SonoPath
Clinical Sonography & Telecytology
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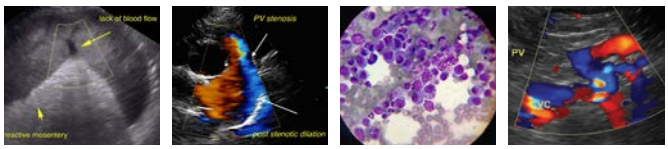

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1-800-838-4268 info@sonopath.com

PATIENT
LB Lepselter

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
8 Years

WEIGHT
N/A

INTERPRETED BY
Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
Westwood Regional

REFERRING VET
Dr. Taylor McConnell

INVOICE
24718

DATE
8/16/21

PRESENTING CLINICAL SIGNS

Inappetence, lethargy, severely anorexic, R/O GI lymphoma vs. hyperthyroidism, vs. other. Current meds: IVF, Cerenia, and famotadine. Prior U/S 7/14/21 revealed chronic triad presentation, intestinal thickening, regional lymphadenopathy.
Abnormal PE/Chem/CBC/UA Results: Blood work: pending.

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** 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. Slight corticomedullary rim sign noted. Slight pyelectasia noted. The right kidney measured 3.99 cm. The left kidney measured 3.44 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having largely normal shape, size, position and acceptable echogenicity for this age group and breed. Some heterogeneity was noted within the adrenal parenchyma without concerning capsular distortion. These changes are likely age related but should be monitored by sonogram should the patient be suspected of having adrenal disease. The right adrenal gland measured 0.47 cm. The left adrenal gland measured 0.49 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 were noted. The spleen measured 0.61 cm.

Liver

The **liver** revealed coarse architecture and increased portal markings. The gallbladder was unremarkable. The portal vein was mildly congested. Hepatic lymph nodes were slightly enlarged, reactive.

Gastrointestinal

The **gastric** wall was progressively thickened. Variable intestinal thickening noted without loss of mural detail. However, enteritis is likely. Soft stool noted in the colon. Mesenteric lymph nodes were hypoechoic and mildly irregular, measuring 1.07 cm x 0.93 cm.

Pancreas

Chronic **pancreatic** changes noted with dilated and tortuous duct. Undulating contour noted.

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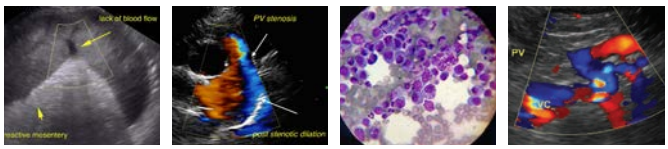

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ULTRASONOGRAPHIC FINDINGS

- Chronic interstitial nephritis renal pattern with medullary rim sign
- Increased portal markings and slightly enlarged hepatic lymph nodes
- Progressively thickened gastric wall and variable intestinal thickening with reactive mesenteric lymph nodes
- Chronic pancreatic changes with dilated and tortuous duct

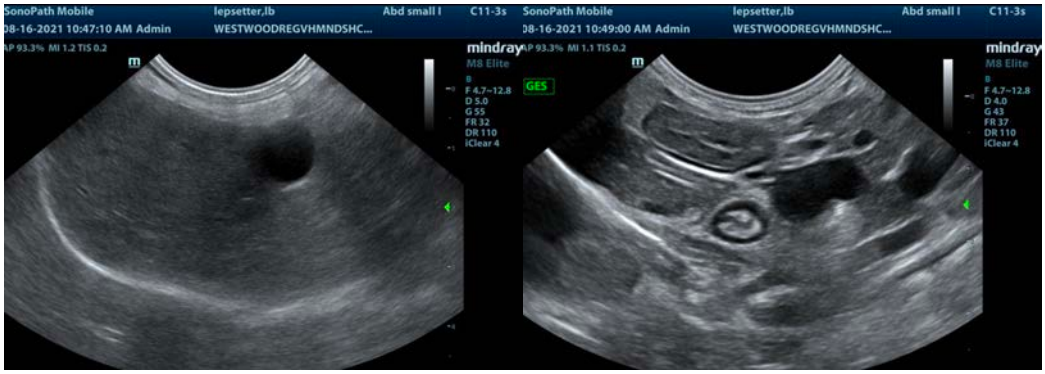
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The triad presentation appears to be mildly progressed from the prior sonogram. However, neoplastic criteria is still not present. There is a mild potential for underlying dry form FIP in this patient given the medullary rim sign. Occasionally these chronic triad type presentations are actually dry form FIP. Given the persistent clinical signs, I strongly recommend a surgical approach to biopsies of the pancreas, liver, gastrointestinal tract and lymph nodes as well as the kidney to assess the overall presentation and rule out underlying granulomatous disease/FIP. FNA of the liver, kidneys +/- pancreas could be considered, yet would not be as definitive. Therefore, surgical biopsies are recommended. Feeding tube placement could be considered at that time if necessary. Treatment for pancreatitis/triad disease warranted in the meantime. 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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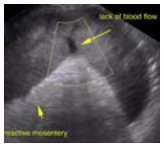
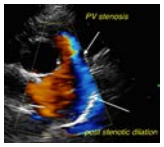
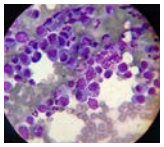
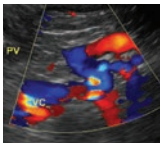

