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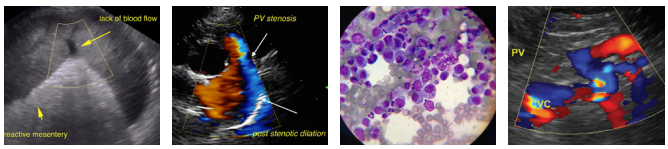

PATIENT

Misty Nugent

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Spayed Female

AGE

7 years

WEIGHT

10.4 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Rosenberg

HOSPITAL NAME

London Cat Clinic

REFERRING VET

Dr. Rosenberg

INVOICE

36792

DATE

4/6/22

PRESENTING CLINICAL SIGNS

History: Inappetence, lethargy started 4 days ago - o had been away but was doing well as per pet sitter. Inappetent first day home, vomited a huge hairball the day after (3 days ago). Vomited yellow fluid 2 days ago, none since. Stool had some fibrous/plant like woody material in it yesterday (did get into old wheelbarrow with old/wet/probably mouldy leaves). Is improving slowly with supportive care (cerenia, mirtazapine, SQ fluids, Convenia, buprenorphine). Generally gets small, infrequent hairballs (every 4 to 6 weeks) and otherwise has been healthy. I am suspicious of esophagitis post hairball but also wonder about something stomach/intestinal.
Abnormal PE/Chem/CBC/UA Results: Hydration good, T N, BAR IC. Abd a bit sore but improved over last couple days. App is slowly improving over last couple days. Blood work all normal including liver, pancreas, CBC. no u/a done. Rads - only able to do lateral abdominal - all wnl

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** 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 3.82 cm. The left kidney measured 3.25 cm.

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.

Spleen

The **spleen** was upper limits of normal at 1.05 cm, unremarkable otherwise.

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. Trace fluid noted between the liver lobes.

Gastrointestinal

Hair density noted in the **stomach**. The pylorus was patent. The small intestine was unremarkable. The colon was slightly thickened with fluid filled lumen.

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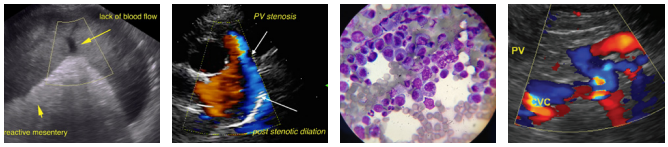

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Pancreas

The **pancreas** revealed undulating contour. The left limb was mildly enlarged at 0.98 cm at maximum width with enhanced surrounding mesentery. Subxiphoid palpation is recommended to assess for pain or discomfort associated with probable pancreatitis.

ULTRASONOGRAPHIC FINDINGS

- Colitis pattern
- Minor pancreatitis
- Hair density in stomach

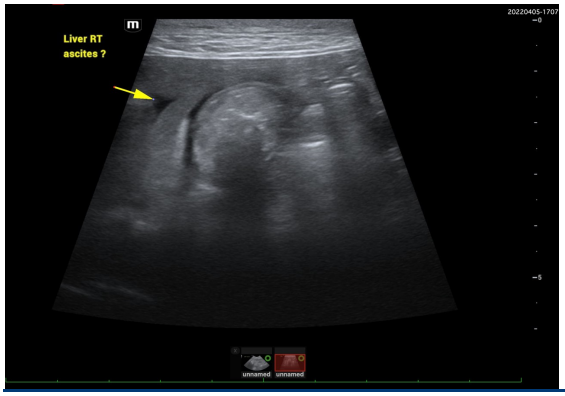
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

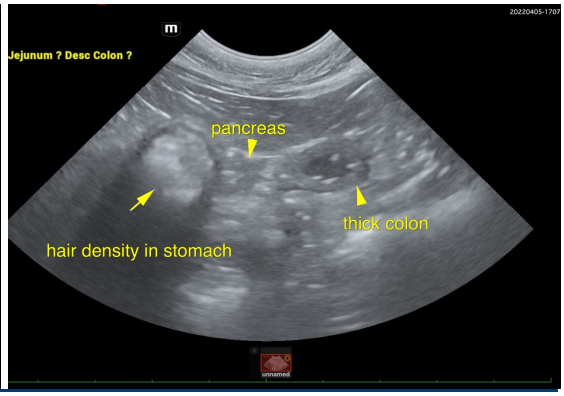
The cause of the slight ascites is unclear in the is patient. This should be monitored carefully. No overt evidence of neoplasia. Fluid may be secondary to abdominal inflammation associated with the colon and pancreas. Supportive care for pancreatitis/colitis indicated. I recommend a fresh fecal smear and fecal floatation analysis. A clinical trial of the following may prove effective. Empirical treatment for hairball accumulation also recommended. No obstructive pattern at this time. Recheck sonogram in 3-5 days, earlier if clinical decline is occurring.

