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Clinical Sonography & Telecytology
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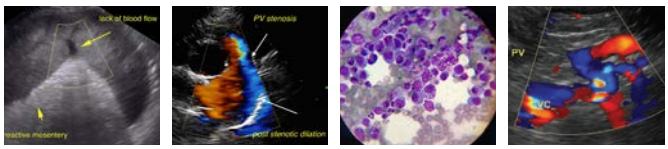

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1-800-838-4268 info@sonopath.com

PATIENT
M. Beau Struble

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
13 Years

WEIGHT
17.3 Pounds

INTERPRETED BY
Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY
Dr. Susan Lincoski

HOSPITAL NAME
University Drive VH

REFERRING VET
Dr. Susan Lincoski

INVOICE
39368

DATE
7/8/22

PRESENTING CLINICAL SIGNS

Beau is here to evaluate weight loss, as he is losing weight but unintentionally. Just switched to DM diet (since littermate Tiddley has diabetes) from metabolic and purina proplan but WLOS predates this. Patient has early HCM and is currentleytaking clopridogrel 1/4 tablet qd. He is acting normally, no changes at all. Today his weight is 1# less than 6/21 visit, where bloodwork all unremarkable except SDMA=15. UA via cysto obtained today, and unremarkable except SG=1.016. EX: Muscle atrophy, lose skin consistent with weight loss. Sedated him with 0.32ml torb/0.5ml midazolam IM to enable exam and radiographs (due to his fractious nature). No increased RR or RE, I cannot hear his murmur today. Abdomen unremarkable. Oral exam mild tartar only. Ears are waxy. 3 views each of abdomen and thorax obtained and sending to synergy. Added 1.6ml alfaxan IM to enable ultrasound. SDEP 17 point scan performed and submitted for review. Spoke to Jackie, will be in touch with reports.
Abnormal PE/Chem/CBC/UA Results: Weight loss. Echo 9/30/21 revealed early HCM.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is well distended with anechoic contents. The wall is smooth and regular. No abnormalities are present with the trigone or proximal urethra. A very small amount of free floating sediment is present, however, there is no evidence of cystoliths, polyps or a mass.

Kidneys

The **left** kidney measures 4.11 cm (3.80-4.40 cm). The capsule is smooth. The cortex is hyperechoic and a mild to moderate loss of the normal definition of the cortico-medullary junction is present. There are no signs of nephroliths or pyelectasia. Blood flow is considered decreased. The surrounding mesentery is very mildly hyperechoic medially.

The **right** kidney measures 4.31 cm (3.80-4.40 cm). The capsule is smooth. The cortex is hyperechoic and a mild to moderate loss of the normal definition of the cortico-medullary junction is present. There are no signs of nephroliths or pyelectasia. Blood flow is decreased, but is superior to the left kidney. The surrounding mesentery is mildly to moderately hyperechoic.

Aortic bifurcation/trifurcation

No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.49 cm in diameter. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

The **right** adrenal gland measures 0.42 cm in diameter. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Spleen

The spleen is within normal limits in echotexture and echogenicity. The capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified. The size varies, i.e. it is 7.7 mm at the beginning of the exam and at the high end of the normal reference range to very mildly enlarged at 10.3 mm (normal = 10 mm) by the end of the exam.

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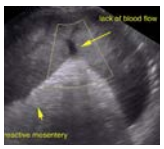
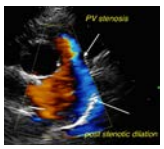
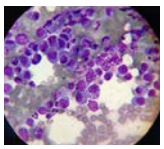
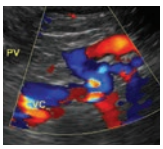

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Liver

Mild hepatomegaly is suspected, however, this is better characterized at the time of the ultrasound or, ideally, radiographically. The liver's borders are smooth and sharp. The liver's echotexture is homogeneous. It is mildly and diffusely hyperechoic, i.e., it is isoechoic to the falciform fat. Focal lesions are not observed and no abnormalities are observed with the hepatic vessels.

The **gallbladder** (GB) wall is within normal limits in thickness and echogenicity. A trivial amount of echogenic material is present within the GB. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction.

Gastrointestinal

The gastric wall is within normal limits in thickness and the wall layers are well defined. No obvious abnormalities are observed with its peristalsis.

The small intestinal wall thickness is within normal limits and the definition of the wall layers is preserved. Abnormally dilated loops of bowel are not observed.

The colonic wall is not thickened and mural detail is considered normal.

Pancreas

The **left limb** has a mildly coarse echotexture. It consists of hypoechoic nodules of variable size and pinpoint to punctate hyperechoic foci scattered throughout the parenchyma. These changes are suggestive of nodular hyperplasia and fibrosis, respectively. Fibrosis may be an age-related change, secondary to previous episodes of pancreatitis, mineralization and amyloid deposition. However, in addition to these changes, the limb is mildly hypoechoic, and most importantly, the surrounding mesentery is severely hyperechoic and irregular.

