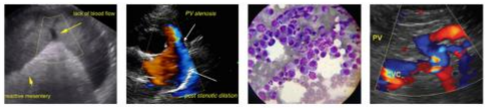


PATIENT

Oreo Mourchid

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

13 Years

WEIGHT

7.9 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

East Boston AH

REFERRING VET

Raman Chopra, DVM

INVOICE

13467

DATE

1/15/22

PRESENTING CLINICAL SIGNS

History: Weight loss; hyporexic. Amylase 1361; Prec PSL 40; WBC 46.6

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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 were noted.

Both kidneys exhibited mild increased size compared to normal kidney size for the species. 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 4.9 cm in length. The right kidney measured 5.0 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.36 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.34 cm width.

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. The spleen measured 0.83 cm in width.

Liver

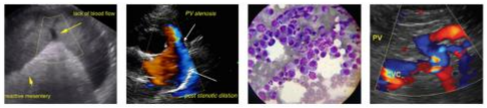
The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with sonographically unremarkable walls. No evidence of gallbladder or peripheral gallbladder inflammation. Mild particulate debris was present with primarily anechoic content. The common bile duct was dilated and tortuous without overt post hepatic obstruction. The common bile duct measured 0.32 cm width. Evidence of subtle nonobstructive proximal mucoduct.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. The gastric walls were intact yet mildly prominent in the area of the antrum and pylorus with minor retained anechoic pyloric fluid. The pylorus wall measured 0.40 cm.

The small intestine presented intact yet prominent wall layering owing to generalized propensity for prominent mucosa layer as well as evidence of increased mucosa echogenicity to mucosal



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speckling/fogging. The duodenum wall measured 0.40 cm. The jejunum wall measured 0.35 cm. No overt pathology at the level of the duodenal papilla.

Normal visible colon wall layers were present with apparent formed feces in lumen. The ileocolic wall measured o.33 cm.

Pancreas

The pancreas was prominent in size with mild swollen to asymmetrical contour and generalized hypoechoic parenchyma compared to adjacent reactive peripancreatic omentum.

Free Abdomen

Small pockets of scant peritoneal free fluid were present. Intermittent, focally enlarged jejunocolic lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 0.96 cm in diameter.

ULTRASONOGRAPHIC FINDINGS

- Mild urinary bladder sediment
- Bilateral mild renomegaly, exhibiting increased cortex echogenicity- nonspecific, age-related renal changes, nonspecific nephritis (such as interstitial nephritis), while the potential for early renal neoplasia cannot be excluded.
- Nonspecific hepatomegaly
- Nonobstructive proximal common bile duct dilation
- Pancreatitis
- Enteropathy- inflammatory or neoplastic infiltrative enteropathy possible
- Intermittent nonspecific jejunocolic lymphadenopathy
- Scant peritoneal free fluid- lymphoid hyperplasia, reactive lymphadenitis (owing to underlying intestinal disease) with potential for early neoplastic lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

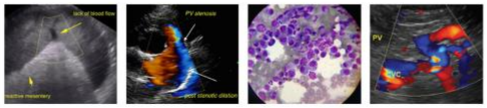
Assuming normal clotting status, hepatic FNA, using a 25-gauge needle warranted for screening cytology, primarily to assess for evidence of inflammatory cells or occult hepatic neoplasia. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Full thickness intestinal biopsies would be required for further clarification and definitive diagnosis. Potential for triad disease could be considered in this patient, even without reported hepatic enzyme elevations given the short half-life of hepatic enzymes in cats. CBC pathology review +/- recheck retroviral status may be considered.

Empirically, some or all of the following protocol or similar protocol could be considered:

Triaditis/Pancreatitis protocol

Part or all of this protocol may be considered based on your clinical impression of the patient:

Recommend pain management when anorexic with **Buprenorphine** (0.01-0.02 mg/kg IM or SC), clinical trial of **Zithromax** (50 mg sid/cat x 10 days, 3 weeks if bartonella +), **Prednisolone** (0.5-2 mg/kg tapering over 1 week to minimal effective dose), and **B12 injections** if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet (***Hydrolyzed diets have been shown to be*