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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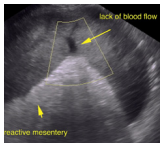

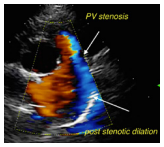

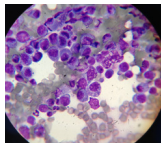
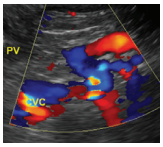

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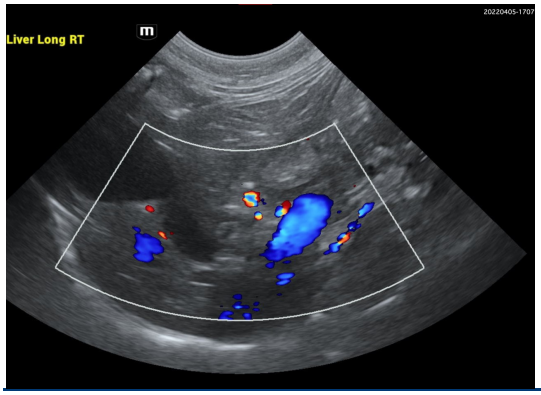

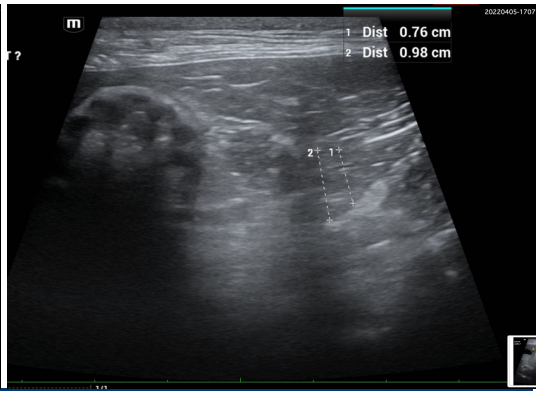

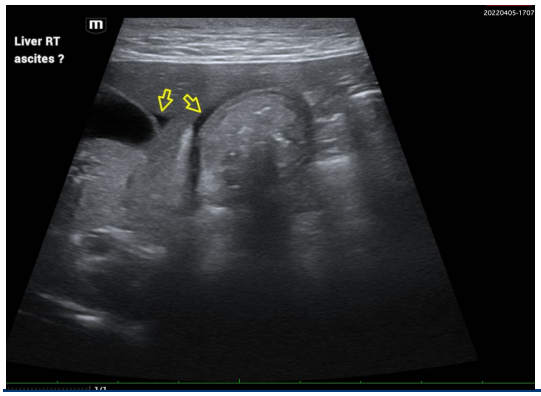

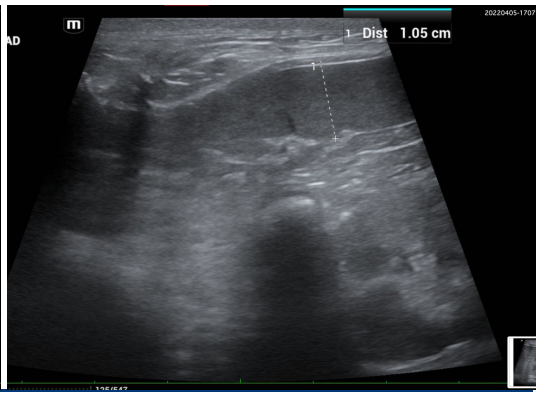

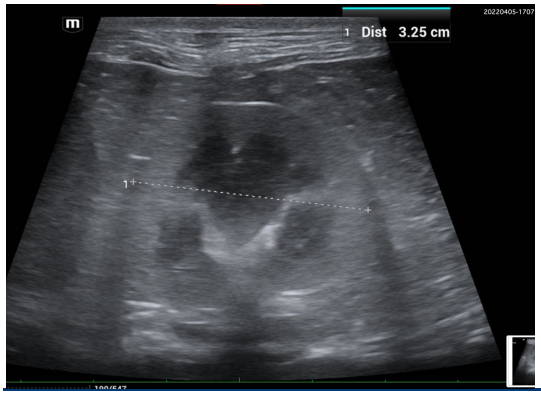

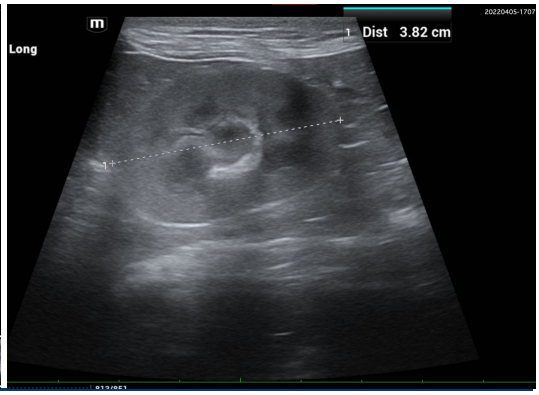

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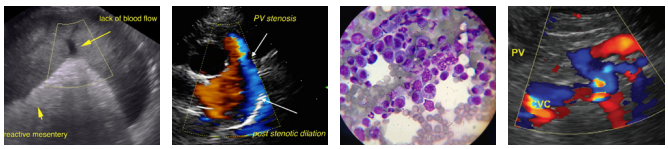

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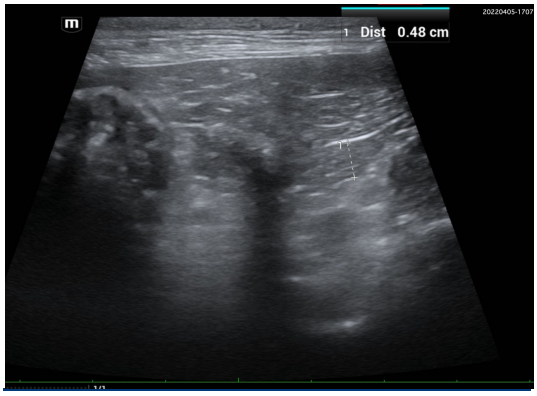

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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