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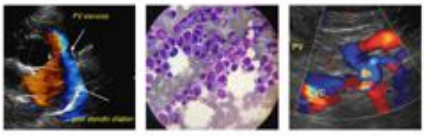

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PATIENT

Kattie FTLOC

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

10 years

WEIGHT

6 Pounds

INTERPRETED BY

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY

Amy Mayhew LVT

HOSPITAL NAME

SVS Imaging Michigan

REFERRING VET

Wixom Family Practice

INVOICE

32133

DATE

7/1/22

PRESENTING CLINICAL SIGNS

History: Current Medications: Methimazole 2.5mg PO BID Patient History: History of PU/PD, urinating outside of litterbox, now defecating outside of box, vocalizing at night and having some trembling. Patient is with a rescue right now, was treated with antibiotics and did improve for awhile. Recent BW on 7.19.22 revealed mild azotemia, BUN 44.6 (15-32mg/dL), Creat 1.9 (0.8-1.8mg/dL), T4 5.0 (0.8-4.7 ug/dL), Lipase 68 (0-61 U/l), USG 1.020, mild neutropenia 2.77 (3.12-12.58 10^3/uL) Abnormal PE/Chem/CBC/UA Results: Abnormal Examination Findings: Thin, mildly dehydrated, abdomen soft, non-painful, intestines feel fluidy/gassy on palpation. UA/culture pending **Please see attached labs

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

Kidneys

The **left** kidney measures 2.87 cm (3.80-4.40 cm). The capsule is smooth, however, the kidney is decreased in size and round. A moderate to marked loss of the normal definition of the cortico-medullary junction is present. Nephroliths and pyelectasia are not observed. Blood flow is adequate. The surrounding mesentery is not hyperechoic.

The **right** kidney measures 2.91 cm (3.80-4.40 cm). The capsule is smooth. The kidney is decreased in size, the cortex is hyperechoic (it is hyperechoic to the liver) and a moderate to marked loss of the normal definition of the cortico-medullary junction is present. A small mineralization is noted, without signs of nephroliths or pyelectasia. Blood flow is mildly decreased. Signs of fibrosis and fat are noted. The surrounding mesentery is not hyperechoic.

Aortic bifurcation/trifurcation No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.43 cm. 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 0.39 cm. 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 size 8.3 mm (normal = 10 mm), echotexture, and echogenicity. The capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

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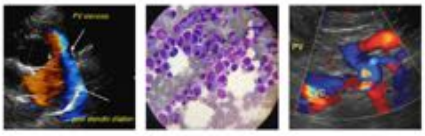

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Liver

Mild hepatomegaly is suspected, however, this is better characterized at the time of the ultrasound or radiographically. The liver's borders are smooth and vary between sharp to very mildly rounded. It is diffusely hyperechoic, i.e. it is isoechoic to the spleen. A subtle coarse or granular echotexture is observed. Focal lesions are not observed and no abnormalities are noted with the hepatic vessels.

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

Gastrointestinal

A small amount of gas is present within the lumen of the stomach. The gastric wall is within normal limits in thickness and the wall layers are well defined. No obvious abnormalities are observed with its peristalsis.

Jejunum: wall thickness is within normal limits and the definition of the wall layers is preserved, however, fogging of the mucosa is observed.

The ileo-cecal-colic junction: within normal limits

The colonic wall is not thickened and mural detail is considered normal. Gas and a large volume of soft or semi-formed stools are present in the colon.

There are no obvious signs of a mass, foreign body, infiltrative disease or an obstruction in the gastrointestinal tract.

Pancreas

The **left limb** is somewhat enlarged, mildly hypoechoic and has smooth borders. The surrounding mesenteric fat is mildly hyperechoic. Overt signs of neoplasia are not noted.

No abnormalities are observed with the architecture, contours, echogenicity or echotexture of the pancreas. There is no evidence of hyperechogenicity of the surrounding mesentery, i.e., signs of active pancreatitis are not present.

Other

Lymph nodes

No abnormalities are observed, including the LNs in the region of the ICCJ.

Abdominal effusion is not visualized.

