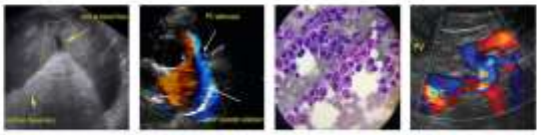


PATIENT

Saphire Lore

SPECIES

Feline

BREED

Siamese

SEX

FS

AGE

13 years

WEIGHT

11.5 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

12969

DATE

1.5.2022

PRESENTING CLINICAL SIGNS

History: Lethargy, inappetence, weakness, history of asthma, constipation, possible IBD, elevated renal values, ALT

BUN 67, Creatinine 4.1, ALT 268, Specific gravity 1.025

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. Primarily anechoic urine was present in the lumen. Mild to moderate, nondependent, particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were 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 was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pyelectasia was present. The left kidney measured 3.8 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

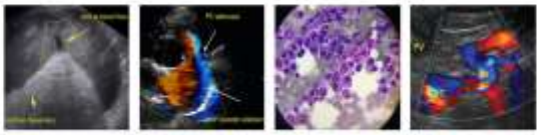
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.33 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.33 cm width at the caudal pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. Mild asymmetrical medial capsule contour was present. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic criteria. The spleen measured 0.83 cm width.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. 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.



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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 0.26 cm.

The small intestine presented intact wall layering with subjective propensity for segmentally prominent muscularis layer. The duodenum wall width measured 0.34 cm. The jejunum wall width measured 0.26 cm. No evidence of loss of intestinal wall layering or Intestinal masses was noted.

Normal visible colon wall layers were present with subjective formed feces and luminal gas in lumen. No overt evidence of colonic distention with feces was noted.

Pancreas

The pancreas was mildly prominent In size with primarily uniform, mildly hypoechoic parenchyma.

Free Abdomen

Subtle evidence of peri Intestinal reactive mesentery was noted. No effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Urinary bladder sediment
- Bilateral mild chronic renal changes - no overt pyelonephritis
- Low-grade hepatopathy - subjectively benign
- Probable inflammatory enteropathy
- Mild active to chronic active pancreatitis pattern

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.

The small intestine exhibited subtle mural changes which are suggestive of underlying inflammatory enteropathy. However, given the lack of reported weight loss, vomiting or diarrhea, this finding is nonspecific. Potential for Triad Disease may be possible in this patient, given the elevated ALT, which may suggest low-grade inflammatory hepatopathy, as well as probable pancreatitis. Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate.

Pending additional diagnostics, some or all of the following protocol may be considered empirically.

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 more effective in dietary intolerance case management compared to hypoallergenic*

