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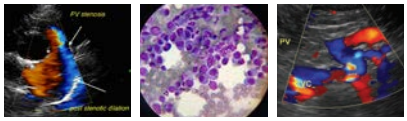

SonoPath
Clinical Sonography & Telecytology
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DATE

6/8/22

PATIENT

T'challah Patterson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7/31/18

WEIGHT

11.6 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Andi Parkinson RDMS

HOSPITAL NAME

Timonium AH

REFERRING VET

Dr. Falkowski

INVOICE

38512

PRESENTING CLINICAL SIGNS

5/19/22: Presenting for 1lb of weight loss since 11/21. Unsure if P eating well in multi-cat household. No vomiting or diarrhea. PE: Mild tartar; remaining exam unremarkable.

Current Medications: None.
Lab Results: Bloodwork 5/19/22: CBC: wnl. Chemistry: Mild hypoglobulinemia 2.9g/dL Ddx: PLE, malabsorption, malnutrition
Cardiopet ProBNP: 49pmol/L. UA (cysto): USG 1.052, pH 6.0, inactive sediment, T4: 2.2ug/dL, fT4: 1.1ng/dL, FeLV/FIV/HW: neg x 3.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.84 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.71 cm), but slightly irregular in shape (likely due to previous infarct). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measured 0.16 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

- Suspect previous right renal infarct – The solitary renal lesion identified is ill defined and hyperechoic, this could be consistent with a previous renal infarct and can be an indicator of current or previous renal disease.

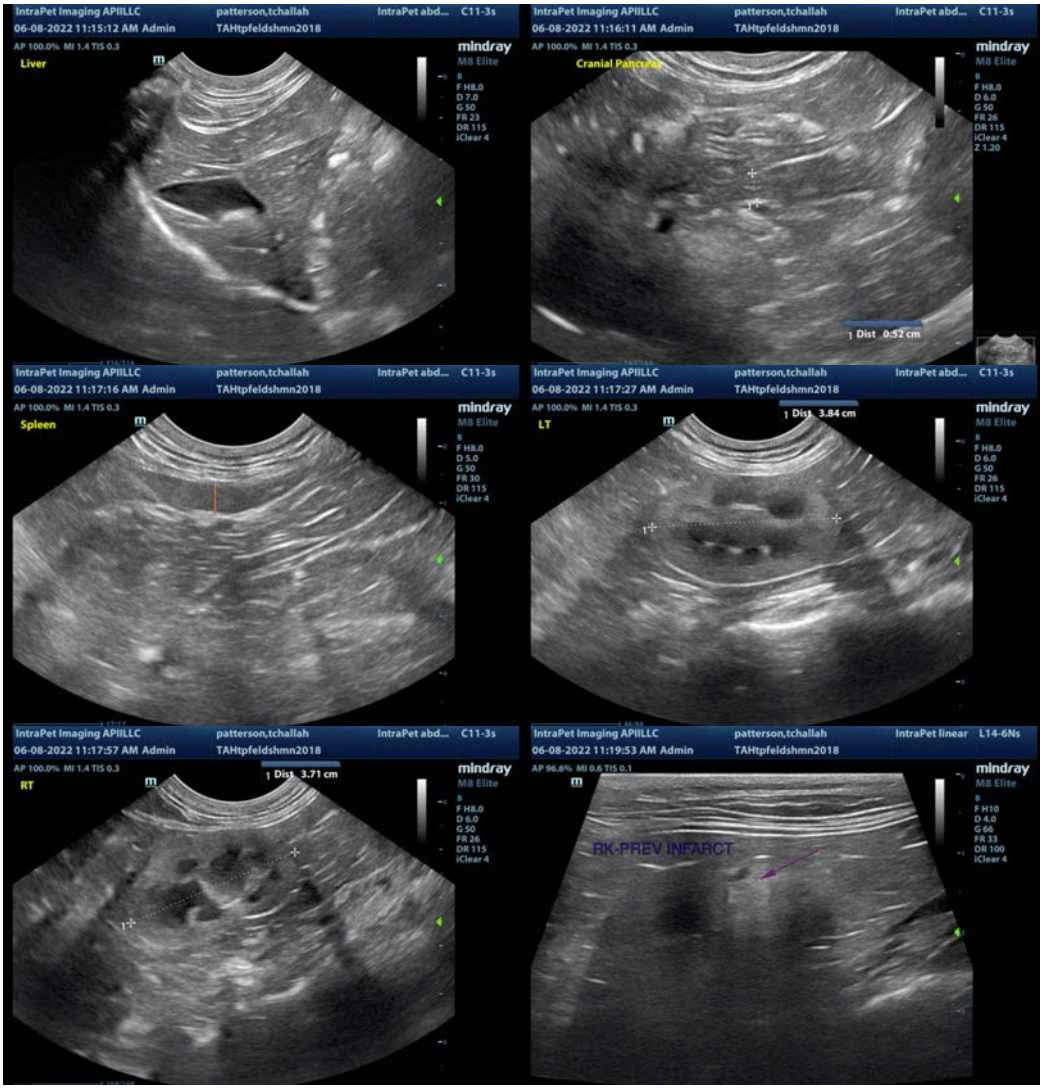
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan is relatively normal. An obvious cause for the reported weight loss is not visualized. The pancreas appears somewhat prominent, but not overtly inflamed. If there is concern for pancreatic disease, consider a quantitative fPLI. Additionally, there is some irregularity to the right kidney, most consistent with a previous infarct. This can be associated with renal disease, hypertension, etc. (renal values and USG looks good).

If not other cause is observed, then consider the possibility of primary gastrointestinal disease. You could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to look for evidence of underlying pancreatic or small intestinal disease, exocrine pancreatic insufficiency, etc.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider chronic probiotic therapy.
- Recommend screening and treatment for GI parasitism (if not already done).
- Recommend the aforementioned GI panel.
- If the GI panel is indicative of small intestinal disease, you could consider obtaining GI biopsies.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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.

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