



PATIENT

Alex Giovaniello

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

11 Years

WEIGHT

4.6 kg

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

**IMAGING
PERFORMED BY**

Dr. Callihan

HOSPITAL NAME

Animal Emergency
Care

REFERRING VET

Dr. Ruark

INVOICE

13799

DATE

2/5/22

PRESENTING CLINICAL SIGNS

History: Presented for weight loss despite ravenous appetite over past few weeks. Presently having vomiting and diarrhea No other health issues reported

Abnormal PE/Chem/CBC/UA Results: PE pretty unremarkable; no heart murmur; ambulatory, BCS 5/9; coat and skin appear healthy; Lab 17 - Chem: WNL - CBC: WNL - T4 - 3.3 WNL - UA SpG 1.050 pH 7.0 PRO 30 BLD 25 RBC 31 HPF No bacteria, crystal, or casts Thoracic radiographs unremarkable

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. A minor amount of debris was noted. No evidence of inflammatory or neoplastic changes were 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 moderate chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. A cortical infarct was noted at the cranial pole of the right kidney. The right kidney measured 4.36 cm. The left kidney was similar to the right and measured 4.38 cm.

Adrenal Glands

The regions of the **adrenal glands** revealed no evident pathology.

Spleen

A hyperechoic lipogranulomatous nodule (0.5 cm) was noted in the mid **spleen**. The remainder of the spleen was unremarkable. The spleen measured 0.96 cm in width.

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.

Gastrointestinal

The **stomach** was empty with no evidence of masses. One portion of intestine (approximately 2.0 cm in length) revealed minor excessive thickening with loss of mural detail, maximum wall thickness of 0.49 cm. A portion of colon was also thickened.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some mild parenchymal remodeling, however, with mild deviation from curvilinear normalcy was



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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 subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

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ULTRASONOGRAPHIC FINDINGS

- Age-related renal and pancreatic changes
- Splenic nodule
- Intestinal thickening
- Minor urinary bladder debris

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Intraoperative ultrasound and full thickness intestinal biopsies would be necessary in this patient to assess the potential emerging intestinal lymphoma. Then remainder of the presentation is most consistent with chronic inflammatory bowel and likely history of pancreatitis. If sampling is not an option, a clinical trial of the following may prove effective from an empirical standpoint. Assessment for malassimilation of nutrients warranted. 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.

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Triaditis/Pancreatitis protocol

