



PATIENT

Moonah Tihista

SPECIES

Feline

BREED

Ragdoll

SEX

Spayed Female

AGE

11 Years 6 Months

WEIGHT

6.26 Pounds

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Ave Vet

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

39695

DATE

7/20/22

PRESENTING CLINICAL SIGNS

subjective: first time here not eating, lost a lot of weight spends a lot of time under the bed only food o has been able to get p to eat is tuna and canned chicken, tea spoon or less at a time this has been going for about two and a half weeks, but has been losing weight longer than that metronidzol mirtazapine o just lost another kitty long ago, moonah doesnt sit with o very much, doesnt like to be held the last time she ate was this morning, had a couple licks last night had a half of a tea spoon coughs while she eats seems very weak, o does not notice any pain, doesnt meow at full strength been between D+ and soft e/d- drinks water v/d- vomitted two days ago for the first time o has seen, white clear foam c/s- just coughing while she eats l/b- none indoor only litterbox- good concerns- none jk Objective QAR. Eyes mild debris. Teeth G2 tarter. pale mm. CRT <3s. Heart tachycardia, irregular. Past murmur detected but difficult to fully assess given HR. Lungs clear. Abd doughy on palpation, gas present. Bladder palpable. BCS 3/9- sarcopenia, muscle loss present. Skin and coat appear healthy CBC NSF Chem elevated BUN, hyperglycemia SDMA elevated, T4 WNL Abnormal SDMA Assessment Historic heart murmur/tachycardia- RO cardiac cachexia, other Diarrhea/weight loss- RO infiltrative GI disease, other Anorexia Plan Disc previous bloodwork and recommend work-up today. 90% of former energy. Unwilling to eat beyond a lick. Did have another cat in the home Stella (not related) that passed in November with similar signs. Another cat Duke in the home and no signs (littermates) O consented to imaging. Plan to move forward with US and chest US JME

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 pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

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 chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. A cortical infarct was noted in the cranial pole of the left kidney. The left kidney measured 3.0 cm. The right kidney was subnormal in size and presented pyelectasia and mineralization, measuring 2.7 cm. Pericapsular inflammatory pattern noted.

Adrenal Glands

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

Spleen

The **spleen** in this patient was uniform, yet volume contracted. Hydration status should be assessed.

Liver

The **liver** was diffusely hyperechoic to falciform fat. The gallbladder and common bile duct were unremarkable. This is most consistent with hepatic lipodosis.

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,



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chronic disease. 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.

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Pancreas

The **pancreas** presented generalized enlargement, a dilated duct and mild undulating contour. Echogenic debris present. Enhanced surrounding mesentery noted.

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Heart

The heart presented subjectively normal chamber sizes, structure and volume. Function was normal. No evidence of cardiac disease.

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PRIMARY FINDINGS

- Enlarged, irregular pancreas with regional inflammation
- Renal dystrophy and mineralization as well as infarcts
- Diffuse intestinal thickening, no neoplastic criteria met

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SECONDARY FINDINGS

- Volume contracted spleen
- Hepatic lipidosis liver pattern

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Chronic inflammatory bowel with pancreatitis likely. A clinical trial of the following may prove effective:

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Triaditis/Pancreatitis protocol