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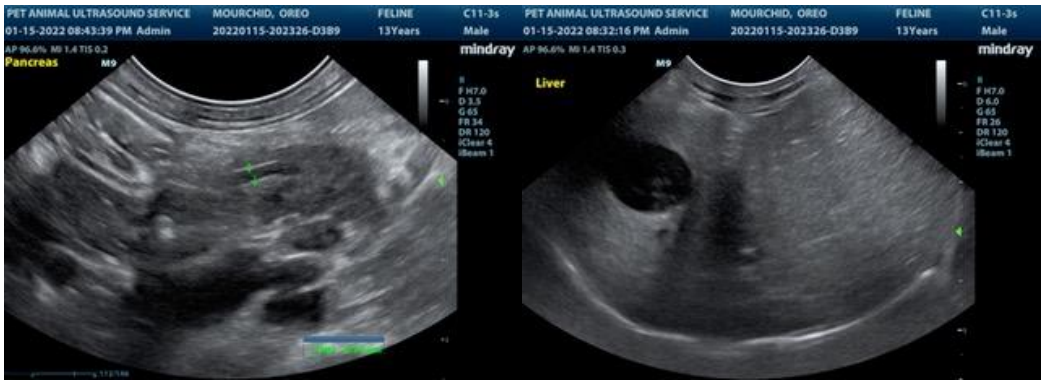
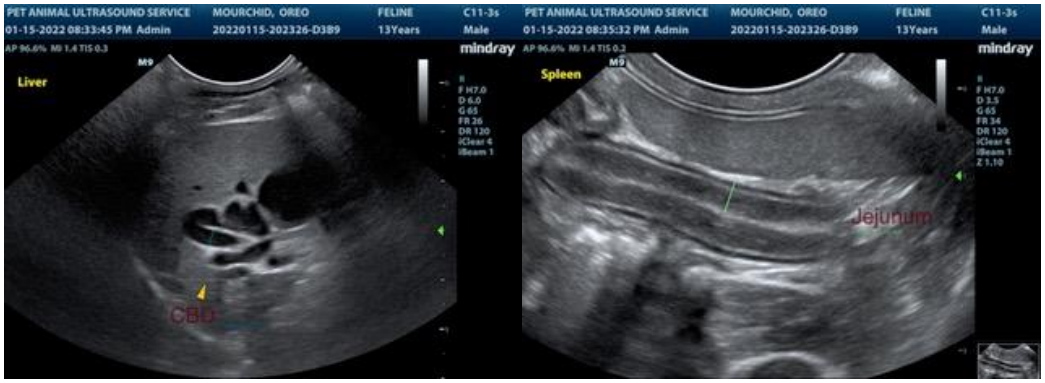
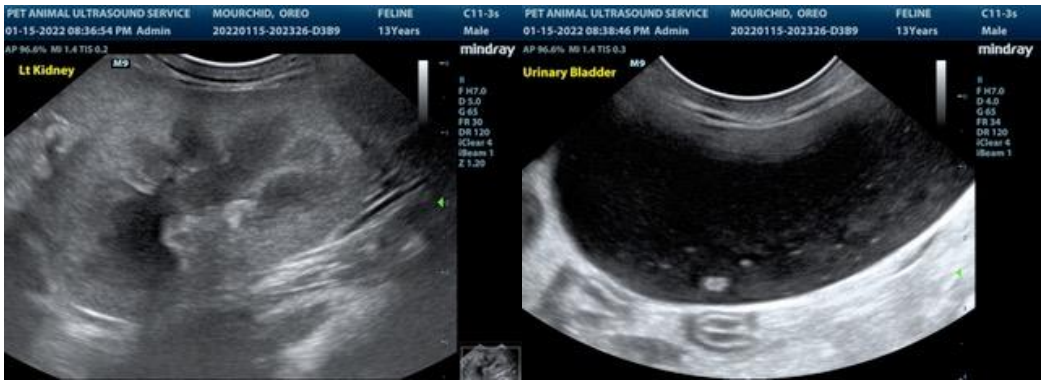
more effective in dietary intolerance case management compared to hypoallergenic diets) or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes a persistent issue then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. One diet does not work for all patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.







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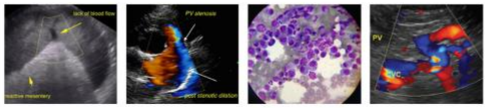
4paus.com 781-635-5677



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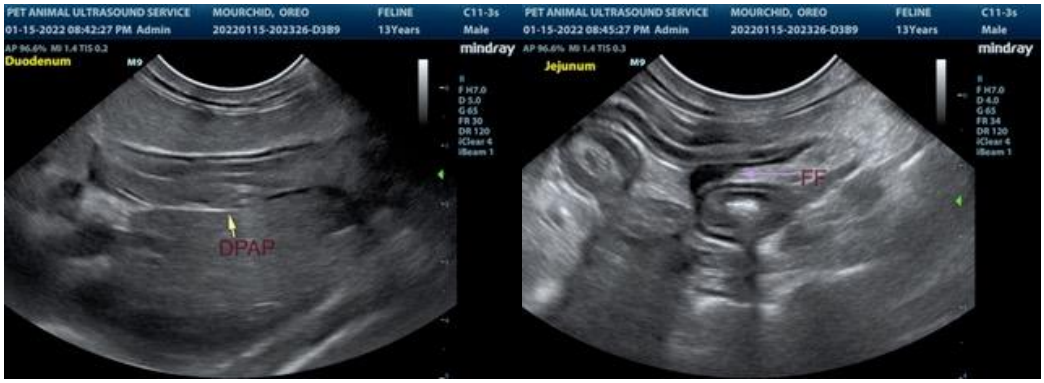

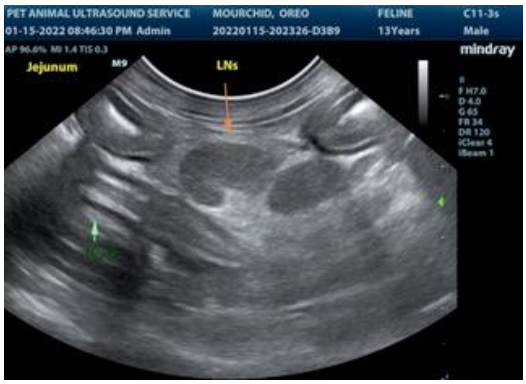

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com