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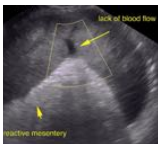

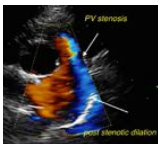

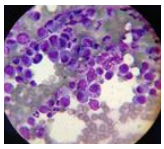
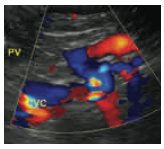

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1-800-838-4268 info@sonopath.com

PATIENT

Maxx Ross

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

15 years

WEIGHT

3.7 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Callihan

HOSPITAL NAME

Animal Emergency Care

REFERRING VET

Dr. Bailey

INVOICE

30776

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PRESENTING CLINICAL SIGNS

S: Patient presents for: Eats 4 small meals daily. Ate last meal last night 11PM and vomited up shortly after. Then continued vomit on/off for an hour, then every couple of hours. Seemed perkier earlier today, ate/drank a little but vomited again/lethargic. Historically sleeps a lot. Last bloodwork 2 years ago, liver values were normal then. Had ultrasound for liver issues ~8 years ago, was unremarkable. History of: Liver issues, constipation, tumours in chest that have been there for 4 years No known medical issues or sensitivities Medications: Cisapride 2.5 mg BID, Metoclopramide 1.25 mg BID, Constulose 1 cc SID-BID, Denosyl 90 mg SID, Milk thistle 1/8 tsp. BID
Abnormal PE/Chem/CBC/UA Results: PE: thin body condition, dull unkempt coat; mild discomfort to caudal abdominal palpation; - Bloodwork = Mild hyperglycemia 205, ALT 154, GGT 5, Chol 297, Amyl 1880, TT4 WNL 1.3, leukocytosis 33,700, neutrophilia 29,100 -Urine: nsf other than isosthenuria 1.020

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction. 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 left kidney measured 3.4 cm. The right kidney measured 3.6 cm.

Adrenal Glands

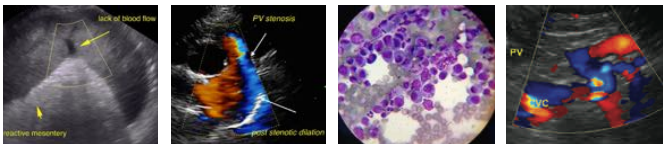
Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 0.4 x 0.8 cm. The left adrenal gland measured 0.77 x 0.4 cm.

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 was noted. The spleen measured 0.8 cm.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Slight, cystadenomatous type lesion was noted in the left cranial liver measuring approximately 2.0 cm with ill-defined margins. Some age-related parenchymal remodeling



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was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. The distal small intestine was mildly thickened in this patient with areas of early loss of mural detail and muscularis hypertrophy. . The mesenteric lymph nodes are enlarged and measured up to 1.0 x 0.5 cm with reactive mesentery.

Pancreas

The **pancreas** was hypoechoic and irregular with a mildly enhanced surrounding mesentery. The left limb was mildly enlarged and measured up to 1.2 cm in the left limb. Undulating contour was noted with nodules and duct dilation. The right limb of the pancreas was also enlarged and irregular.

ULTRASONOGRAPHIC FINDINGS

Pancreatitis. Chronic active formation with mesenteric lymphadenopathy/lymphadenitis.

Enteritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pancreatitis, lymphadenitis and enteritis is all likely. There is a possibility of emerging round cell neoplasia. FNA of the pancreas and mesenteric lymph nodes are recommended with cytology and culture of the lymph nodes. 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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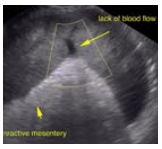
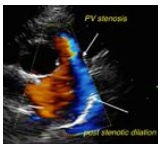
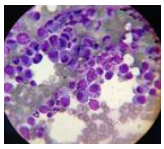
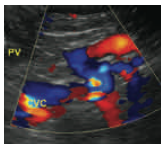

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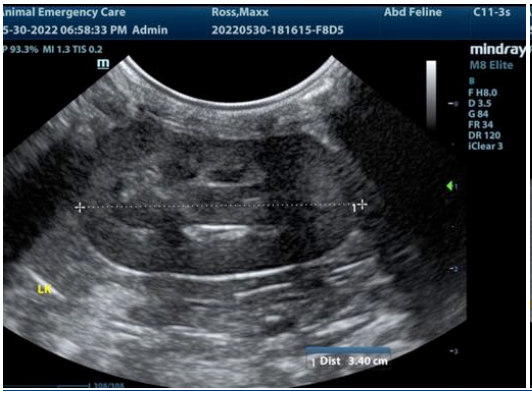