ULTRASONOGRAPHIC FINDINGS

- **Gallbladder (GB):** Gallbladder sludge may be clinically insignificant, however, a secondary bacterial infection cannot be excluded. Furthermore, cholecystitis cannot be ruled out despite the absence of sonographic signs.

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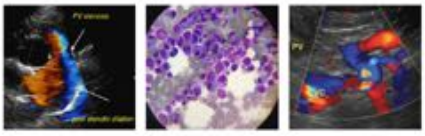

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- **Liver**: Hyperthyroidism may be the cause of the changes observed. However, cholangitis/cholangiohepatitis and hepatic lipidosis may also be contributing to the subtle abnormalities observed, including those noted on blood work and Kattie's urinalysis.

- **Gastrointestinal (GI) tract**: Signs of mild inflammation are noted with the jejunum. Although the subtle changes may not be clinically significant, they may be attributed to inflammation in some individuals. Furthermore, soft stools are present in Kattie's colon. A chronic enteropathy due to inflammatory bowel disease, food intolerance, dysbiosis, etc., must be considered. Obvious signs of neoplasia are not identified, however, neoplasia cannot be excluded without performing tissue biopsies. Note, a *chronic enteropathy is considered more likely*.

- **Pancreas**: Although overt signs of pancreatitis are not present, mild, active or a smoldering pancreatitis is suspected. Signs of neoplasia are not appreciated.

- *"Triaditis" cannot be excluded.*
- **Kidneys**: Chronic renal disease with fibrosis. However, pyelonephritis must be considered as a cause of Kattie's clinical signs, despite the absence of classical sonographic signs.

- **Urinary bladder**: Although the free floating sediment is mild to moderate and most likely clinically significant, it should not be disregarded due to the renal changes noted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture and sensitivity to exclude pyelonephritis

+/- urine protein: creatinine ratio if the urine culture is negative

Analgesia for visceral pain, such as buprenorphine (0.005-0.01 mg/kg sublingually every 8-12 hours) for a minimum of 7-10 days. Continue for 3-4 weeks if an improvement is noted; the dose and frequency may be weaned to the minimum effective dose during that time. Administer, even if Kattie does not "appear" to be in pain.

+/- gabapentin

Supportive care (maropitant, mirtazapine, SQ fluids, etc.)

If signs of GERD present, 10-14 day trial with famotidine or omeprazole (0.7-1 mg/kg PO q12h)

+/- cobalamin supplementation due to renal disease

Deworm (fenbendazole)

Diet trial (veterinary prescription brand hypoallergenic, i.e., ideally, a hydrolyzed diet); ensure appetizing to prevent hepatic lipidosis, sarcopenia and cachexia

Cholangitis/cholangiohepatitis and cholecystitis cannot be excluded, including a secondary ascending bacterial infection. Although indiscriminate use of antibiotics is not normally recommended, one could start treatment with a broad-spectrum antibiotic if an improvement is not observed with the above therapies.

TLI, serum cobalamin, and folate, to assess for underlying maldigestion and malabsorption disease and

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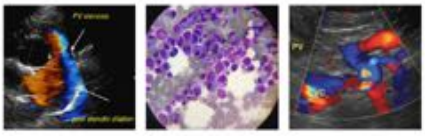