Findings are similar with the **right limb**.

Other

Lymph nodes No abnormalities are observed

Abdominal effusion is not visualized.

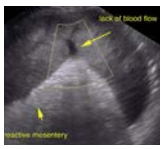
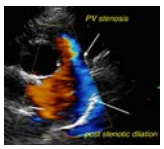
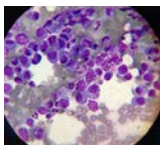
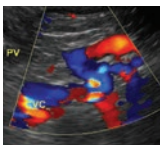
ULTRASONOGRAPHIC FINDINGS

- **Kidneys**: Degenerative changes are noted, however, other abnormalities are present which may be due to pyelonephritis or glomerulonephritis/interstitial nephritis. Further diagnostics are warranted given M. Beau's weight loss, the decreased urine specific gravity and SDMA of 15 ug/dL.

- **Urinary bladder**: Although the sediment in the lumen of the urinary bladder is most likely clinically insignificant, in the absence of inflammatory changes with the wall, a urine culture and sensitivity is suggested to exclude subclinical pyelonephritis due to M. Beau's weight loss, decreased urine specific gravity and very mildly elevated SDMA.

- **Liver**: Very mild and non-specific changes are observed. Possible mild hepatomegaly which would have to be confirmed radiographically. Subclinical cholangitis/cholangiohepatitis, and cholestasis may be present.

- **Pancreas**: Subclinical, smoldering pancreatitis is suspected.

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- **Spleen**: The spleen's change in size is most likely due to splenic contraction, secondary to stress. Sedation used to perform the physical exam, diagnostic tests and abdominal ultrasound most likely contributed to the spleen's size.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following are suggested/recommended

Repeat T4 or consider a T4 (EQD) or a TSH, even if no clinical signs

Urine culture and sensitivity to exclude pyelonephritis

If the urine culture is negative, a urine protein: creatinine ratio is suggested to exclude proteinuria

If proteinuria is present, exclude underlying causes, including infectious diseases

Deworm M. Beau (fenbendazole)

Spec fPL, cobalamin and folate to confirm pancreatitis and exclude malabsorptive disease and determine whether dysbiosis is present.

Note, M. Beau may be suffering from exocrine pancreatic insufficiency, which may be a component of the weight loss, however, a TLI in the face of pancreatitis may be falsely negative. The test may be performed at a later date.

Consider thoracic radiographs (three-views) to exclude neoplasia

Analgesia trial with buprenorphine for 7 to 10 days; evaluate demeanour, activity level and re-assess weight. Dose 0.005-0.01 mg/kg every 8-12 hours.

Evaluate water consumption and food consumption; SureFeeder systems may be purchased, if too stressful to separate the cats when feeding

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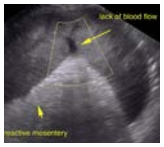
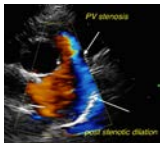
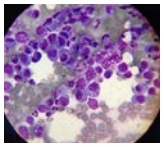
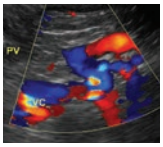

