



PATIENT

Juice Fesler

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 ½ years

WEIGHT

8.5 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Todd

HOSPITAL NAME

Lambs Gap AH

REFERRING VET

Dr. Campbell

INVOICE

95823

DATE

2/3/22

PRESENTING CLINICAL SIGNS

Juice is a fourteen year old, MN, DSH cat. Over the last few months, Juice's owners have noticed weight loss, decreased appetite and occasional vomiting and diarrhea. He has a history of chronic, mild renal disease. His Michigan State thyroid panel was normal. His fPL value was 3.7 (range 0-3.5). A fasted maldigestion panel is being sent out today (TLI, folate, cobalamin). Current treatments include aluminum hydroxide, Cerenia, Cosequin and a probiotic. Positive Murphy sign at position 14 C-Loop

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** presented a relatively uniform cortical hyperechogenicity when compared to the renal medulla, spleen and liver. No overt masses were noted. Corticomedullary definition was nebulous and the ratio favored the cortex slightly. The ureters were not visible and assumed to be normal. These changes are most consistent with chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. Corticomedullary mineralization was noted as well as areas of cortical collapse. Idiopathic medullary rim sign was noted. The right kidney measured 3.75 cm. The left kidney measured 3.4 cm. Blood flow to the kidneys was subnormal on Power Doppler assessment.

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 0.31 cm. The right adrenal gland measured 0.4 cm.

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. The spleen measured 0.91 cm.

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.



PATIENT *Gastrointestinal*

Juice Fesler 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. The mesenteric lymph node was reactive and measured 0.48 cm.

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Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

Chronic interstitial nephrosis pattern with idiopathic medullary rim sign.
Diffuse intestinal thickening.

Otherwise, unremarkable geriatric abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I am concerned for long term viability of the kidneys. 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. Malassimilation of nutrients, occult parasitism and non-visible emerging neoplasia are all possible. FNA of the mesenteric lymph nodes with PCR or PARR evaluation could also be considered. Emerging round cell neoplasia is a potential. From an empirical standpoint if sampling is not an option a clinical trial of the following can be considered.

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Triaditis/Pancreatitis protocol

