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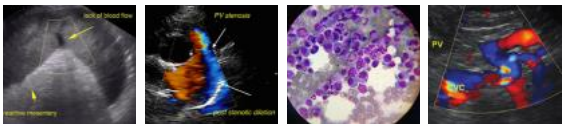

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Harry Casey

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

8.8 Pounds

INTERPRETED BY

Eric Lindquist, DMV, DABVP, Cert. IVUSS

HOSPITAL NAME

Jenna Walsh, CVT

REFERRING VET

VCA Salem AH

INVOICE NUMBER

Dr. Hallden

DATE

12/16/22

PRESENTING CLINICAL SIGNS

History: Weight loss trend in 2022 despite eager, but not escalating or extreme appetite. Last FIV test was negative 5/22/2020 (normal CBC, Chem 9 at that time). Was 13 pounds in 5/2020, 11 pounds in late 2020 following fever of unknown origin in 8/2020, 10.3 lb 4/15/2022 and 8.8 lb 12/8/2022. Stable water intake. Indoor/outdoor lifestyle. Decreased muscle mass of hindquarters, possibly impacted by youthful history of HBC trauma. Lacking GI patterns. Physical examinations of 4/15/2022 and 12/8/2022 were relatively unremarkable with normal palpation and auscultations. Mild tartar accumulation. Profender broad-spectrum intestinal deworming was applied at 12/8/2022 exam. Adult commercial major brand diet in use. Infrequent OTC flea control use (once in summer 2022). Appropriate current vaccination history (Rabies, FVRCP, FeLV) Current Medications 100 mg po gabapentin upon hospital arrival Primary Question/Differential to Be Answered in This Exam Screening for neoplasia, other cause of weight loss trend and marginal anemia in this geriatric cat. Weight loss is the only recognized sign supporting hyperthyroidism.

Abnormal PE/Chem/CBC/UA Results: See attached blood panels of 4/15/22, 12/8/22 and 5/22/2020. Utilizing resources for AUS vs. additional thyroid testing due to clinical signs. 12/8/22: Marginal anemia HCT 28%, Hgb 8.9, tT4=2.4. Lacking urinalysis. Negative FeLV. Marginal eosinophilia. 4/17/22: HCT 31%, 10.3 Hgb, tT4=2.5. USG=1.043, 2+ proteinuria with only 4-10 RBC/hpf. Marginal eosinophilia.

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 were 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 mild 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 his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 4.33 cm. The right kidney measured 4.5 cm. Hyperechoic medullary rim sign was noted in both kidneys, this is an idiopathic finding.

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 right adrenal gland measured 1.08 cm x 0.66 cm. The left adrenal gland measured 1.08 cm x 0.48 cm.

Spleen

The **spleen** exhibited fairly normal size and uniform parenchyma. Cranial folding was noted.

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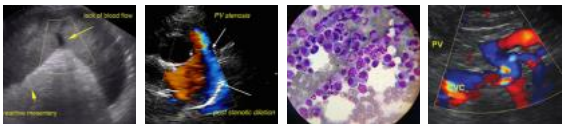

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Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some mild 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

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall. Muscularis/mucosal ratio was 1:1. The intestinal submucosa was slightly irregular, thickened (up to 0.35 cm) and hyperechoic suggestive of low grade, chronic disease. No concerning lymphadenopathy was visible. No evidence of obstruction was present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as lymphoma. Full thickness tissue biopsies via open laparotomy, ideally guided by intraoperative ultrasound in order to obtain the most representative mural sample, would be necessary to rule out this possibility. This is a minor change. The cecum was dilated with mild enhanced surrounding mesentery. Some areas of mucosal fogging were noted in the small intestine.

Pancreas

The **pancreas** revealed coarse architecture, hypoechoic irregular parenchyma, primarily in the left limb. No enhanced mesentery was noted. Hyperplasia, remodeling or low grade inflammation are all possible.

