINGS

Geriatric abdomen with smoldering, chronic active pancreatitis pattern. Mild potential for emerging pancreatic carcinoma.

Reactive hepatopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Subxiphoid palpation is recommended to assess for pain-solicited response. If pain is noted low grade pancreatitis is suspected. Ultrasound-guided FNA of the hypoechoic portion of the pancreas would be ideal in this patient even though it is a small region. There is a possibility of carcinoma. Empirical treatment for pancreatitis could be considered such as the following. Pain management is also indicated. Recheck sonogram is recommended in a week to assess regression or progression.

Triaditis/Pancreatitis protocol

Part or all of this protocol may be considered based on your clinical impression of the patient:

Recommend pain management when anorexic with **Buprenorphine** (0.01-0.02 mg/kg IM or SC), clinical trial of **Zithromax** (50 mg sid/cat x 10 days, 3 weeks if bartonella +), **Prednisolone** (0.5-2 mg/kg tapering over 1 week to minimal effective dose), and **B12 injections** if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet (***Hydrolyzed diets have been shown to be more effective in dietary intolerance case management compared to hypoallergenic diets***)** or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes a persistent issue then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. One diet does not work for all patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.

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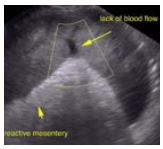
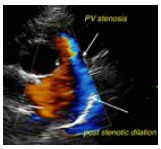
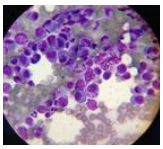
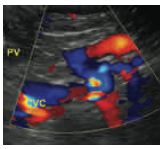

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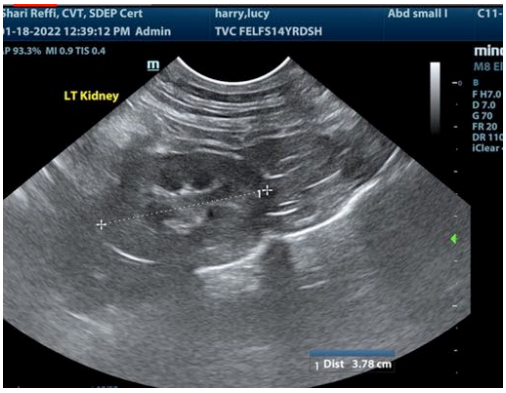

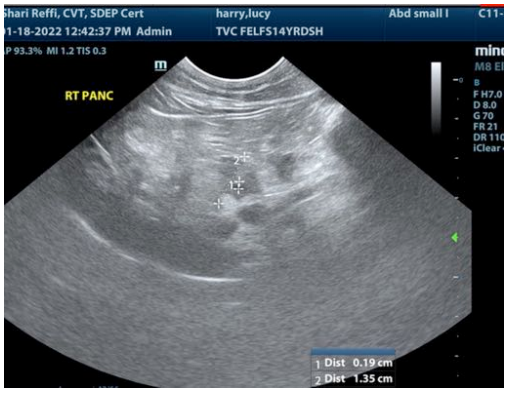

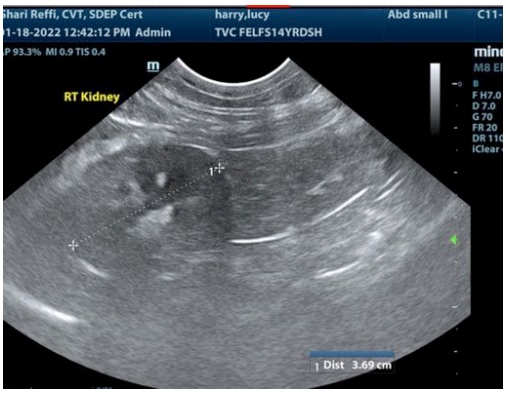

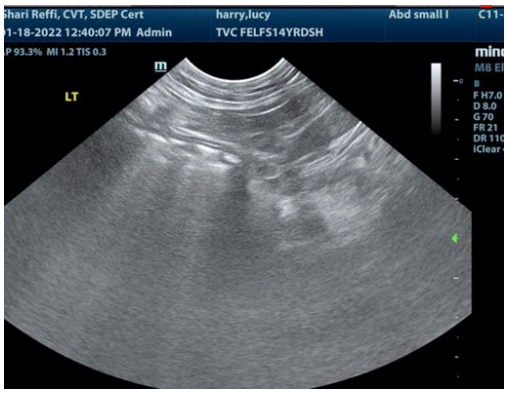

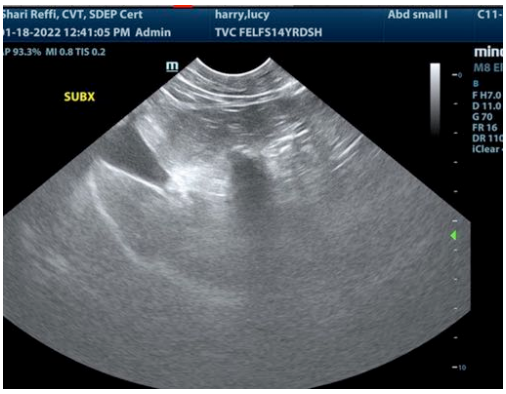

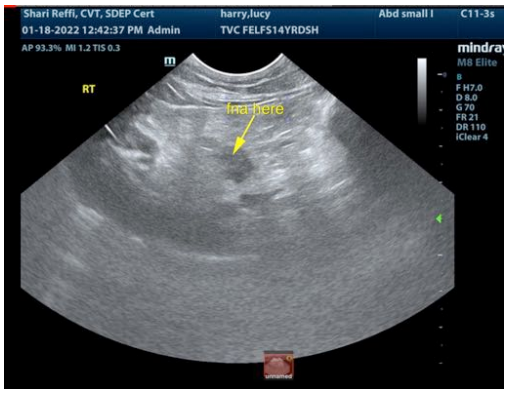

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
Info@SonoPath.com