

**DATE**

4/19/22

**PATIENT**

Simba Turner

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

8/1/20

**WEIGHT**

11.5 Oz

**INTERPRETED BY**Eric Lindquist, DMV  
DABVP, Cert. IVUSS**IMAGING PERFORMED BY**Stephanie Pearce  
RDMS, RVT**HOSPITAL NAME**Cat Sense Feline  
Hospital**REFERRING VET**

Dr. Sinclair

**INVOICE**

37000

**PRESENTING CLINICAL SIGNS**

Has been vomiting on and off shortly after eating the past couple of weeks but now is vomiting without having eaten. This morning he vomited twice, once with a bloody tinge to it. He had had a problem with projectile vomiting that occurred last year and was ultrasounded at that time and nothing was noted. His vomiting resolved with dexSP injections and he was eventually weaned off it and had been fine until the last week of March, when he started to vomit intermittently.

Current Medications: 100mL LRS SQ and 0.9mg Ondansetron SQ.  
Date of Previous IntraPet Ultrasound: 5/30/21. See attached.  
Sedation: Not required to complete full diagnostic ultrasound.  
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 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 right kidney measured 3.9 cm. The left kidney measured 3.58 cm.

**Adrenal Glands**

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

**Spleen**

The **spleen** was progressively enlarged compared to the prior sonogram up to 1.2 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.

**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 intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. Progressive intestinal thickening up to 0.28 cm. Some areas of 1:1 muscularis/mucosal ratio noted. Some reactive mesentery noted around the small intestine. 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.

## **Pancreas**

The **pancreas** revealed slight hypoechoic parenchyma with undulating contour. The right pancreatic limb measured 0.80 cm.

## **ULTRASONOGRAPHIC FINDINGS**

- Prominent, irregular pancreas
- Minor intestinal thickening
- Slight splenic enlargement

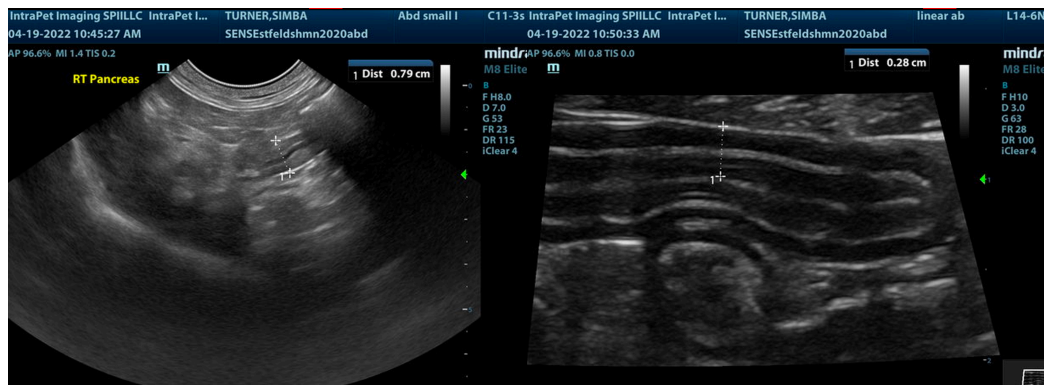
## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