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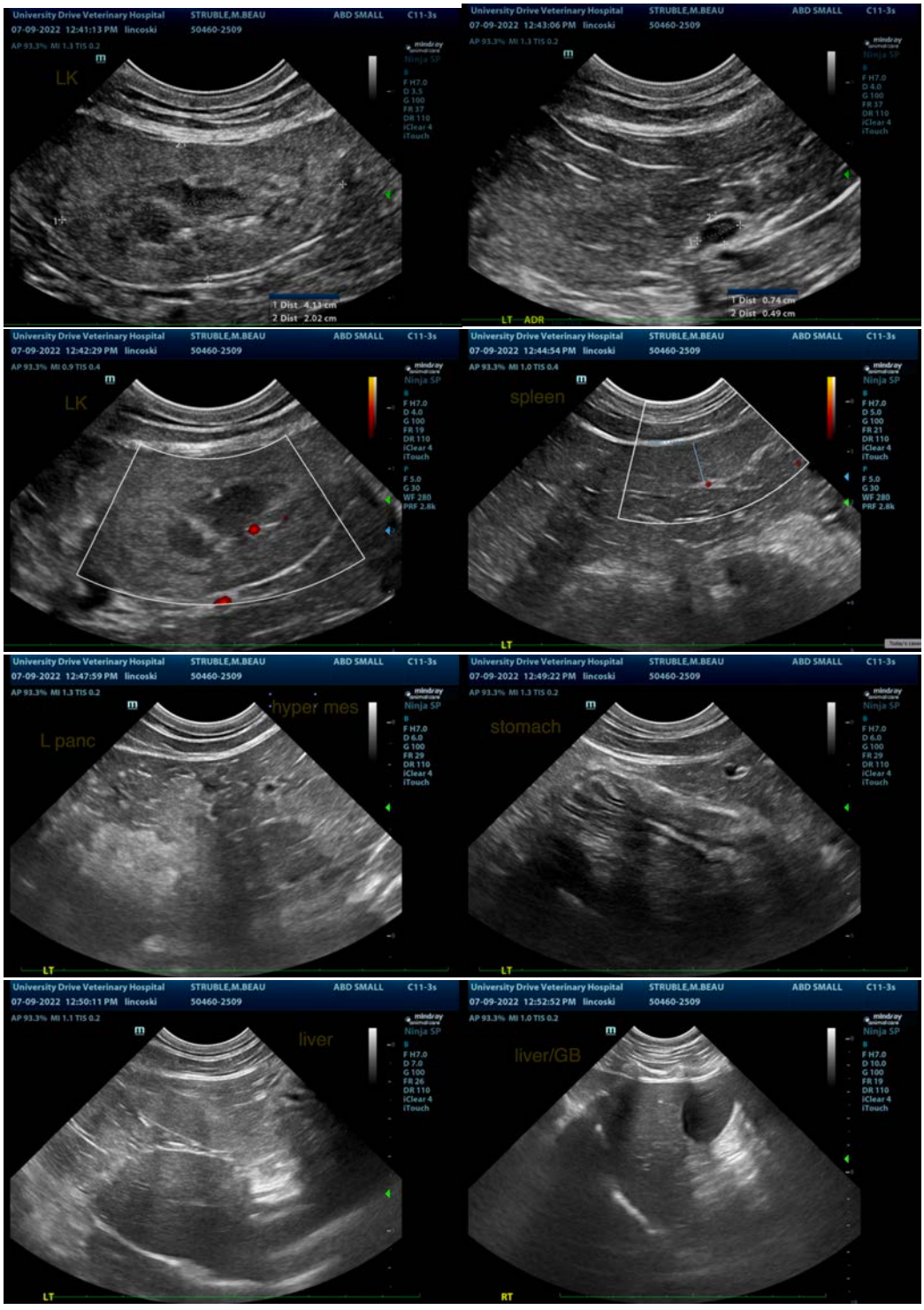

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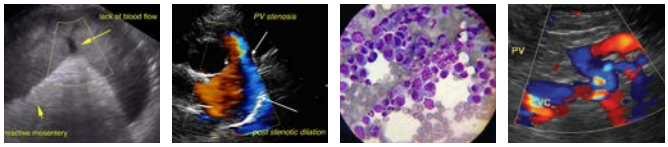

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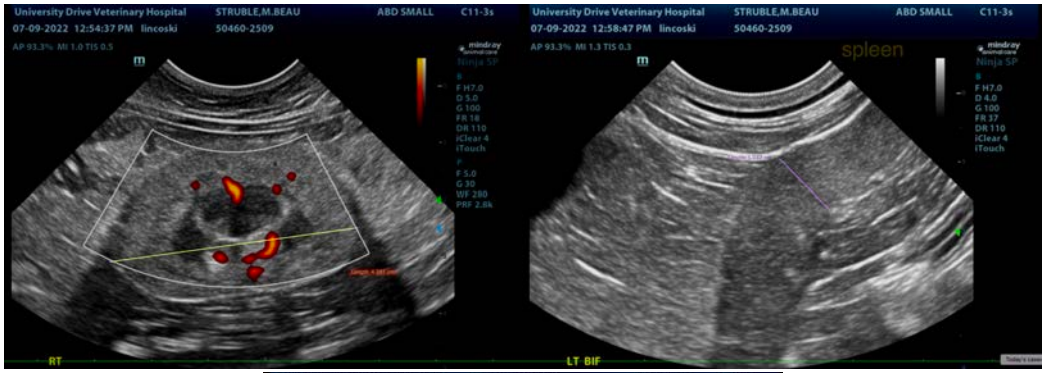

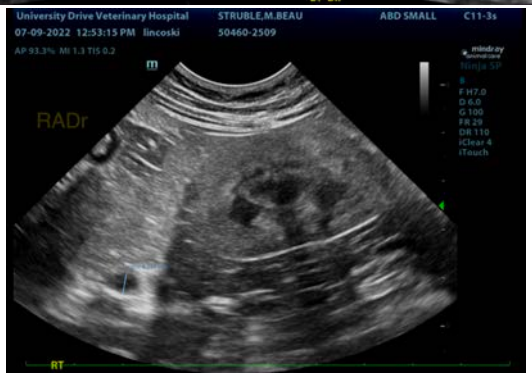

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

Lisa.Carioto@sonopath.com