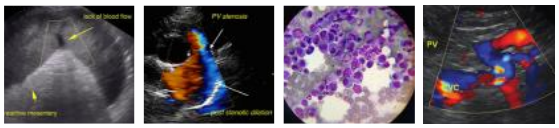

PATIENT

Mr. Kitty Jackson

SPECIES

Feline

BREED

Russian Blue

SEX

MN

AGE

7 years

WEIGHT

7.74

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Santa Clara AH

REFERRING VET

Dr. Elsbree

INVOICE

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PRESENTING CLINICAL SIGNS

11/08/2022: presented for senior wellness visit. O reported a little more lethargic and grumpy lately. O does feed a raw diet with supplements, because pet has been sensitive in the past and this diet seems to be the most effective to decrease vomiting. A cbc/chem was run and values listed below. No treatment done. 12/28/2022: o reports increased hunger significantly, trying to get human food, more grumpy if not fed, O gave a dewormer 2 weeks ago- then symptoms started, no worms seen, just preventatively. O reports more vocal, more resolved, increased thirst too, and watery eyes. Vomiting is somewhat of an ongoing problem. T4 done (normal). Discussed further diagnostics vs. prednisolone trial. Started prednisolone (5 mg bid, with tapering).

1/10/2023: Recheck. A bit lethargic. Eating normal now. Drinking more water than normal. Having bowel movements outside of litter box. Had a bought out diarrhea this week, and is having soft stool. No vomiting while on prednisolone. Started 3 day course of fenbendazole. The exams have always been quite normal. Smaller, thinner cat- but no obvious problems on exam. Nervous, but nice. The most recent time I noticed more fluid filled loops of bowel, but this was it.

Current Medications 5mg prednisolone every other day Radiographic Findings none Primary Question/Differential to Be Answered in This Exam Any abnormal findings in abdomen? signs of IBD? Recommendations if no abnormalities of next steps. I am suspicious of IBD, but not all the symptoms match. I also think that the diet could be an issue since it is not a commercial diet, but o reports that this has made the symptoms better.

Abnormal PE/Chem/CBC/UA Results: 11/08: full cbc, full chem- all wnl except blood clot in sample caused lower platelets 12/28: tt4=2.1

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.0 cm in length. The right kidney measured 4.0 cm in length.

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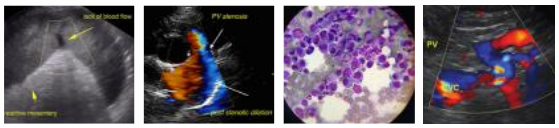

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Adrenal Glands

The left and right adrenal glands were not definitively visualized, likely owing to suspected suppression secondary to Prednisolone therapy. No evidence of pathology was noted in the area of the left and right adrenal glands.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material. The gastric body wall width measured 0.25 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The duodenum wall measured 0.24 cm width. The jejunum wall measured 0.24 cm width. The ileocolic wall measured 0.39 cm width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The left pancreatic limb was mildly prominent in size with symmetrical contour and subtle uniform hypoechoic parenchyma compared to the adjacent nonreactive omentum.

Free Abdomen

No omental masses, lymphadenopathy, or evidence of peritoneal effusion were noted.

ULTRASONOGRAPHIC FINDINGS

- Structurally normal gastrointestinal tract / colon
- Possible low-grade pancreatitis

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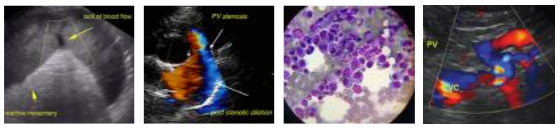