DABVP, Cert. IVUSS

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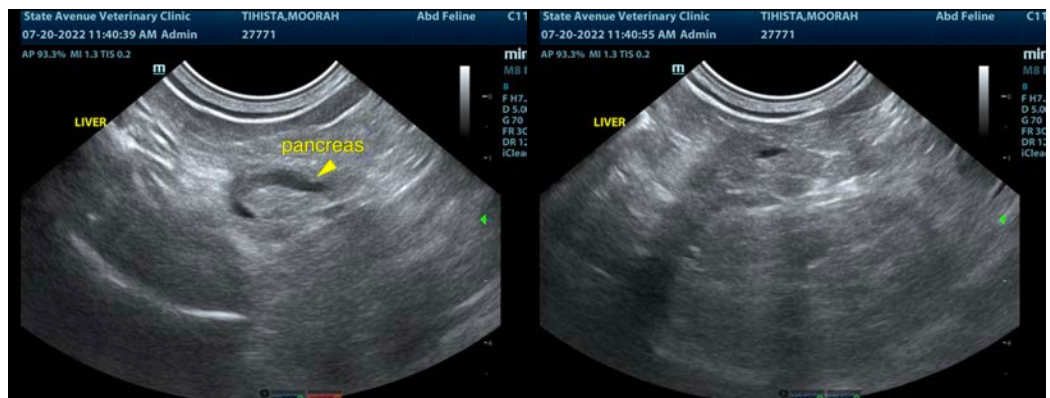
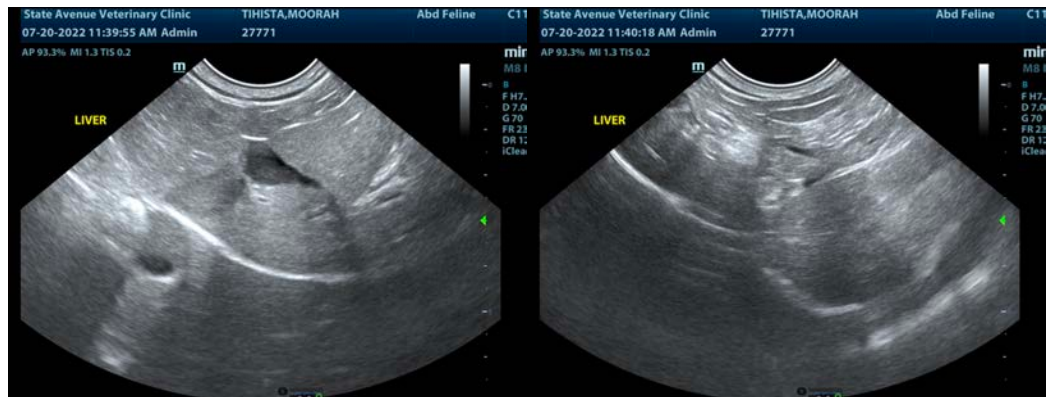
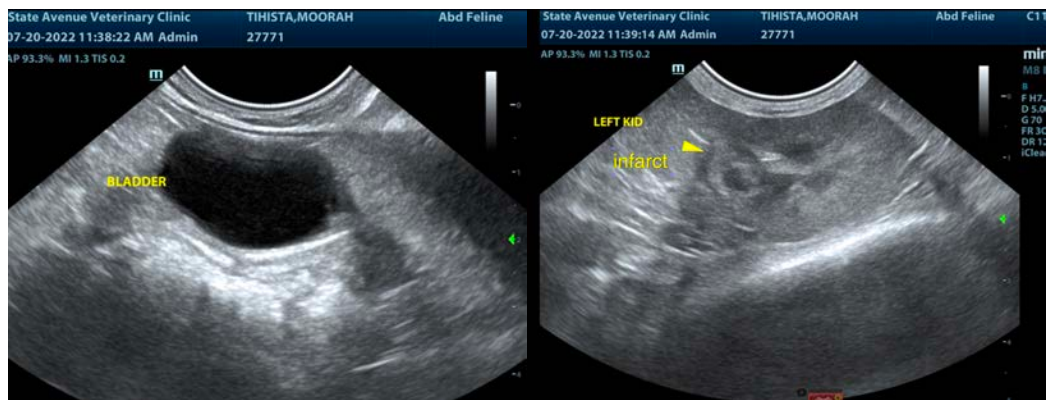
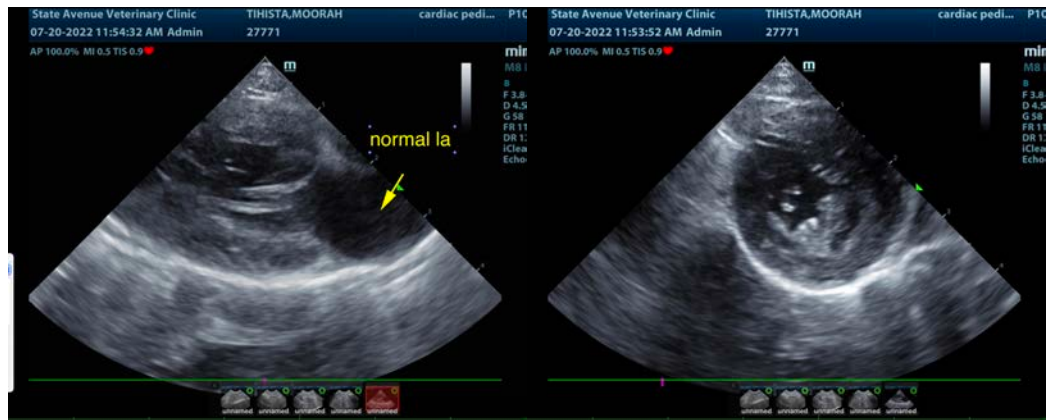
