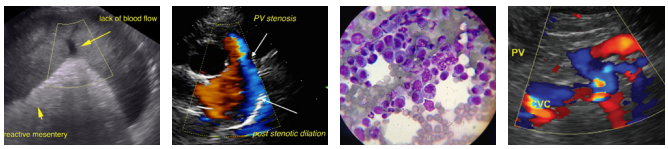

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PATIENT

Harley Logan

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years

WEIGHT

4.8 kg

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Anique McCrea-Spence

HOSPITAL NAME

Woodridge VC

REFERRING VET

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INVOICE

35414

DATE

2/2/22

PRESENTING CLINICAL SIGNS

~ 1 month history of daily vomiting. O reports that the vomiting occurs at random times during the day, and sometimes shortly after eating as well. He will retch/abdominal press, so it sounds like true vomiting rather than regurgitation. O has tried diet change to RC GI moderate calorie and has done hairball treatment with Therabite Hairball chews, as per my recommendation, and no change in the vomiting. He is vomiting mostly whole unchewed food. O said he manipulates his food a lot in his oral cavity before he swallows it. There is no change in his appetite. No diarrhea or coughing/sneezing. He is not losing weight. No changes in his water in take. Indoor only. No chance of FB according to the O. Other cat in house hold is normal. Other history is that he was diagnosed with severe degenerative lumbosacral disease and possibly IVDD and is on pain relief (meloxadin) and laser therapy for pain. He does walk a bit plantigrade. This has been an ongoing issue for <1.5 years. The meloxadin was started after he was already vomiting daily, so not the likely cause of the GI upset.
Abnormal PE/Chem/CBC/UA Results: Unremarkable PE, other than mild periodontal disease, and mildly overweight at 3.5/5 BCS. Bloodwork: CBC/Chem/T4/SDMA all unremarkable. Abdominal radiographs were taken in clinic about 1 week ago, and were found to be unremarkable. He had moderate fecal material in his colon, but he is not constipated at this time. Abdominal ultrasound performed today. I see some evidence of mineral or debris in the bladder, otherwise his ultrasound seemed unremarkable to me. Ddx - Hoping to rule in or out GI tract thickening (IBD? Lymphoma?), and pancreatic changes if pancreas was visualized.

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 normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 4.34 cm. The right kidney measured 4.28 cm.

Adrenal Glands

The regions of the **adrenal glands** were unremarkable.

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 were noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

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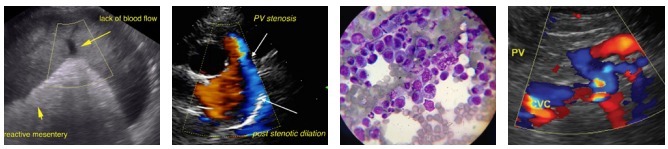

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Gastrointestinal

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio. The stomach was empty, no evidence of foreign body. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. An epigastric lymph node was slightly enlarged with a slight amount of reactive mesentery. 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.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

- Minor IBD GI pattern with slight epigastric lymphadenitis, no evidence of neoplasia or foreign bodies

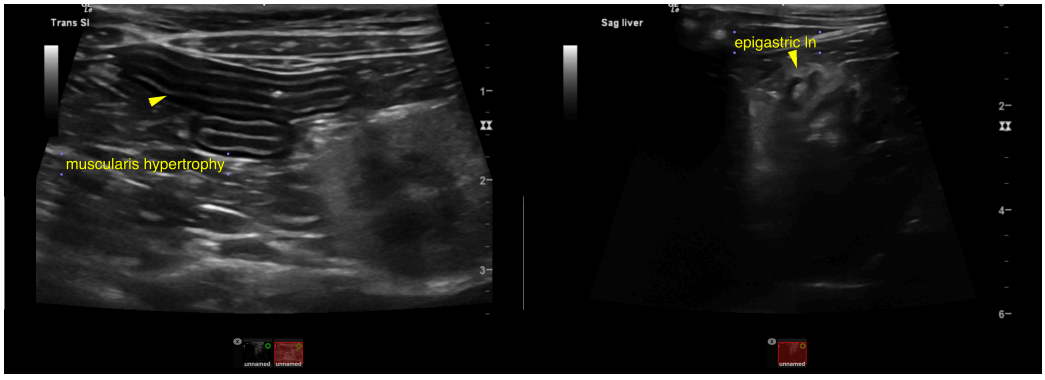
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Treatment for inflammatory bowel should prove effective. Underlying food intolerance may be an issue. A clinical trial of the following may prove effective.

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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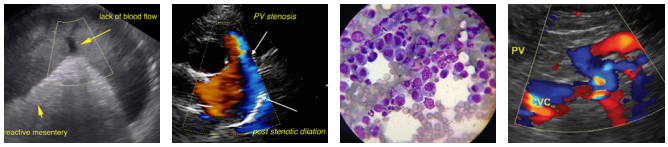

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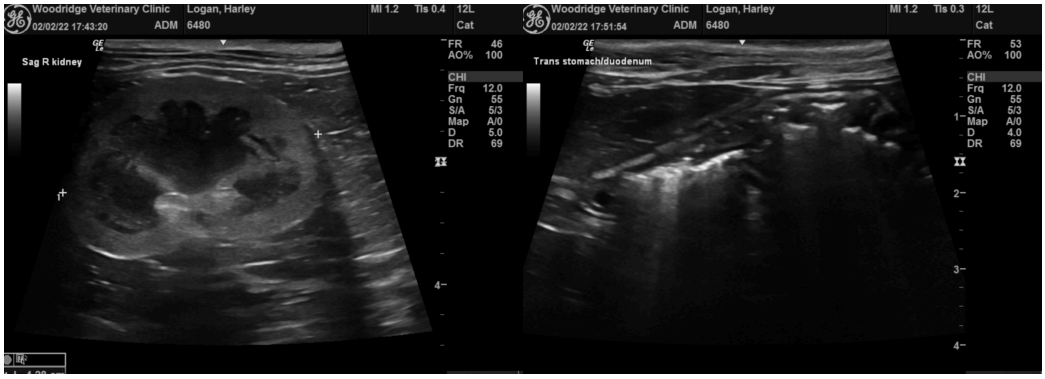

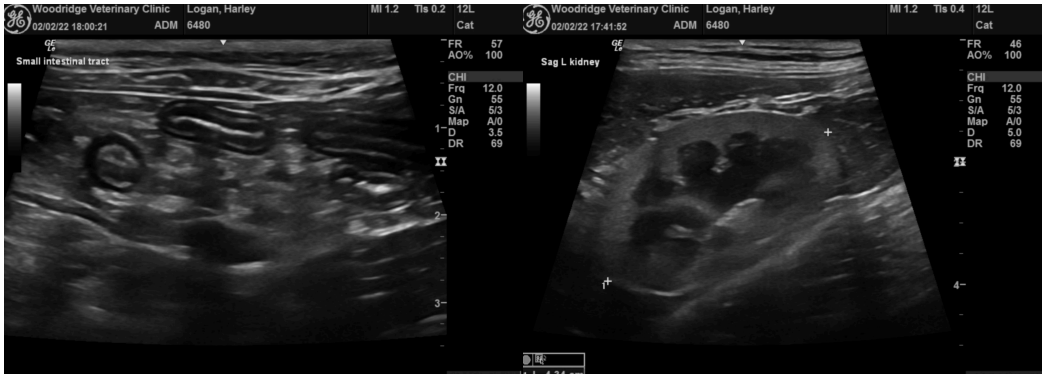

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com