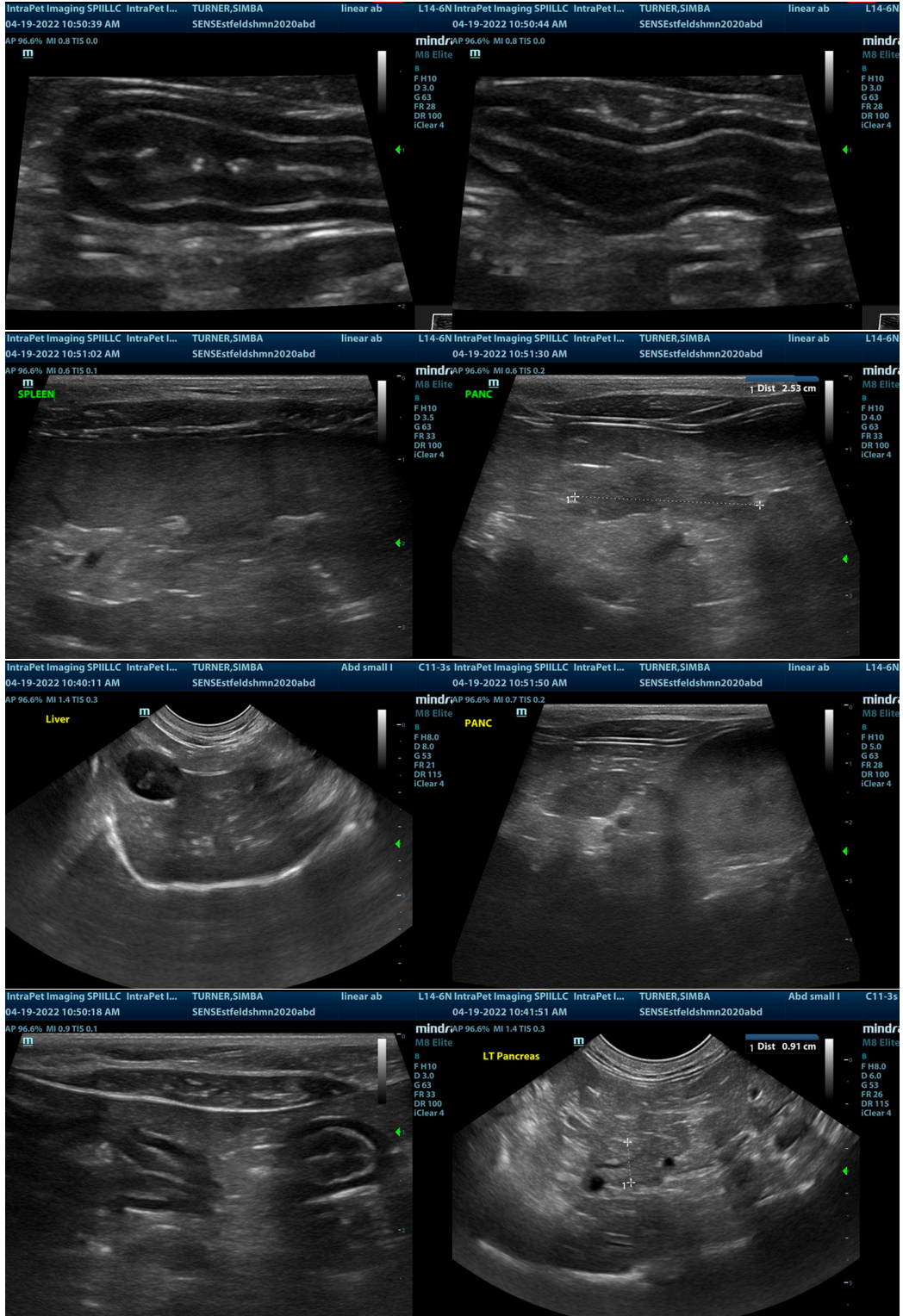
Splenic FNA indicated. No evidence of neoplasia or obstructive disease. Low-grade chronic active pancreatitis and inflammatory bowel likely. A clinical trial of the following may prove effective. Hydrolyzed diet may be in this patient's best interest long-term.

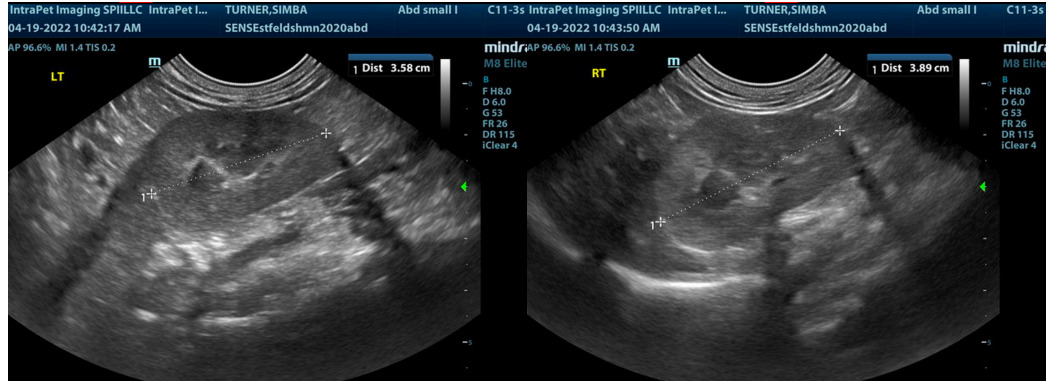
### **Triaditis/Pancreatitis protocol**

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.

**Radiographs: Mild hepatomegaly.**







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](mailto:info@SonoPath.com)