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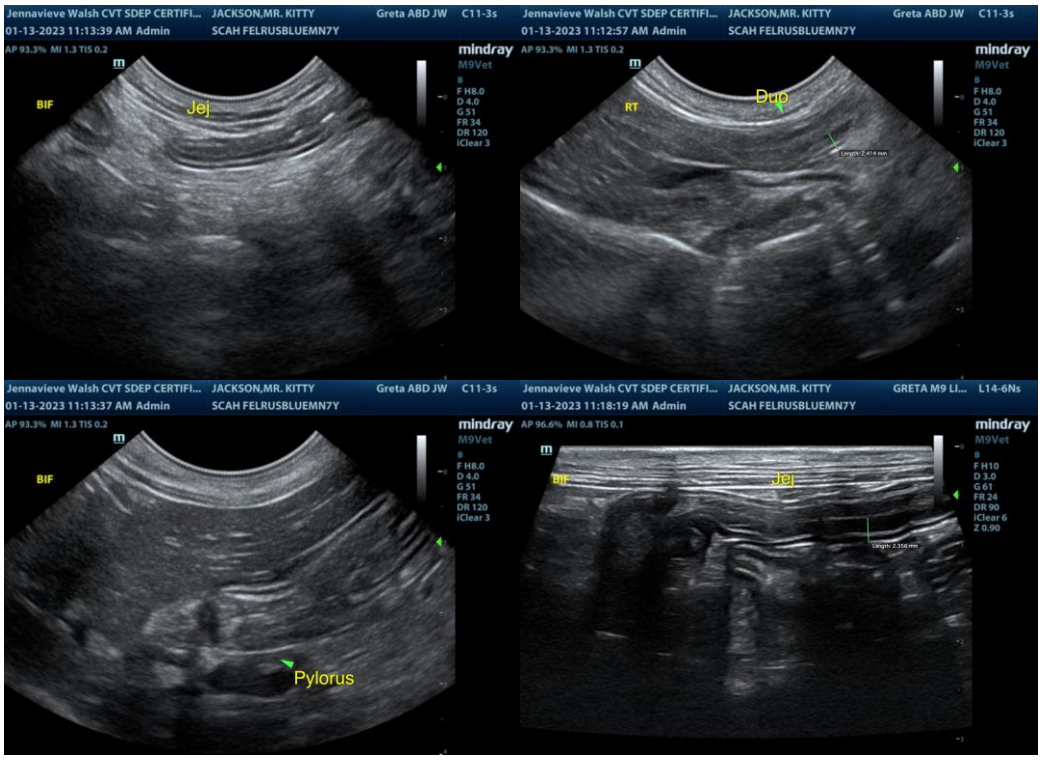
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No sonographic evidence of significant visceral pathology, specifically gastroenterocolic mural pathology. Sonographically, the appearance of the gastrointestinal tract was not overtly or classically consistent with IBD, yet some degree of intestinal mural changes owing to current prednisolone therapy could be possible. Dietary intolerance / food allergy, dysbiosis, Inflammatory bowel disease, low-grade or chronic pancreatitis, less likely occult parasitism given recent deworming, or less likely occult infiltrative intestinal neoplasia are all potentials.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. Assessment for evidence of cranial abdominal or subxiphoid discomfort on palpation, which may allude to low-grade pancreatitis is suggested. Empirically and in addition to the current Prednisolone protocol, hydrolyzed diet trial with potential long-term dietary therapy, high colony count probiotic, empirical cobalamin supplementation pending assessment of cobalamin levels, and as-needed gastrointestinal support with an assessment of clinical response and monitoring of bodyweight is recommended.