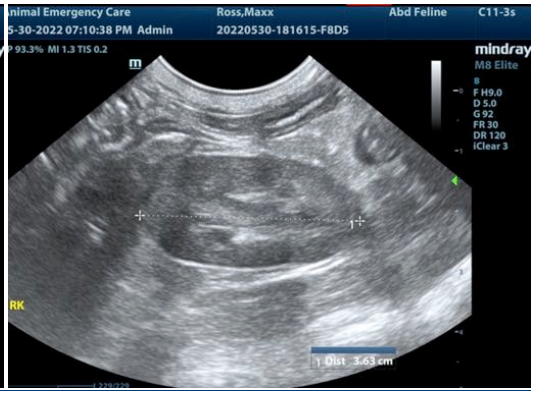

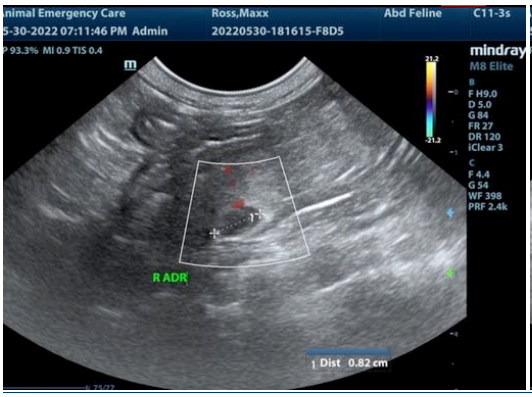

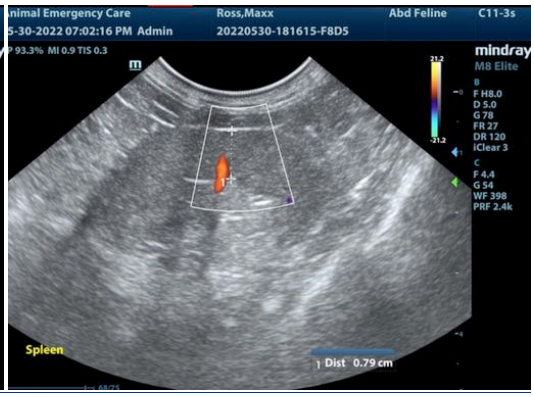

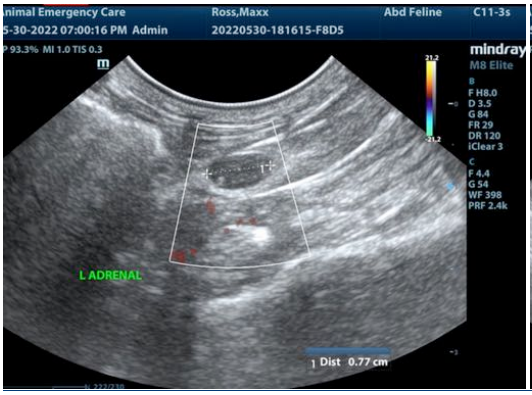

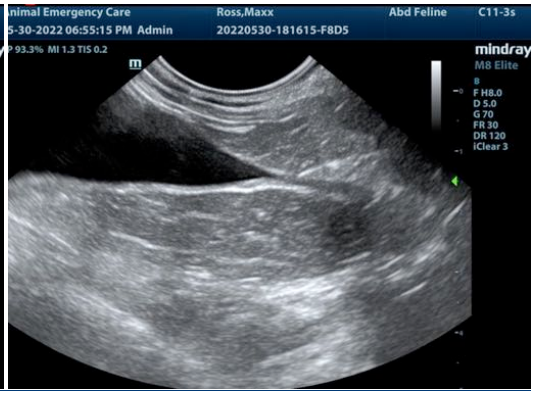

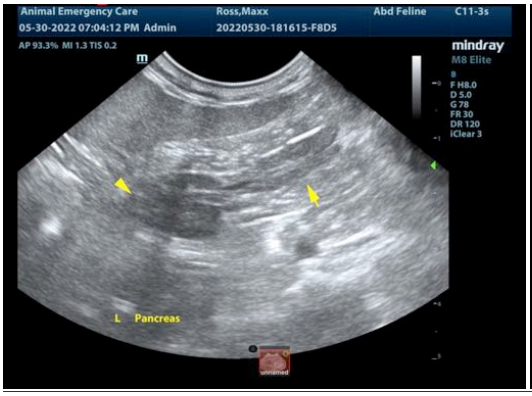

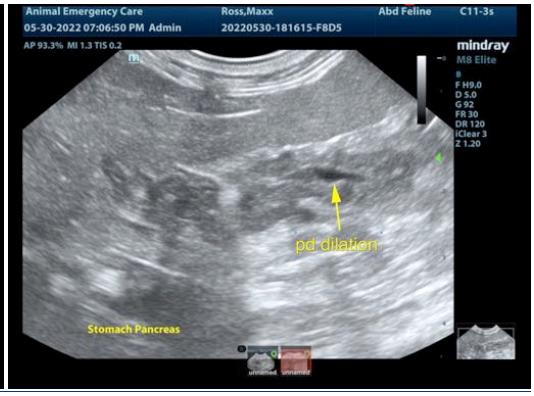

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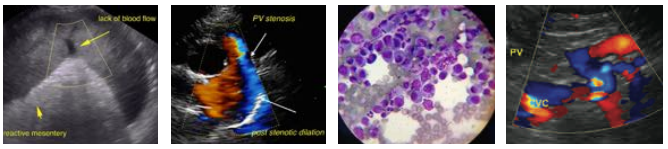

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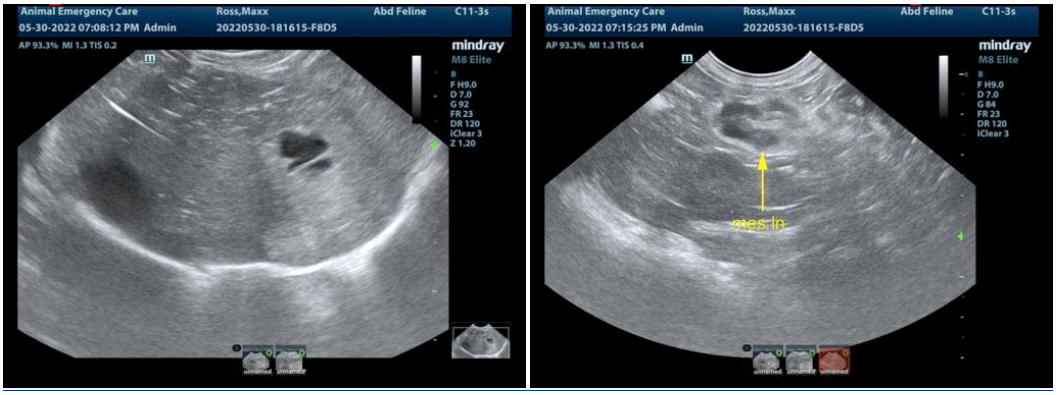

