IMAGING PERFORMED BY

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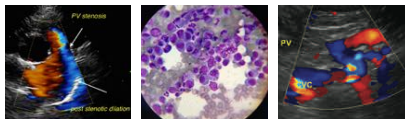

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE
6/7/22

PATIENT
Dixie Stevens

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Spayed Female

AGE
4/24/13

WEIGHT
5.5 lbs

INTERPRETED BY
Eric Lindquist, DMV
DABVP, Cert. IVUSS

HOSPITAL NAME
Friendly Paws VC

REFERRING VET
Dr. Price

INVOICE
30903

PRESENTING CLINICAL SIGNS

Weight loss, vomiting, inflammatory response. PE: BCS 2.5/9, 2+ calculus, stage 2 periodontitis.
Current Medications: None.
USG 1.041, pH 6.0, protein 2+, chem -, micro - creat 0.6 (0.8-1.7), Glob 6.0 (2.6-5.1), Lipa 91 (0-32), T4 1.5, WBC 39.5, mono 2.51 (0-1.5), Neut 30.48, Hct 25.5
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Tiletamine / Zolazepam 0.05cc, Butorphanol 0.1cc, midazolam 0.1cc.
Stat Report: Not requested.
Imaging Performed By: Stephanie Pearce RDCS, RVT.

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 largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. Blunting of the caudal pole of the right kidney was noted and likely owing to infarct. The right kidney measured 3.08 cm. The left kidney measured 3.61 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 0.39 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.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Minor hepatic vein dilation was noted. The biliary tracts were normal. 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 free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Transit of chyme into the small intestine appeared to be unremarkable. Variable intestinal thickening was noted without neoplastic criteria. This is likely owing

to chronic inflammatory bowel. Areas of mucosal fogging were noted. The mesenteric lymph node measured 4.0 x 1.5 cm.

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.

Free Abdomen

There was a trace amount of free fluid likely owing to passive congestion.

ULTRASONOGRAPHIC FINDINGS

Mild hepatic vein dilation, may be owing to sedation or aggressive fluid therapy.
Minor amount of free fluid noted.
Reactive mesenteric lymphadenopathy.
Chronic inflammatory bowel with malassimilation.
Otherwise, geriatric abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No obvious neoplastic criteria was present; however, this cannot be completely ruled out. Mesenteric lymph node FNA, cytology and culture and PCR would all be appropriate. Malassimilation of nutrients may be an issue. A clinical trial of the following may prove effective.

Triaditis/Pancreatitis protocol

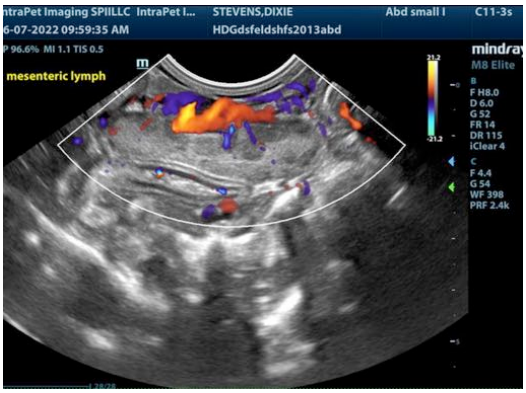
Part or all of this protocol may be considered based on your clinical impression of the patient:
Recommend pain management when anorexic with **Buprenorphine** (0.01-0.02 mg/kg IM or SC), clinical trial of **Zithromax** (50 mg sid/cat x 10 days, 3 weeks if bartonella +), **Prednisolone** (0.5-2 mg/kg 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.


Liver
M8 Elite


STOM
M8 Elite


RT Adrenal
Dist 0.39 cm
M8 Elite


RT
Dist 3.08 cm
M8 Elite


mesenteric lymph
M8 Elite


mesenteric lymph
Dist 3.96 cm
M8 Elite


LT Pancreas
Dist 0.88 cm
M8 Elite


LT
Dist 3.61 cm
M8 Elite

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