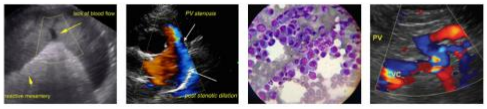
PAUS
Pet Animal Ultrasound Service



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Gizmo Brennan

SPECIES

Feline

BREED

Ragdoll

SEX

MN

AGE

10 years

WEIGHT

10.1 lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Norfollk County VS

REFERRING VET

Christina Poor, BVetMed

INVOICE

13529

DATE

1/20/22

PRESENTING CLINICAL SIGNS

Increased vomiting, especially at night. Poor body condition. All labs normal, but previous AUS showed IBD presentation with likely reactive lymphadenopathy (7/7/17, Eric Lindquist, DVM, Sonopath).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – 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.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.8 cm in length. The right kidney measured 3.7 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 0.37 cm width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.36 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 0.60 cm in width.

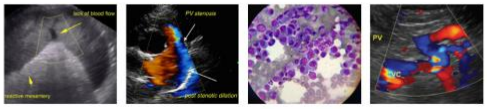
Liver/ Gallbladder

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 measured 0.25 cm.

The duodenum was normal. The duodenum wall measured 0.24 cm. The jejunum exhibited intact wall layering with segmental to generalized propensity for prominent walls along with prominent mucosa to



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muscularis layer. No overt loss if intestinal wall layering or masses. The jejunum wall measured 0.33 cm in width.

Normal visible colon wall layers were present with semi- formed feces in lumen. The ileocolic wall measured 0.30 cm.

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Asymmetrical capsule contour was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. Mild to moderate pancreatic duct dilation was present, measuring 0.24 cm- 0.30 cm in width. No overt evidence of neoplasia.

Free Abdomen

Multiple, 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 0.42 cm in diameter.

Small pockets of scant, primarily periintestinal free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Chronic enteropathy, exhibiting segmental altered yet intact wall layering- consistent with chronic infiltrative enteropathy (inflammatory versus neoplastic infiltrative enteropathy possible).
- Associated jejunocolic lymphadenopathy- chronic lymphoid hyperplasia, reactive lymphadenitis or potential early neoplastic lymphadenopathy possible.
- Chronic active pancreatitis pattern

Secondary Findings

- Mild chronic renal changes

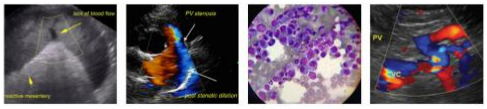
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Full thickness intestinal biopsies as well as lymphatic biopsies would be required for a definitive diagnosis. Alternatively, ultrasound guided FNA of the enlarged jejunocolic lymph node (if accessible) could be considered for screening cytology. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. If previous or current history of elevated liver enzymes, triad disease may be a potential in this patient. Empirically, some or all of the following protocol could be considered with (as needed) gastrointestinal support:

