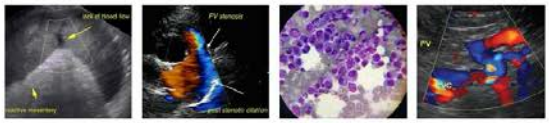


PATIENT

Trouble Dunn

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years 2 Months

WEIGHT

9.71 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

VCA Feline AC

REFERRING VET

Dr. Renee Dippon

INVOICE

25956

DATE

9/30/21

PRESENTING CLINICAL SIGNS

anorexia- Presented for recheck sedated abdominal ultrasound with aspirates if indicated. Owner requests oropharyngeal and laryngeal exam; is concerned that region may be contributing to anorexia. Recently evaluated at SVS for second opinion on oral exam, confirmed dental disease unlikely to be contributing to anorexia and was recommended to consult with internist and re-evaluate abdominal ultrasound. PPH: Previously diagnosed EPI Suspected IBD Splenomegaly (reactive) Concern for emerging DM (fructosamine Aug. 2021 was WNL at 344) Overgrooming Intermittent anorexia weight loss Current medications: Prednisolone 2.5 mg PO in the AM, 5 mg PO in the PM PancreaPlus 50 mg PO BID Cobalequin PO q48h Cyproheptadine 1 mg PO q24h PRN Famotidine 5 mg PO q24h in AM Cerenia 4 mg PO q24h in PM
Abnormal PE/Chem/CBC/UA Results: BG in house was 412 (cat does stress) back in August but fructosamine was 344- and when sent out to LAB repeated BG was 167. August LABS WBC 3.0 RBC 7.4 HGB 8.9 HCT 30 % MCV 40 37 - 61 fL MCH 12.1 11 - 21 pg MCHC 30 30 - 38 g/dL Poikilocytosis Slight Blood Parasites None Seen Platelet Count 113 200 - 500 10^3/uL Platelet count reflects the minimum number due to platelet clumping. Platelet Estimate Adequate Neutrophils 84 35 - 75 % Bands 0 0 - 3 % Lymphocytes 13 20 - 45 % Monocytes 3 1 - 4 % Eosinophils 0 2 - 12 % Basophils 0 0 - 1 % Absolute Neutrophils 2520 2500 - 8500 /uL Absolute Lymphocytes 390 1200 - 8000 /uL Absolute Monocytes 90 0 - 600 /uL Absolute Eosinophils 0 0 - 1000 /uL Absolute Basophils 0 0 - 150 /uL Comment COBALAMIN >1000 290 - 1500 pg/mL FOLATE 8.2

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (4.05 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 has a normal shape and size. 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. A non-obstructive nephrolith is noted measuring 0.44 cm. Mild pyelectasia is noted at 0.18 cm. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

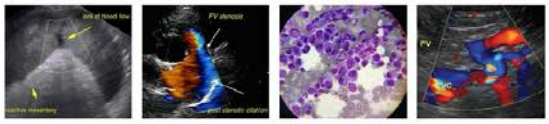
Adrenal Glands

The left adrenal gland is normal in size measuring 0.35 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.37 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is large in size and rounded, measuring 1.41 cm (measured in diameter at the level of the hilus). Previous measurement on 6/1/21 was 1.2 cm. The spleen echotexture is heterogenous and



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mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a small area of hypoechoic, somewhat mottled tissue measuring 1.35 cm x 0.78 cm near the tail of the spleen. This is either a splenic lesion or abnormal pancreatic tissue adjacent to the spleen.

Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. 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. In one view there is a 0.37 cm shadowing structure near the gallbladder neck/proximal bile duct .There is no evidence of an obstruction in this area, and it was not visualized in all views.

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 0.21 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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis. The pancreatic duct is prominent and measures 0.17 cm.

Free Abdomen

Scant free fluid is present. No lymphadenopathy. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is generally of normal uniform echogenicity.

Other

A brief view of the heart was submitted. No significant pericardial effusion was seen.

PRIMARY FINDINGS

- Large, mottled spleen with rounded, irregular margins – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

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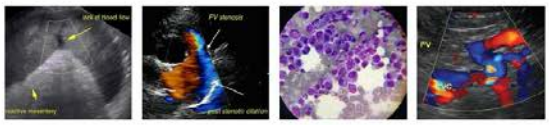

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- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Hypoechoic prominent pancreas with prominent dilated pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Focal hypoechoic lesion adjacent to the spleen – This could represent a splenic mass or adjacent pancreatic tissue.

