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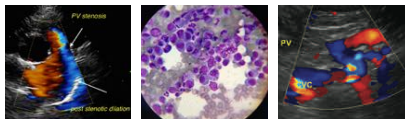

SonoPath
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**DATE**
10/26/21

**PATIENT**
Mr Peabody Hall

**SPECIES**
Feline

**BREED**
Domestic Shorthair

**SEX**
Neutered male

**AGE**
6/1/03

**WEIGHT**
6.1 lbs

**INTERPRETED BY**
Eric Lindquist, DMV DABVP, Cert. IVUSS

**HOSPITAL NAME**
Animal Emergency Hospital

**REFERRING VET**
Dr. King

**INVOICE**
92670

## PRESENTING CLINICAL SIGNS

History: Presenting Complaint: Diarrhea. **Date:** 10-25-2021 **Notes:** diarrhea and weight loss over 1 month has been vomiting about 2 times/day indoor only did add canned food after signs started, thought was having trouble with dry food. **Assessment:** Discussed potential causes such as metabolic (renal, hyperthyroid, DM) , pancreatitis, parasites) IBD, cancer.
Current Medications: Cerenia, pantoprazole, Metronidazole, Vitamin B12.
Lab Results: Attached separately.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: not needed
Stat Report: not requested

## 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. The left kidney revealed slight pyelectasia that measured 0.24 cm. Corticomedullary calculus measured 0.69 cm and was non-obstructive. A cortical infarct was noted adjacent to the calculus in the left kidney. The left kidney measured 3.98 cm. The right kidney measured 3.92 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** was mildly enlarged with uniform, but subtly micronodular parenchyma, and undulating capsular contour. This is consistent with reactive spleen owing to immune stimulus or early infiltrative disease such as mast cell disease or lymphoma. 25-gauge FNA would be ideal if weight loss is an issue to differentiate early round cell neoplasia versus splenitis or reactive spleen all of which can present in this manner.

### *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.

### *Gastrointestinal*

Examination of the **gastrointestinal tract** revealed variable thickening with loss of mural detail particularly in the colon. The colonic wall measured 0.5 cm. The mesenteric lymph nodes were reactive and measured 1.33 x 0.99 cm.

### *Pancreas*

The **pancreas** is enlarged and irregular in contour with a dilated duct. The pancreas measured 1.2 cm in width. The left limb duct dilation measured 0.3 cm.

## ULTRASONOGRAPHIC FINDINGS

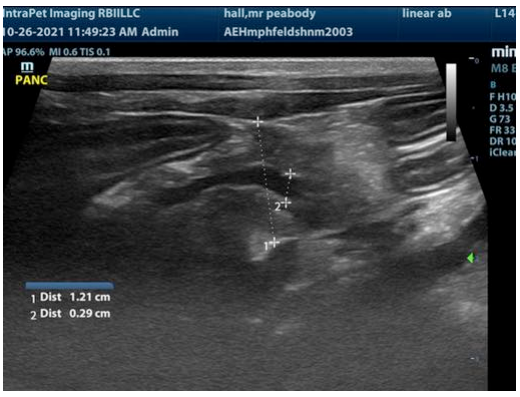
Variable intestinal thickening with some areas of loss of mural detail. Concern for emerging GI lymphoma versus complicated inflammatory bowel and reactive lymph nodes.
Some level of pancreatitis is likely in this patient.
Age related renal changes with pyelectasia and mineralization.

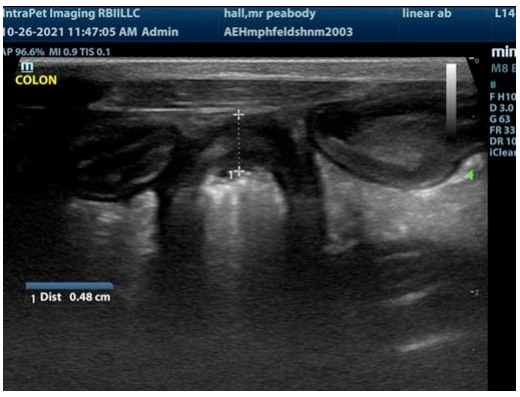
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

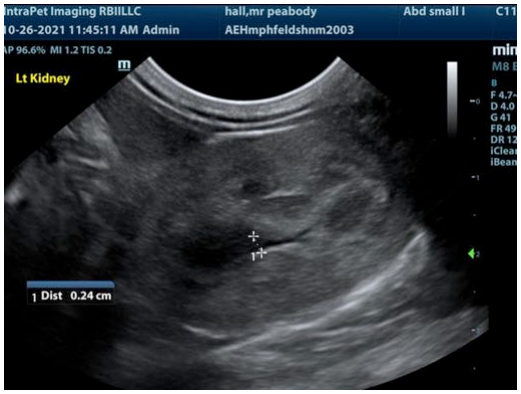
Full thickness gastrointestinal biopsies would be necessary> however, screening FNA of the spleen, pancreas and mesenteric lymph nodes could all be justified. I recommend colonoscopy with mucosal biopsies, yet may not be reflective of the complete pathology. If sampling is not an option a clinical trial of the following may prove effective. Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