Free Abdomen

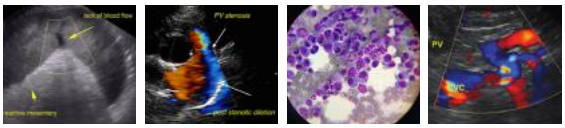
Slight mesenteric **lymph node** enlargement was noted, reactive.

ULTRASONOGRAPHIC FINDINGS

- Mild chronic renal, pancreatic and hepatic changes
- Inflammatory bowel/typhlitis pattern
- Reactive mesenteric lymph nodes
- Splenic fold

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend a fresh fecal smear and fecal floatation analysis. Diet change to hydrolyzed geriatric diet would be indicated. Antiparasitic protocol is warranted. Subxiphoid palpation is recommended to assess for pain or discomfort associated with the pancreas. Given that



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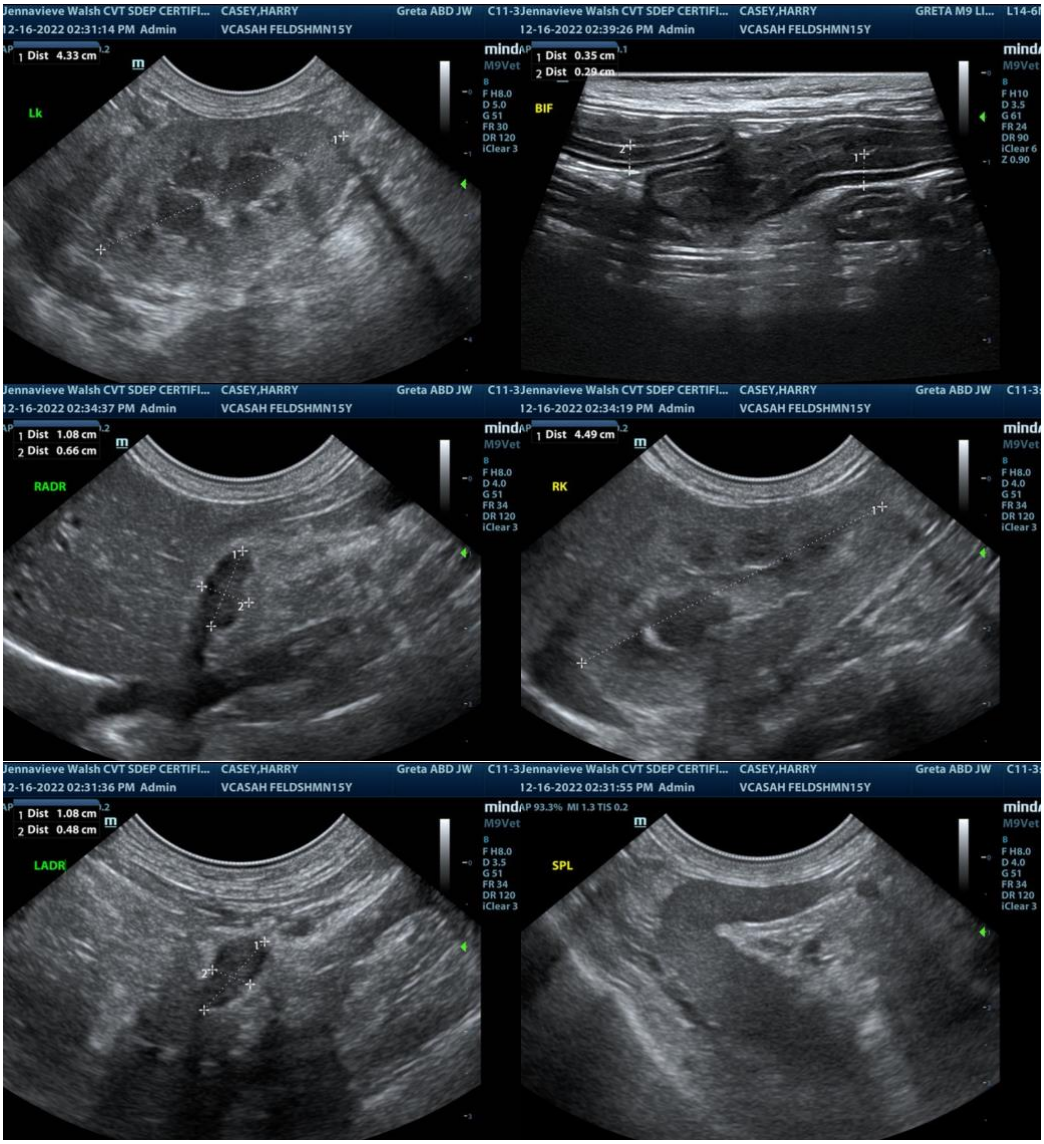
weight loss is an issue, malassimilation of nutrients is suspected. There are no organ systems with any evidence of neoplastic criteria.