SECONDARY FINDINGS

- Echogenic urine in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Mild pyelectasia and non-obstructive nephrolith in the right kidney – The hyperechoic mineralized foci observed at the corticomedullary junction of the right kidney are consistent with small, non-obstructive nephroliths. Pyelectasia of the right kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Scant amount of anechoic abdominal fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although there is no clear mass effect or lesion to explain the reported anorexia, the spleen does appear somewhat larger and rounder on today's scan, and it appears more mottled. The pancreas remains prominent. This has been a longstanding finding that I suspect is somewhat due to previous remodeling, etc. The liver subjectively appears larger and more heterogeneous. This could be due to progressive disease or an incidental finding. Consider the following:

- Fine needle aspirate of the spleen – This could potentially be of benefit even if it was done before and was benign.
- Correlate findings with liver values. If liver values are normal, the changes observed are less likely to be significant. If liver enymes are elevated, you could consider a fine needle aspirate or liver function test.
- Recommend urinalysis and culture due to the mild right-sided pyelectasia and the echogenic debris in the urinary bladder.

Other considerations are progression of the IBD, which may not show significant ultrasonographic changes (particularly while taking Prednisone). You could consider re-biopsy of the small intestine and stomach. If inflammation persists while on steroids, that would be an indication to be more aggressive with therapy.

It is also possible that this pet is on the cusp of diabetes, although this typically should cause polyphagia. If this is a big concern, you could place a freestyle libre for the cat to wear at home for a week or two to see if significant spikes in blood glucose are happening. If thyroid testing has not been done recently, this would be recommended as well.

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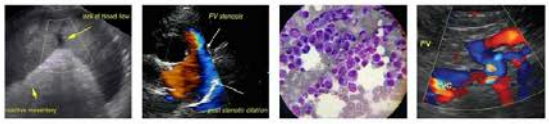

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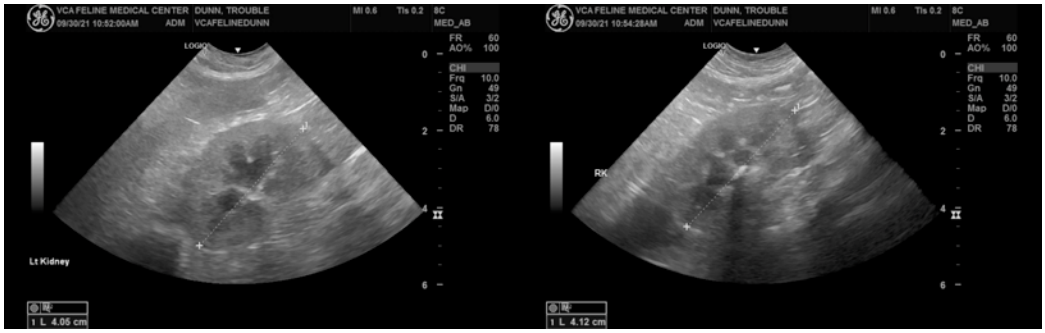