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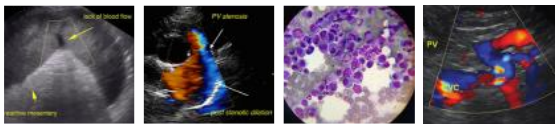

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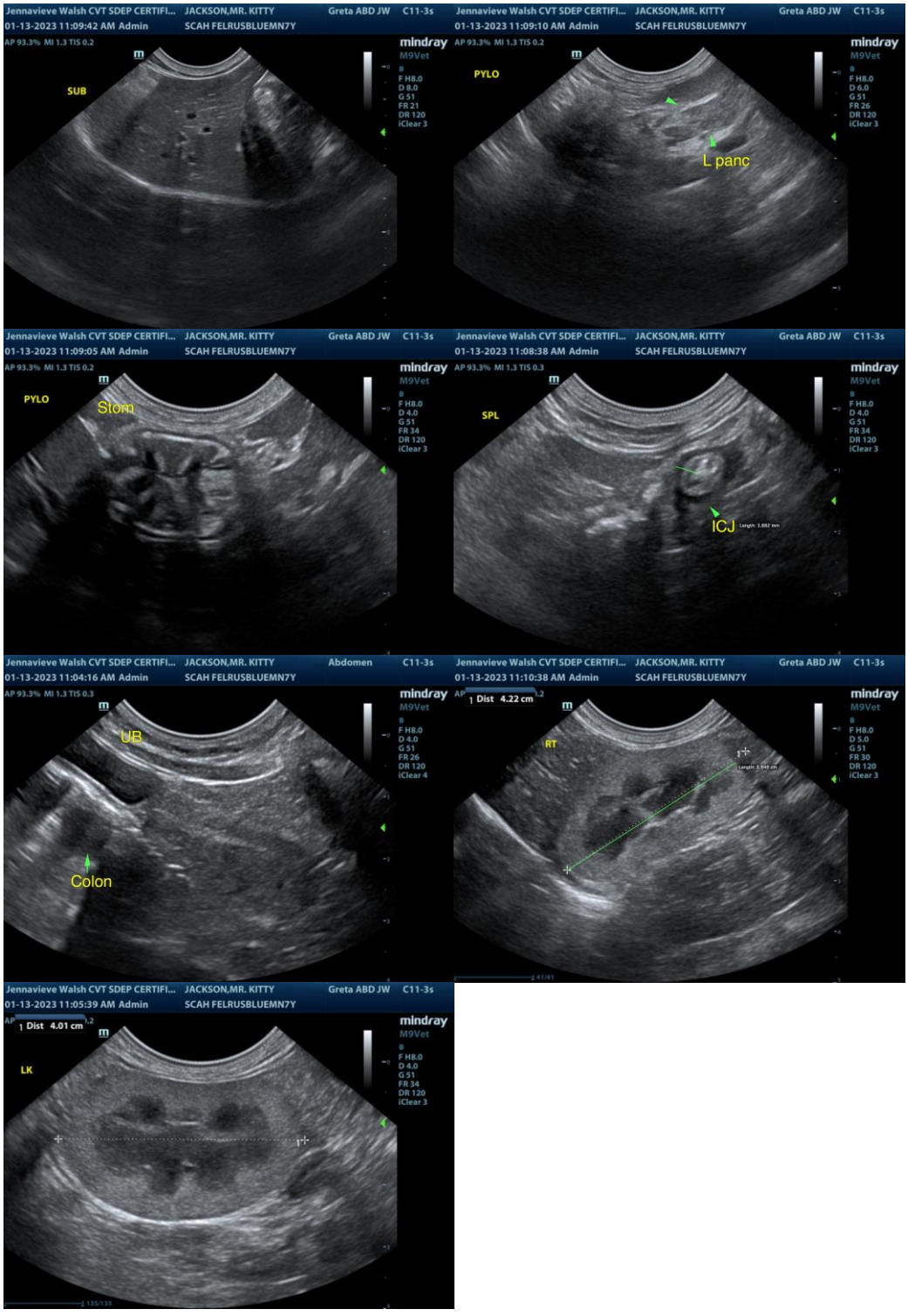

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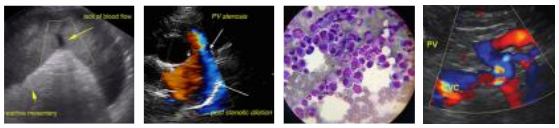

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
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