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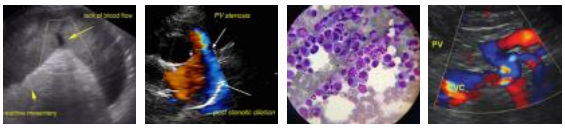

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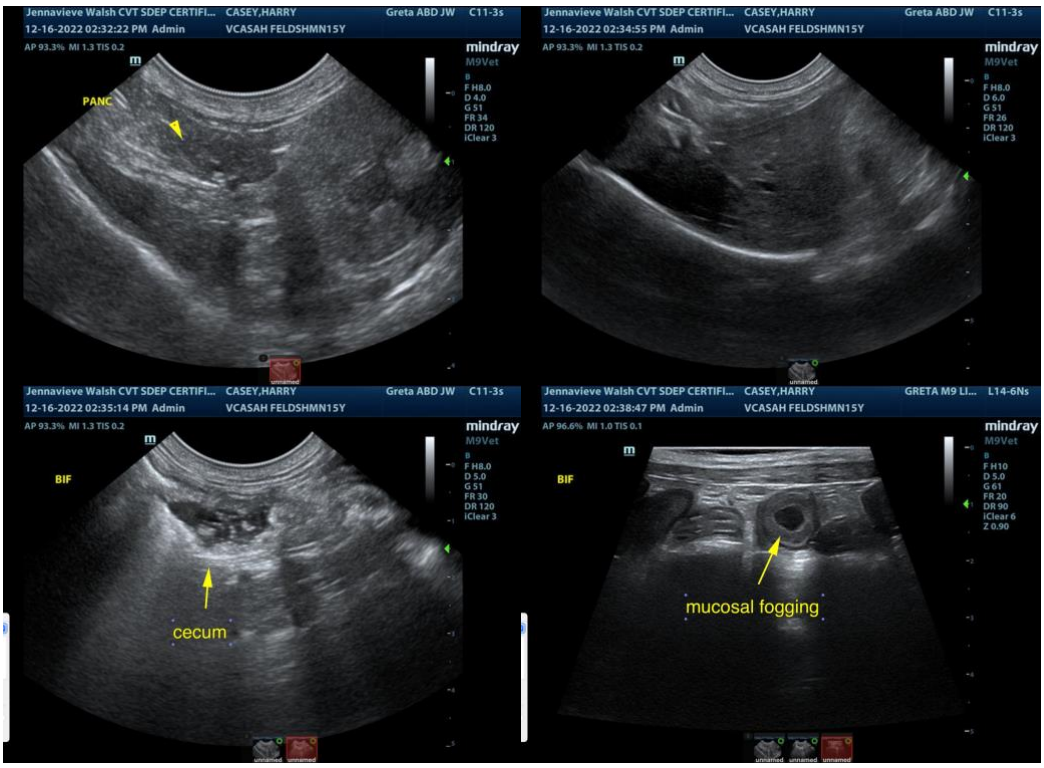

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Eric.Lindquist@SonoPath.com