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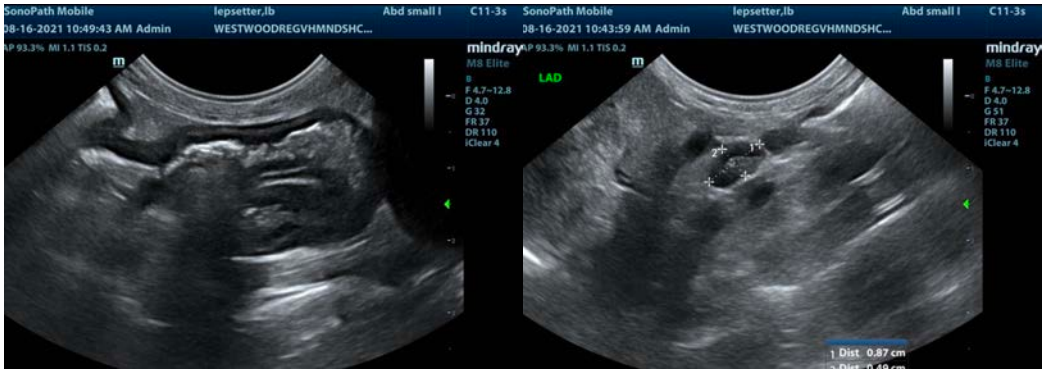

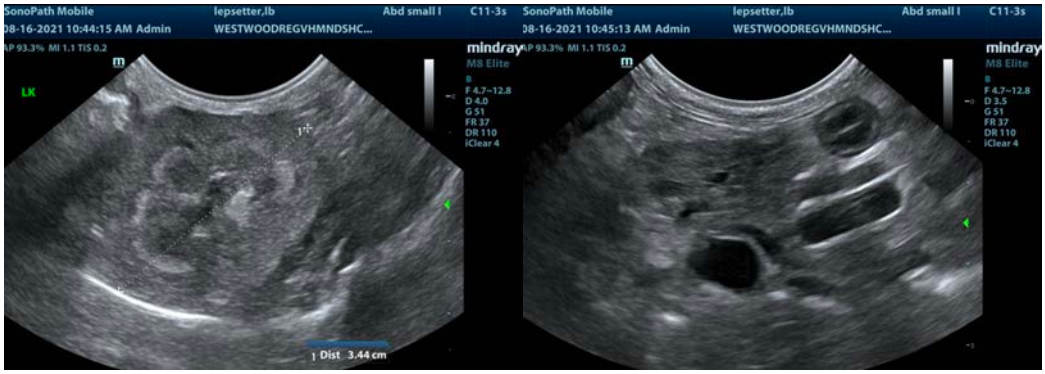

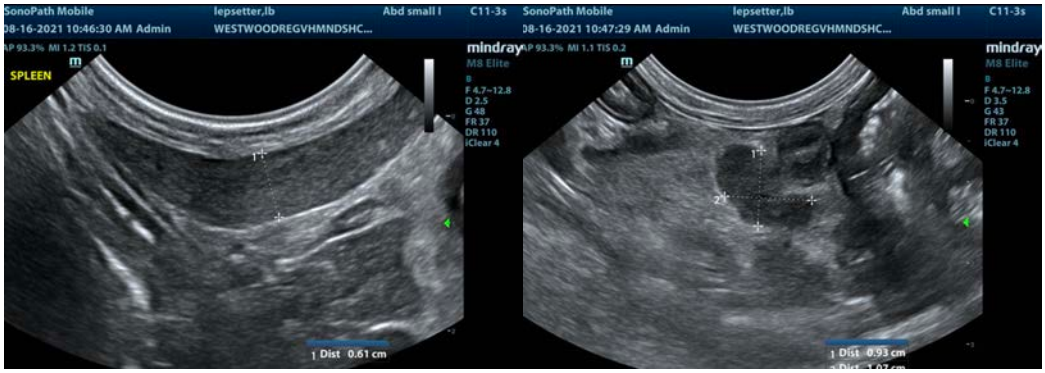

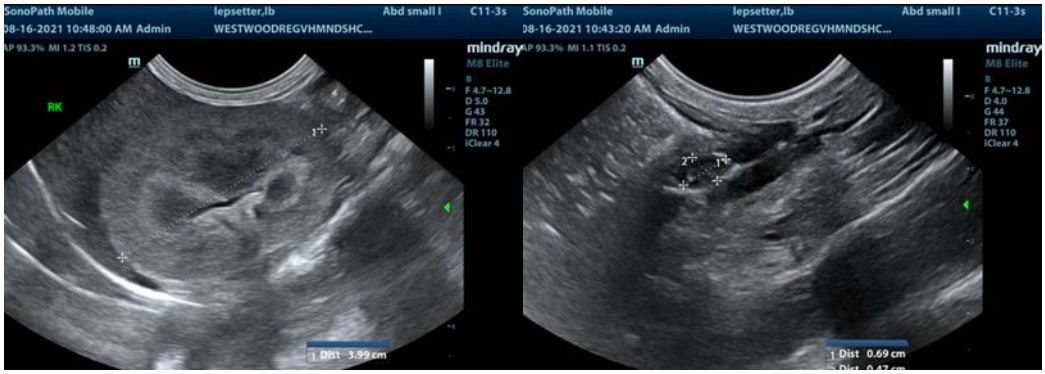

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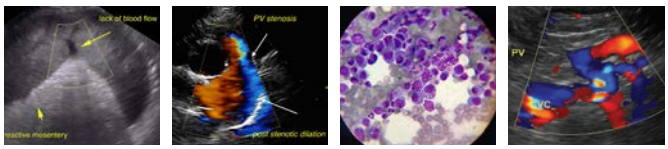

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com