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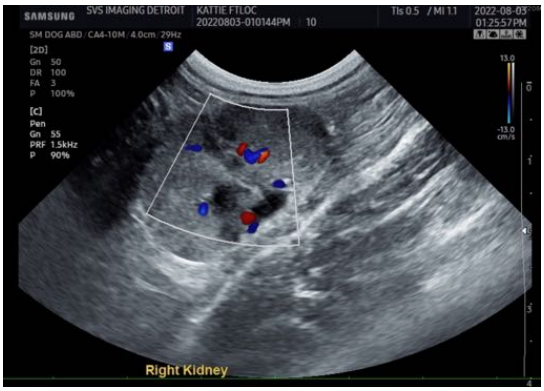
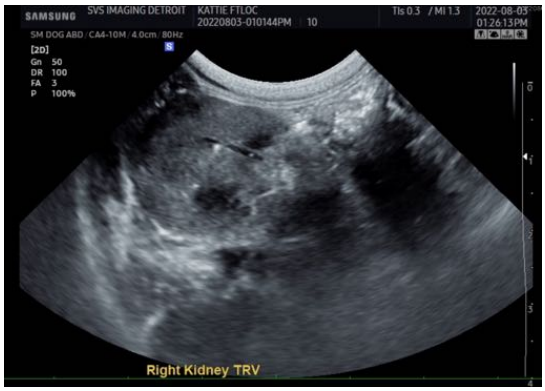
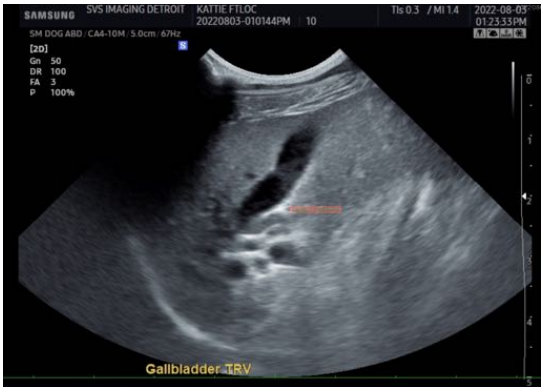
dysbiosis (+/-Spec fPL), depending on response to above treatment plan and diagnostic tests. Note, the TLI may be a false negative if pancreatitis is present.

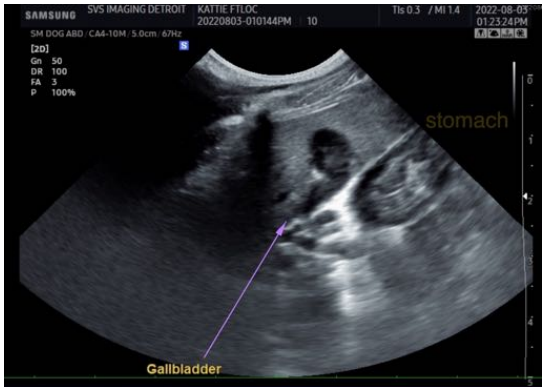
Note, can draw blood, centrifuge and freeze serum for future use if would like to start cobalamin supplementation.

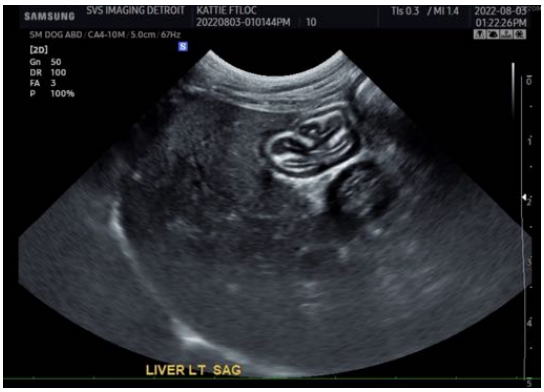
If further diagnostics are not pursued, although not ideal, empirical treatment for inflammatory bowel disease is suggested. A dose of prednisolone (1 mg/kg/day) may be administered for 2 weeks, and then tapered to the minimum effective dose.

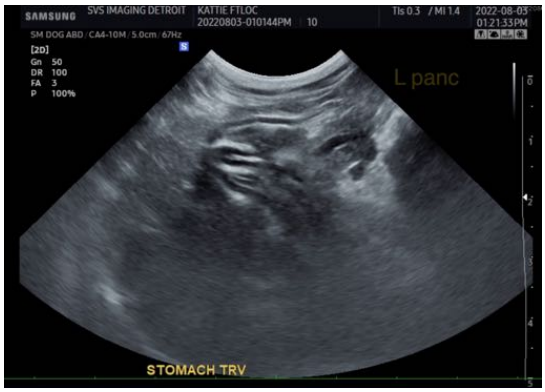












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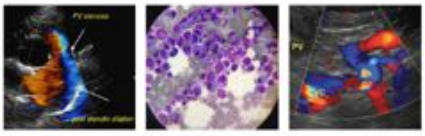