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



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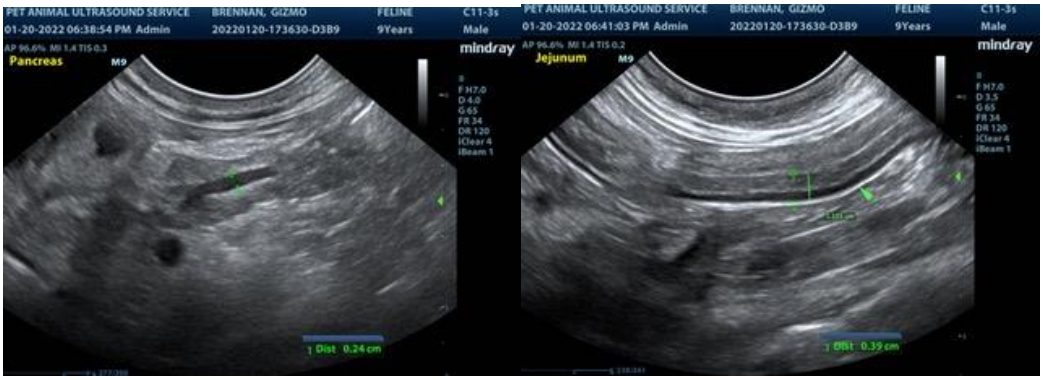
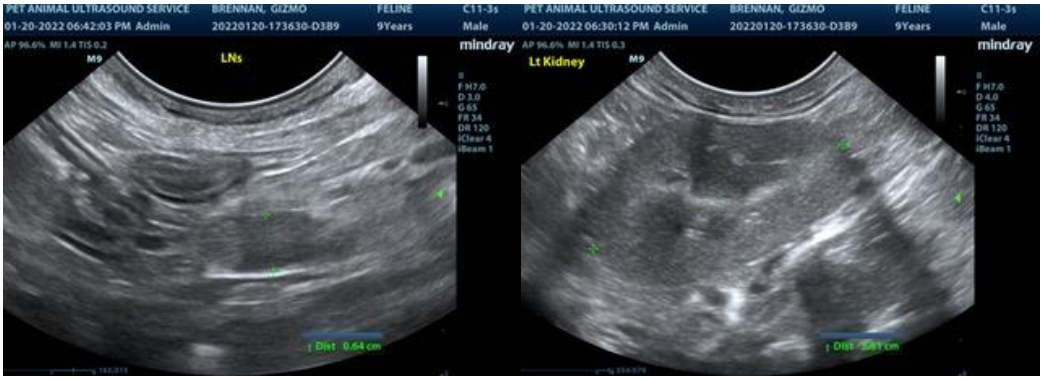
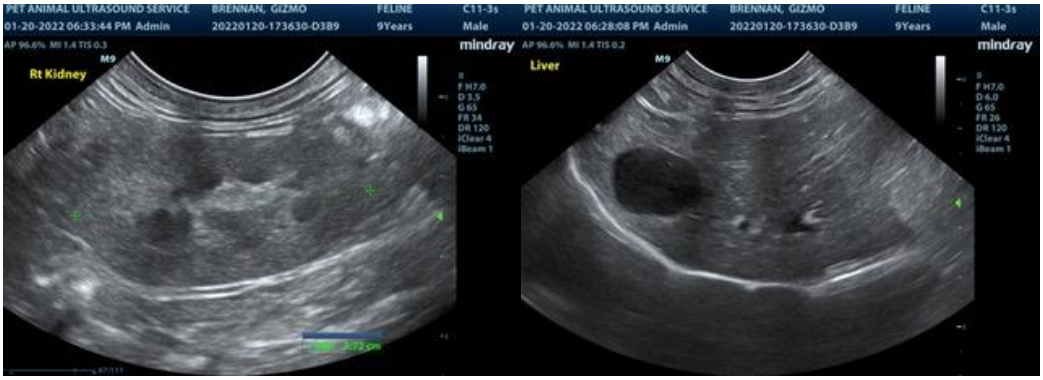
loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet (***Hydrolyzed diets have been shown to be more effective in dietary intolerance case management compared to hypoallergenic 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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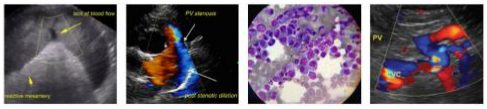

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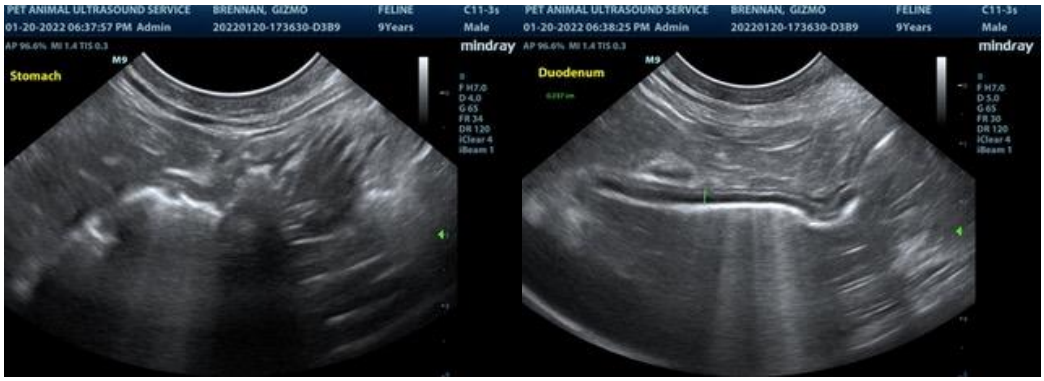

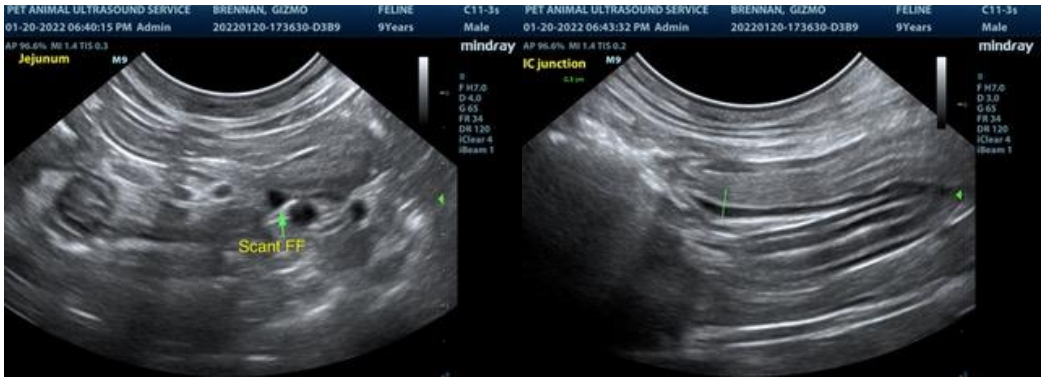

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com