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

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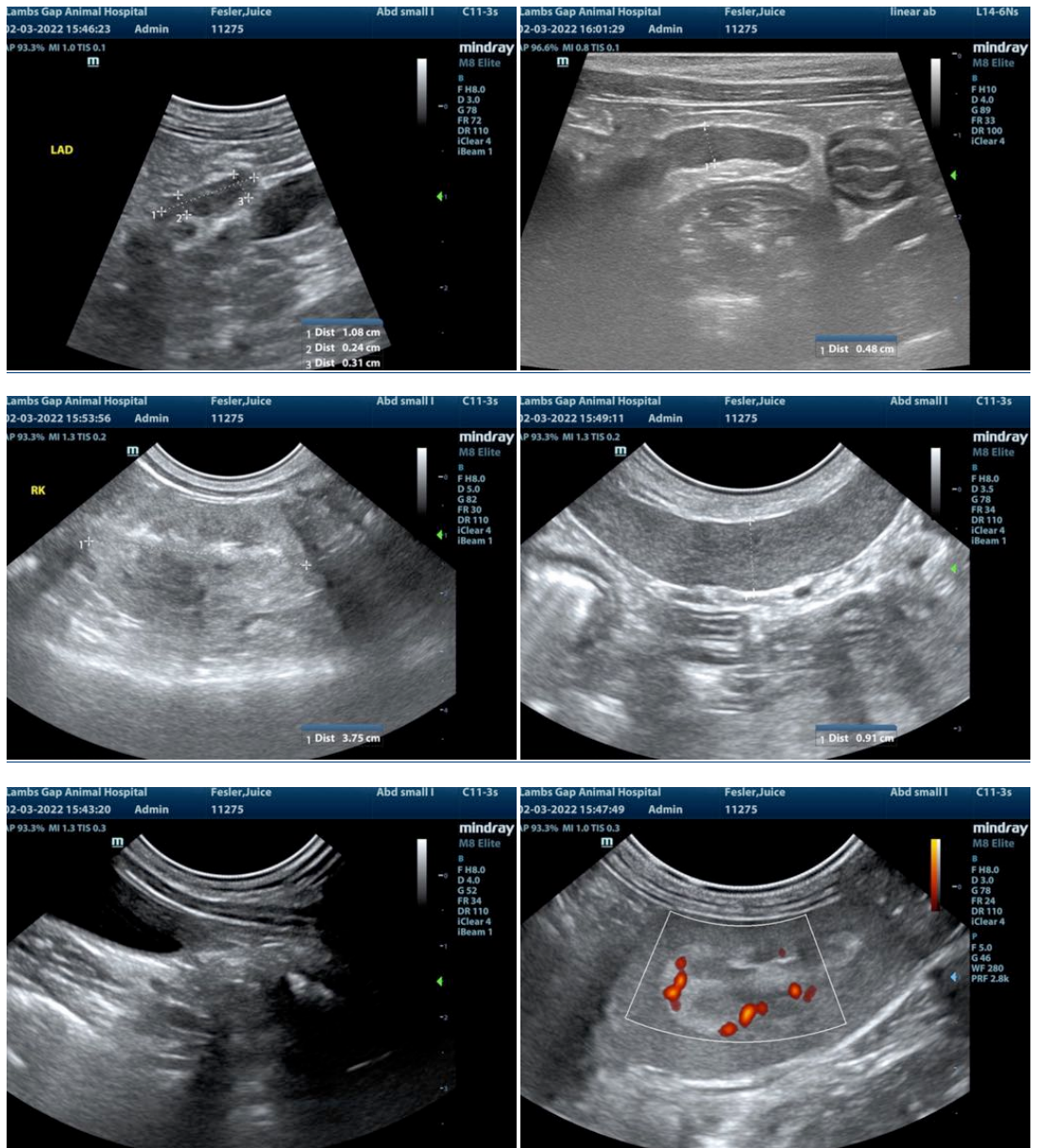
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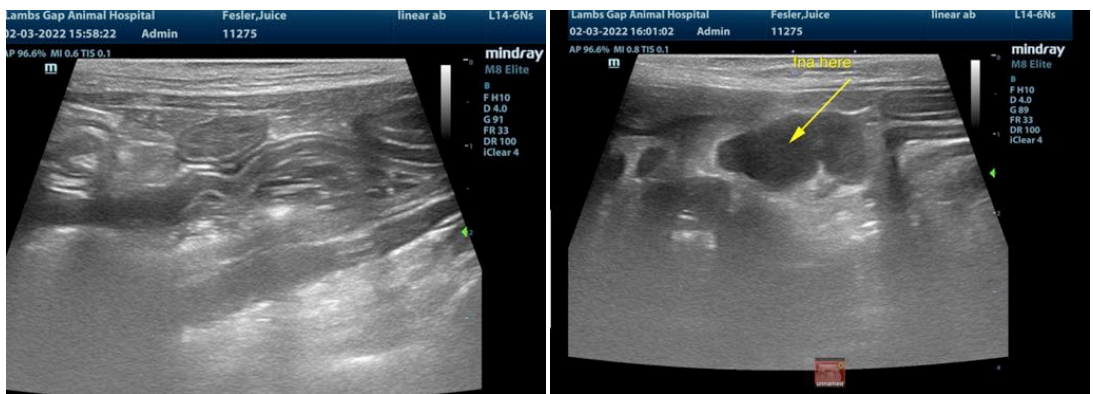
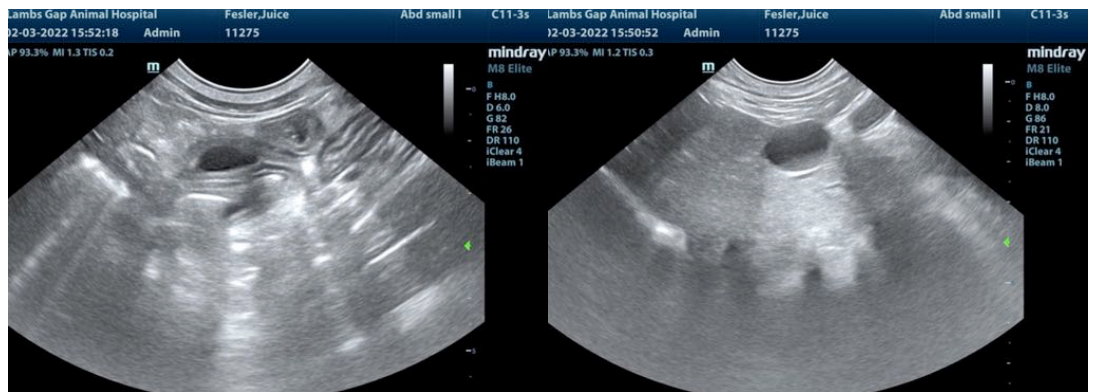
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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