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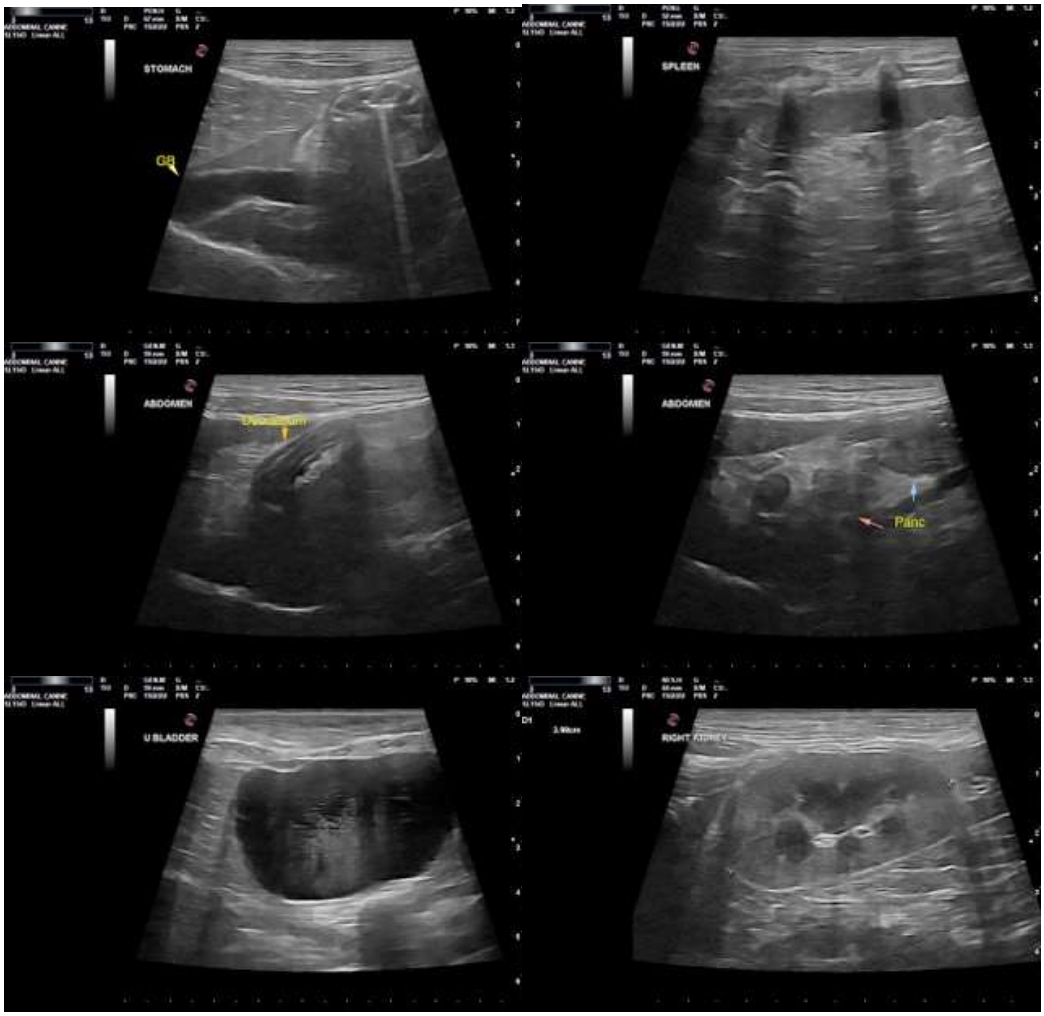
diets) or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes a persistent issue then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. 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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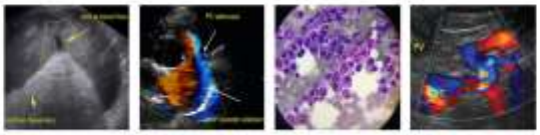

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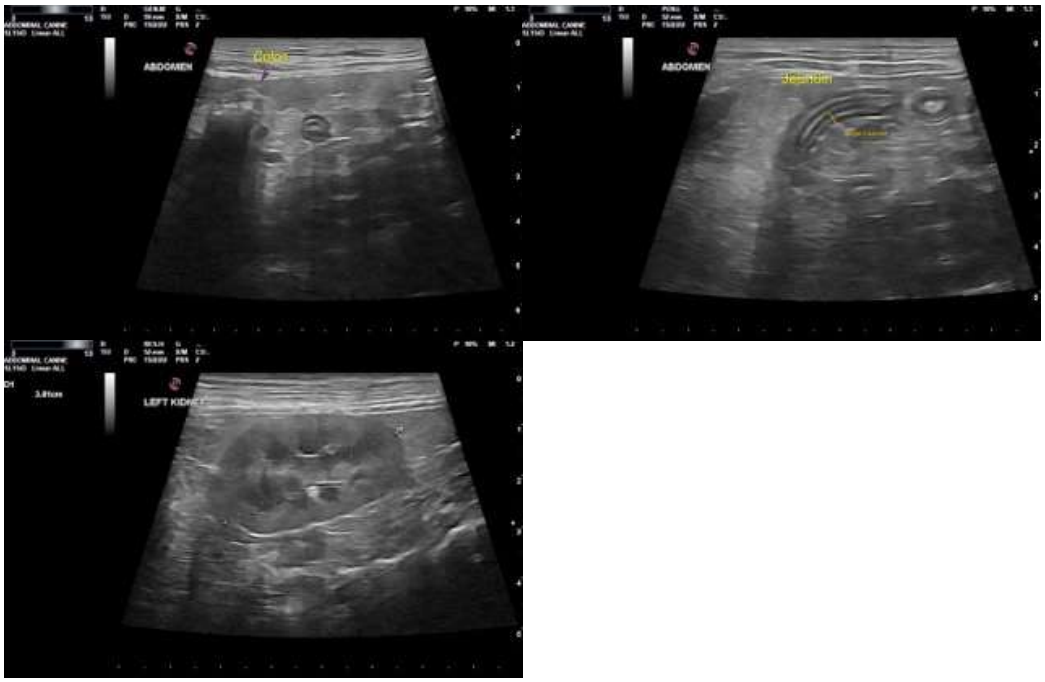

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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