**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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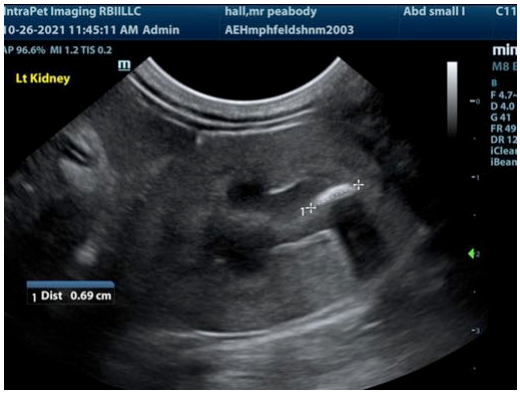
1 Dist 0.24 cm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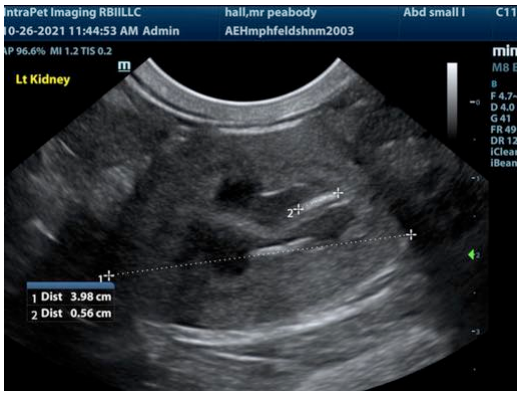
1 Dist 0.69 cm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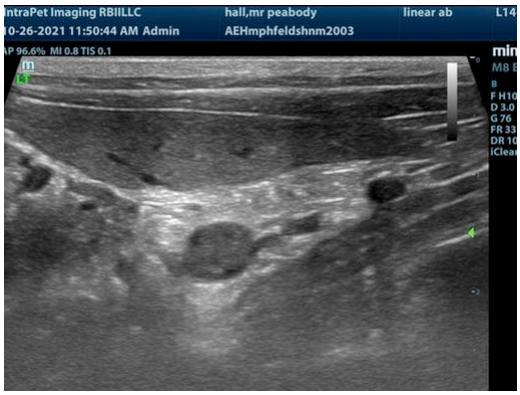
Lt Kidney
1 Dist 3.98 cm
2 Dist 0.56 cm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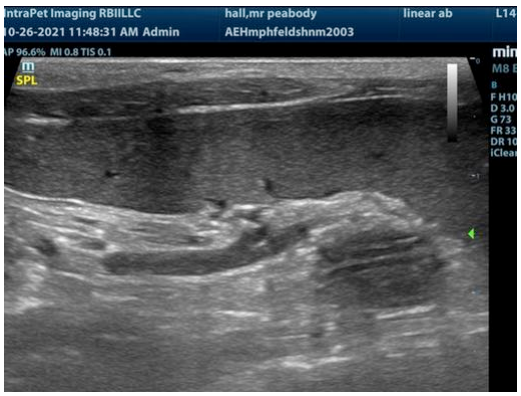
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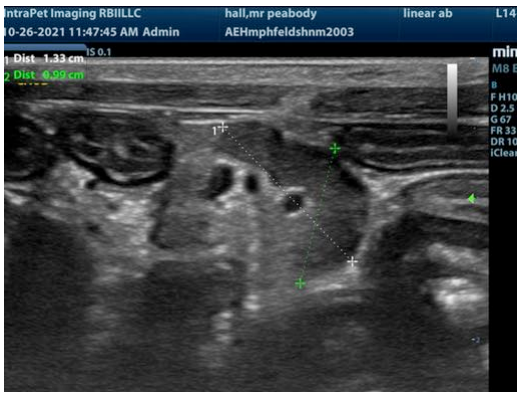
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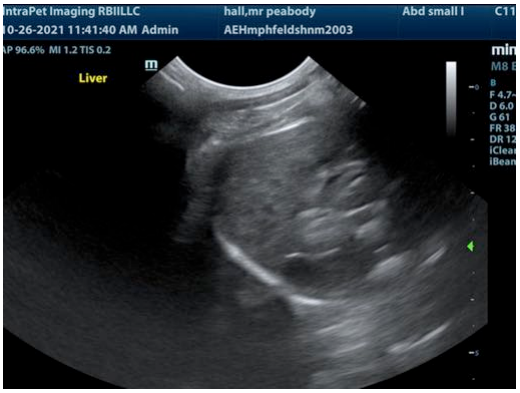


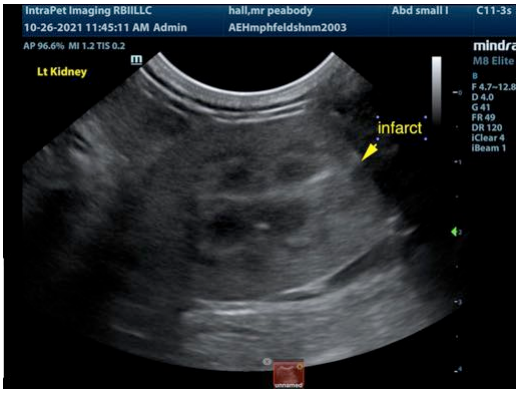


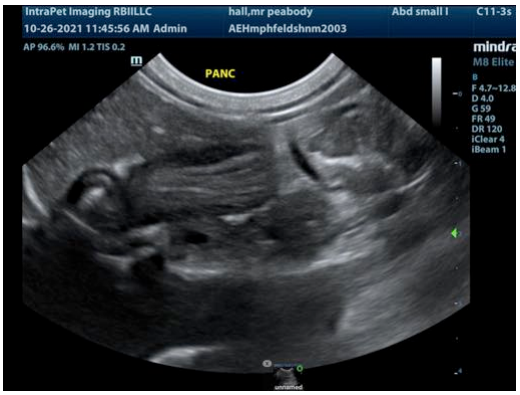


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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
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