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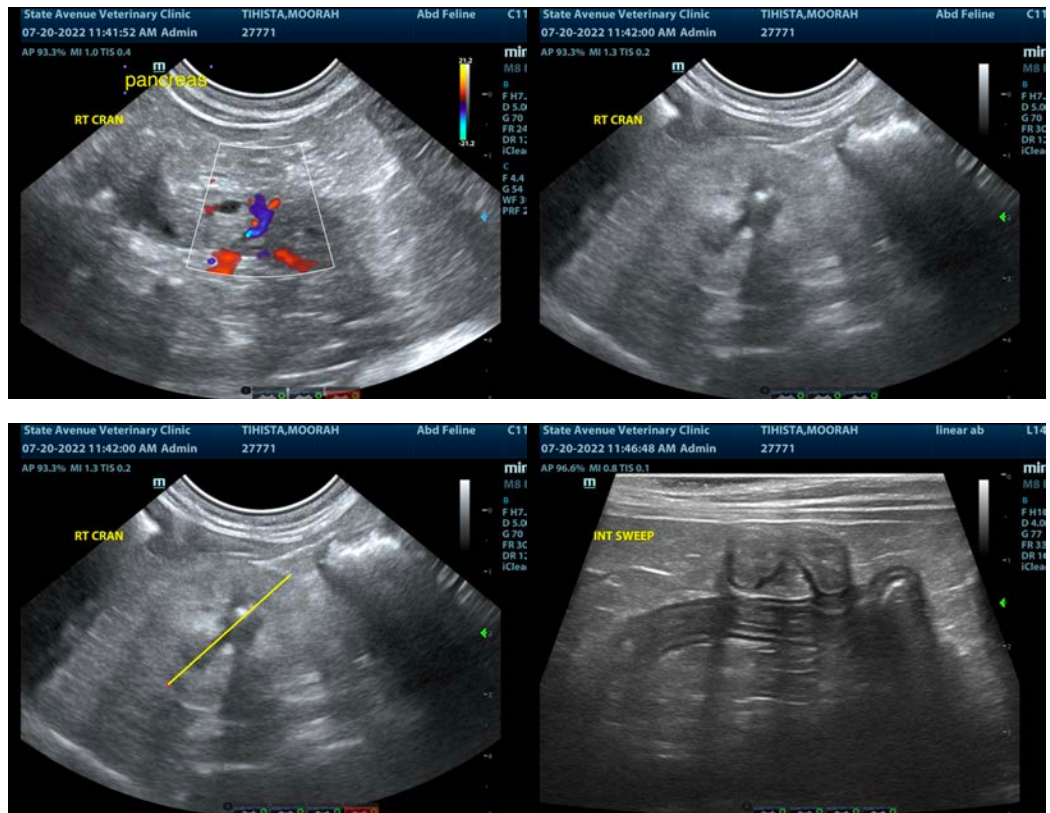
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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