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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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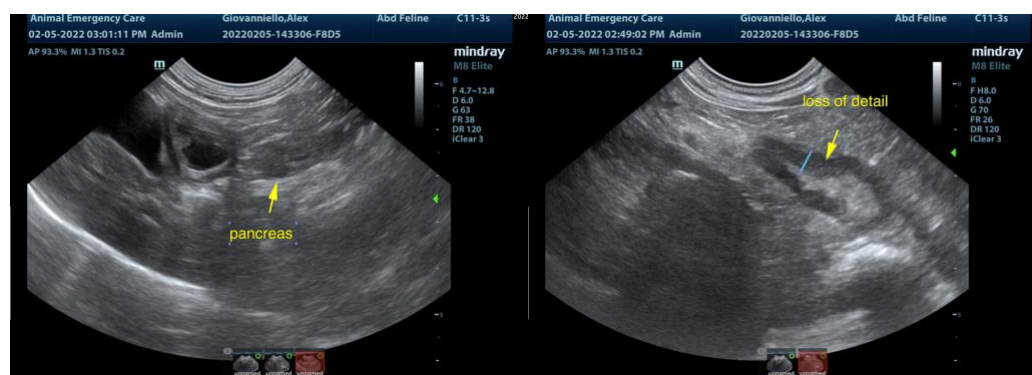
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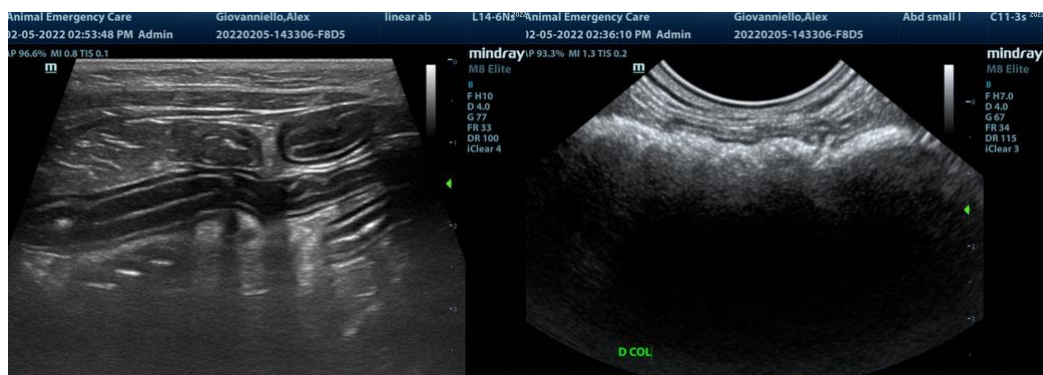
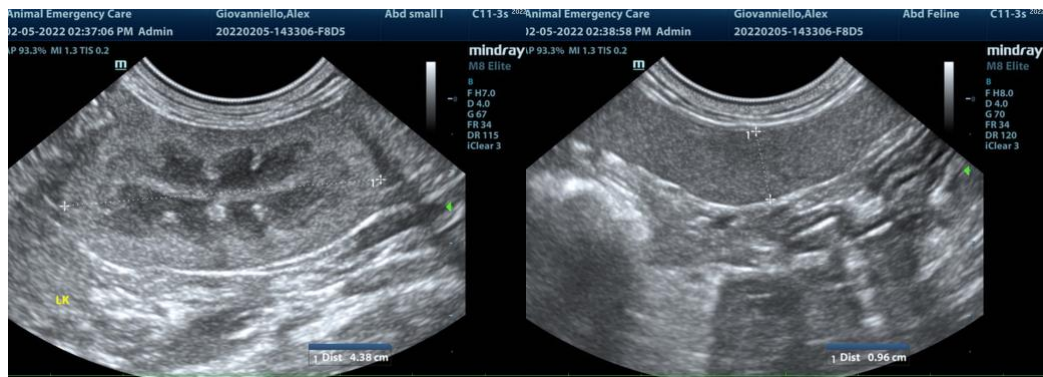
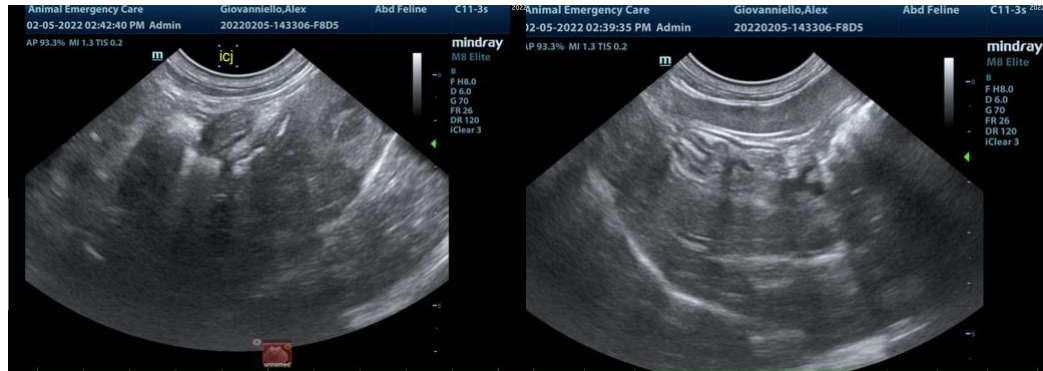
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The information and recommendations provided are based on the images presented by the



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referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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