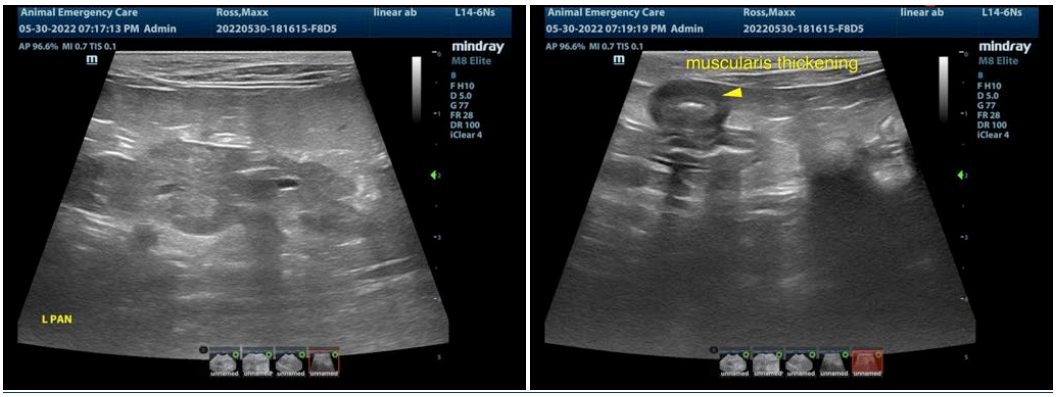

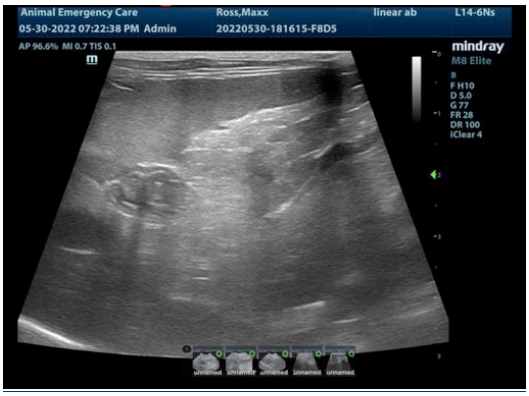

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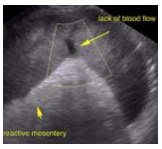

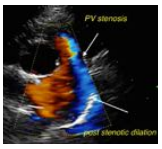

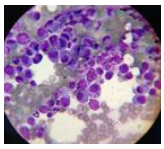
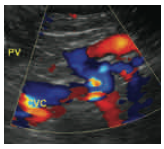

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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