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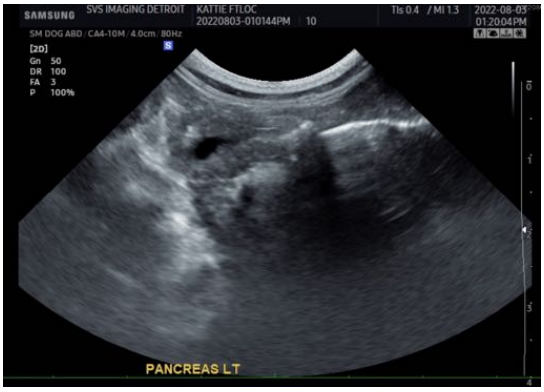

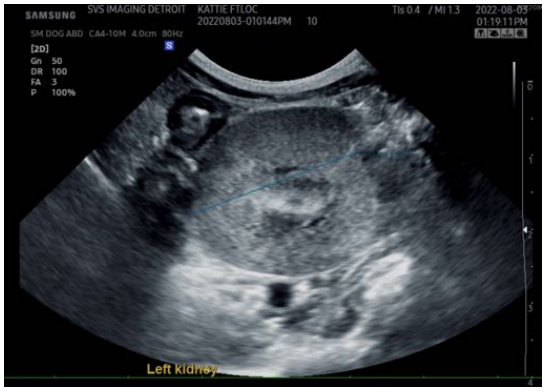

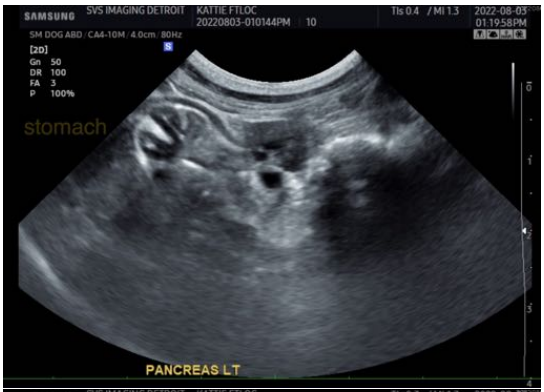

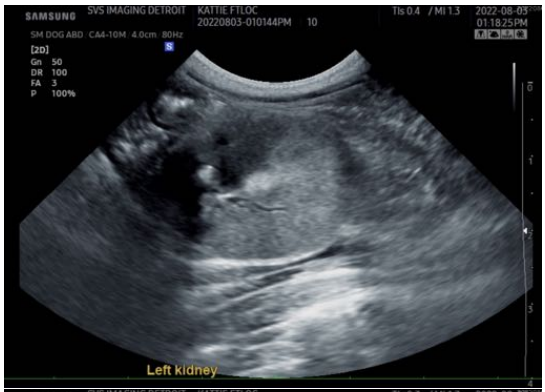

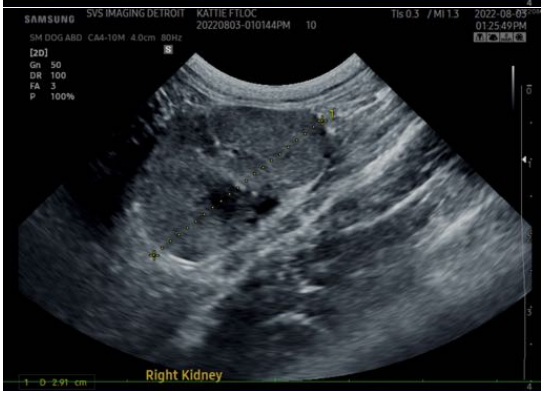

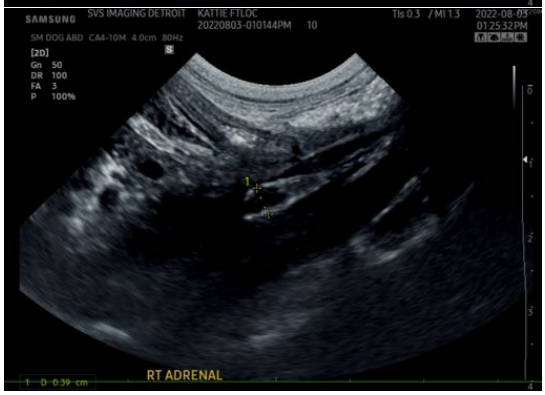

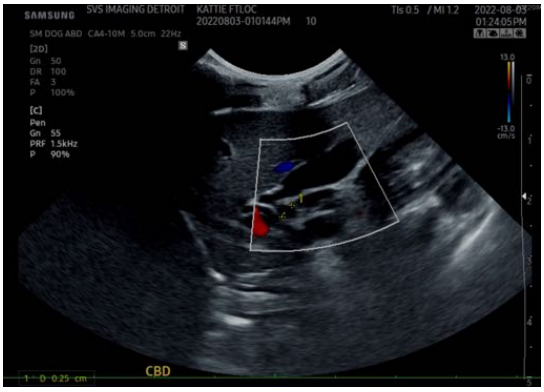

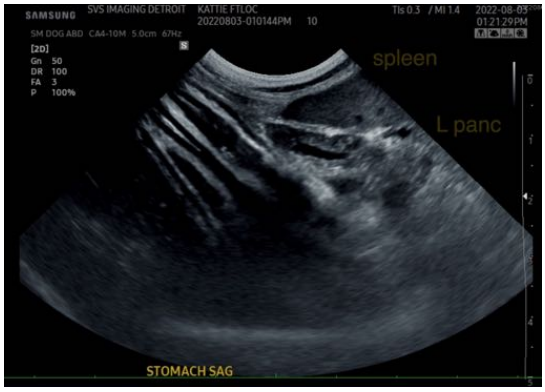

