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VETERINARY ULTRASOUND SERVICES
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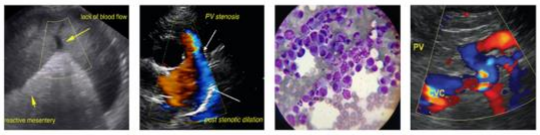


SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Blue Kurdilla

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

15 years

WEIGHT

9.5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME

Stanglein VC

REFERRING VET

Dr. Stanglein

INVOICE

13547

DATE

1.21.2022

PRESENTING CLINICAL SIGNS

History: Diabetic, projectile vomiting, weight loss, concern for IBD/neoplasia

Medication: Laxatone, Cisapride, Miralax, Benazepril, Lantus

Labs: WBC 10.5 with mild monocytosis, Glucose 46, BUN 43, Creat 1.0, ALP 105, Urine Spec Gravity 1.034, 1+ protein, Neg Glucose

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mild to moderately distended in size yet subjective normal tone. Primarily anechoic urine was present with mild nondependent particulate sediment suggestive of minor cellular or crystalline debris. Urethra was normal in structure and tone to a depth of 2.0 cm.

Both kidneys were normal in size and contour. Both kidneys exhibited uniform increased cortex echogenicity and cortical hypertrophy along with nonspecific hyperechoic medullary rim sign. No evidence of pyelectasia. The left kidney measured 4.5 cm in length. The right kidney measured 4.7 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 0.47 cm width.

No overt pathology in the area of the right adrenal gland.

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 0.84 cm in width.

Liver

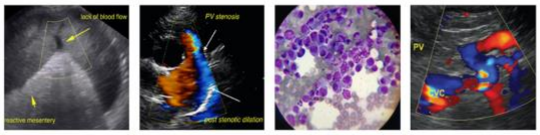
The liver presented increased in size. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic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

The gallbladder was normal in size yet subjectively divided into two separate compartments containing moderate nondependent echogenic luminal debris. 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 0.26 cm.

The small intestine presented intact yet prominent wall layering with subjective propensity for prominent muscularis layer. No overt evidence of loss of intestinal wall layering or distinct intestinal masses.



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Normal visible colon wall layers were present yet potentially distended with formed feces.

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. Mild pancreatic duct dilation was present along with intermittent parenchymal cysts containing anechoic fluid. No overt evidence of neoplasia.

Free Abdomen

Small volume, primarily anechoic peritoneal free fluid was present.

Intermittent, mildly prominent to enlarged mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of a lymph node measured 0.73 cm width.

Generalized reactive mesentery was present.

ULTRASONOGRAPHIC FINDINGS

- Distended urinary bladder with mild sediment
- Bilateral interstitial nephrosis renal pattern with nonspecific medullary rim sign
- Chronic active pancreatitis with parenchymal cysts
- Hepatopathy, exhibiting parenchyma hyperechogenicity
- Bilobed gallbladder with mild luminal debris- bilobed gallbladder is a normal variant in a cat
- Chronic enteropathy- suspect chronic IBD
- Associated mesenteric lymphadenopathy- lymphoid hyperplasia, mild reactive lymphadenitis suspected
- Generalized reactive mesentery and mild volume peritoneal free fluid

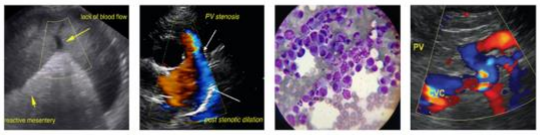
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential for neoplastic infiltrative enteropathy with round cells (such as intestinal lymphoma), which may present in similar sonographic manner, cannot be definitively excluded. Likewise, the possibility of emerging concurrent neoplastic lymphadenopathy, although thought less likely, is possible. The liver may suggest diabetic hepatopathy, lipidosis, vacuolar hepatopathy or cholangiohepatitis. Potential for infiltrative hepatic neoplasia, which may present in similar sonographic manner, cannot be definitively excluded yet thought less likely. Assuming normal clotting status, given the patients weight loss, ultrasound guided FNA of the liver +/- lymph node (if accessible) as well as GI panel to include PLI, TLI, cobalamin and folate warranted. Triad disease could also be considered in this patient. Empirically, some or all of the following 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*



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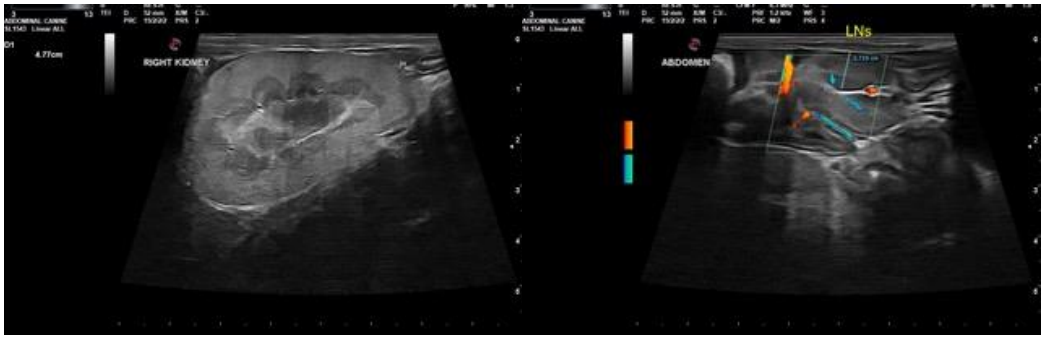
*been shown to be more effective in dietary intolerance case management compared to hypoallergenic diets***)** or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes 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.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.



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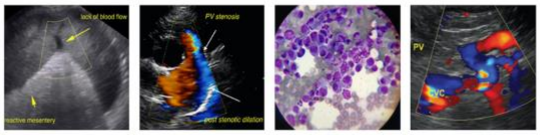

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com