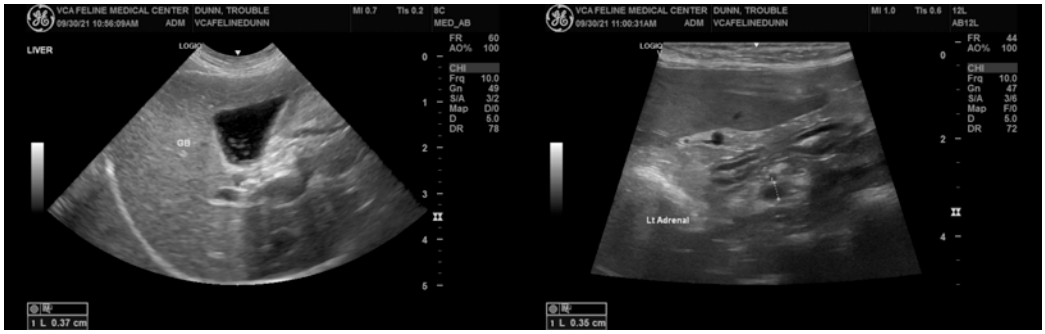

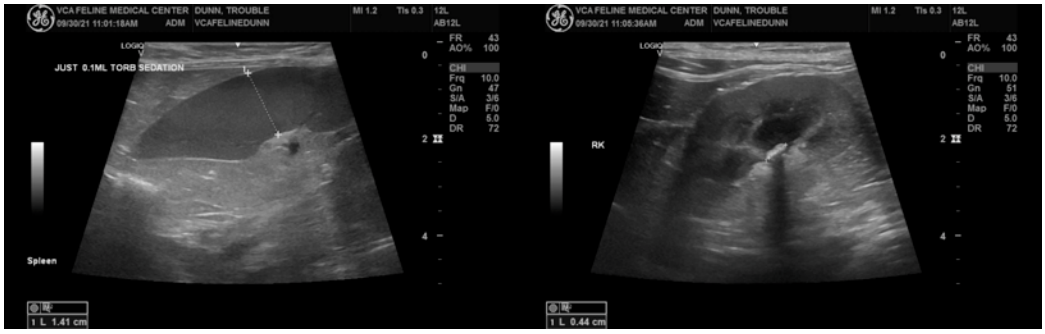

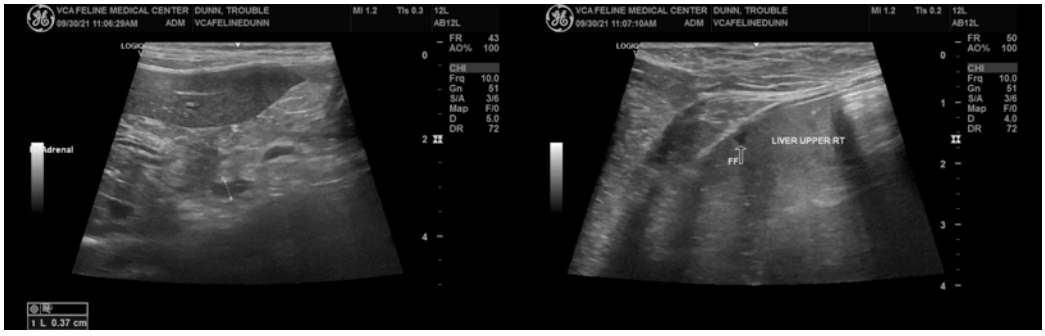

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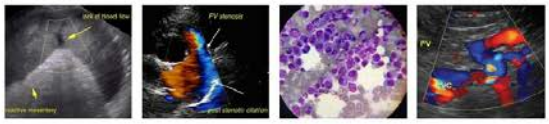

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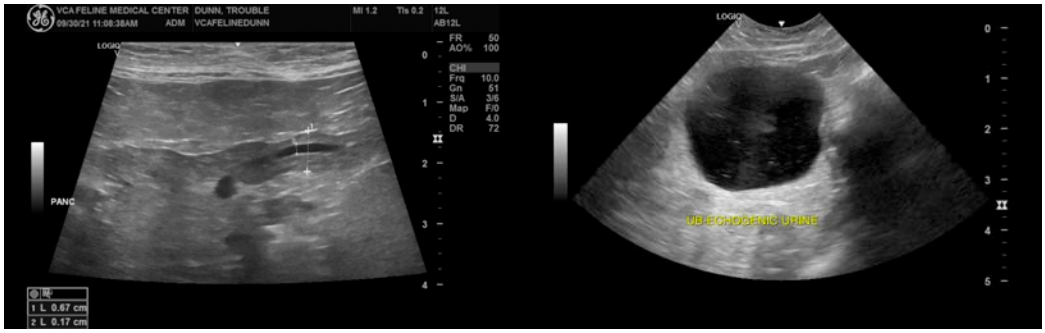

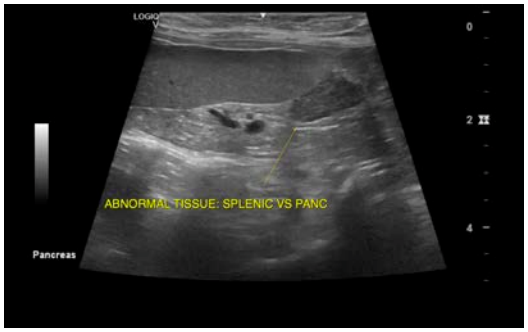

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com