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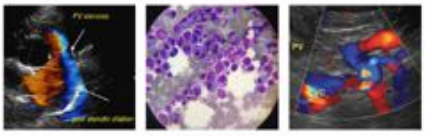

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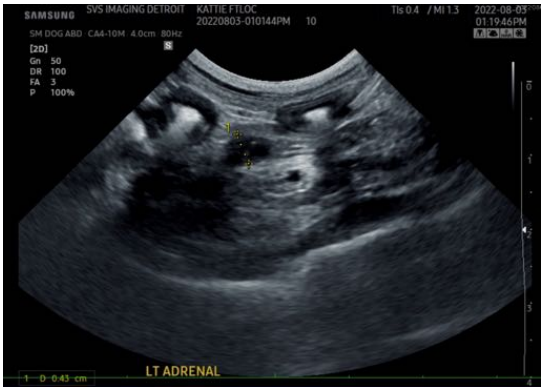

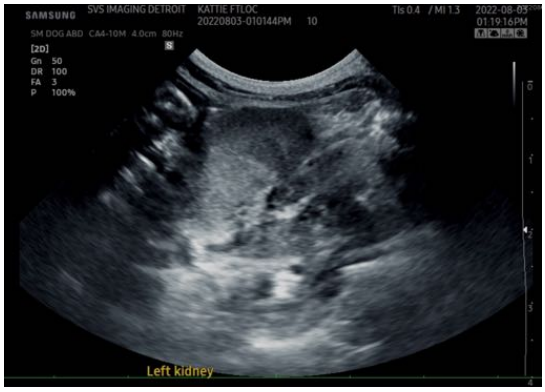

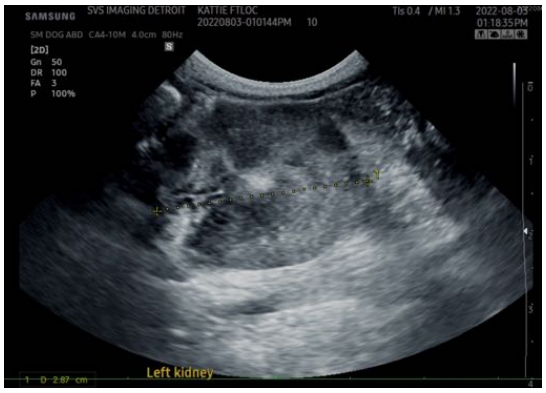

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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