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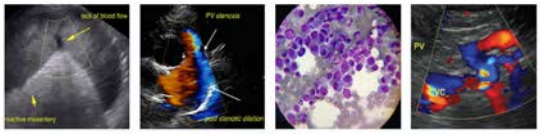

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Leo Budinetz

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

14 years

WEIGHT

7.8 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

26332

DATE

10.15.2021

PRESENTING CLINICAL SIGNS

History: Weight loss

WBC 14.1 w/lymphocytosis, BUN 39, SDMA 17, T4 4.0, USG 1.015, negative protein and glucose.

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 particulate non-dependent 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.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. Mild uniform increased cortex echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.5 cm. The right kidney measured 3.7 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.51 cm in width. The right adrenal gland measured 0.47 cm.

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

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 mild, echogenic, nonmineralized biliary sludge. The proximal common bile duct was dilated (0.20 cm in diameter) and tortuous without overt post hepatic obstruction. This finding may suggest age related changes or secondary to underlying cholangitis / cholangiohepatitis especially if previous or current liver enzymes elevations have been noted.

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. Gastric body wall measured 0.27 cm.

The small intestine presented intact yet subjective generalized prominent wall layering owing to mild generalized prominent muscularis layer. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. Jejunum wall measured 0.32 cm. Duodenum wall measured 0.30 cm.

Normal visible colon wall layers were present with semiformed to soft feces.

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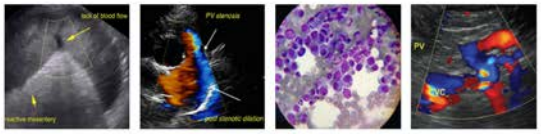

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Pancreas

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 inflammation. No overt evidence of neoplasia.

Free Abdomen

Intermittent, mildly prominent to enlarged jejunocolic lymph 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).

Small volume peritoneal free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Enteropathy – inflammatory infiltrative enteropathy/IBD, potential for neoplastic infiltrative enteropathy with round cells (i.e., lymphoma) possible.
- Concurrent subjective mild chronic active pancreatitis
- Bilateral mild interstitial nephrosis renal pattern – chronic renal changes, potential for mild non-specific nephritis such as interstitial nephritis
- Mild peritoneal free fluid and intermittent, subjectively reactive jejunocolic lymph nodes
- Mild gallbladder debris with mild non-obstructive proximal common bile duct dilation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. 3-view chest radiographs recommended to rule out occult thoracic pathology as potential cause of weight loss. Peritoneal free fluid analysis may also be considered. CBC pathology review +/- flow cytometry (given the lymphocytosis) may also be considered. Full thickness intestinal biopsies would be required for definitive diagnosis. The minor gallbladder debris and non-obstructive proximal common bile duct dilation is non-specific, with the minor gallbladder debris potentially owing to decreased food intake, fasting, non-clinical cholestasis, or mild cholangitis. Empirically, medical therapy for IBD +/- triad disease would be reasonable.

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 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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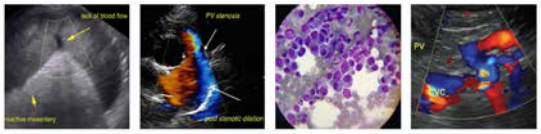

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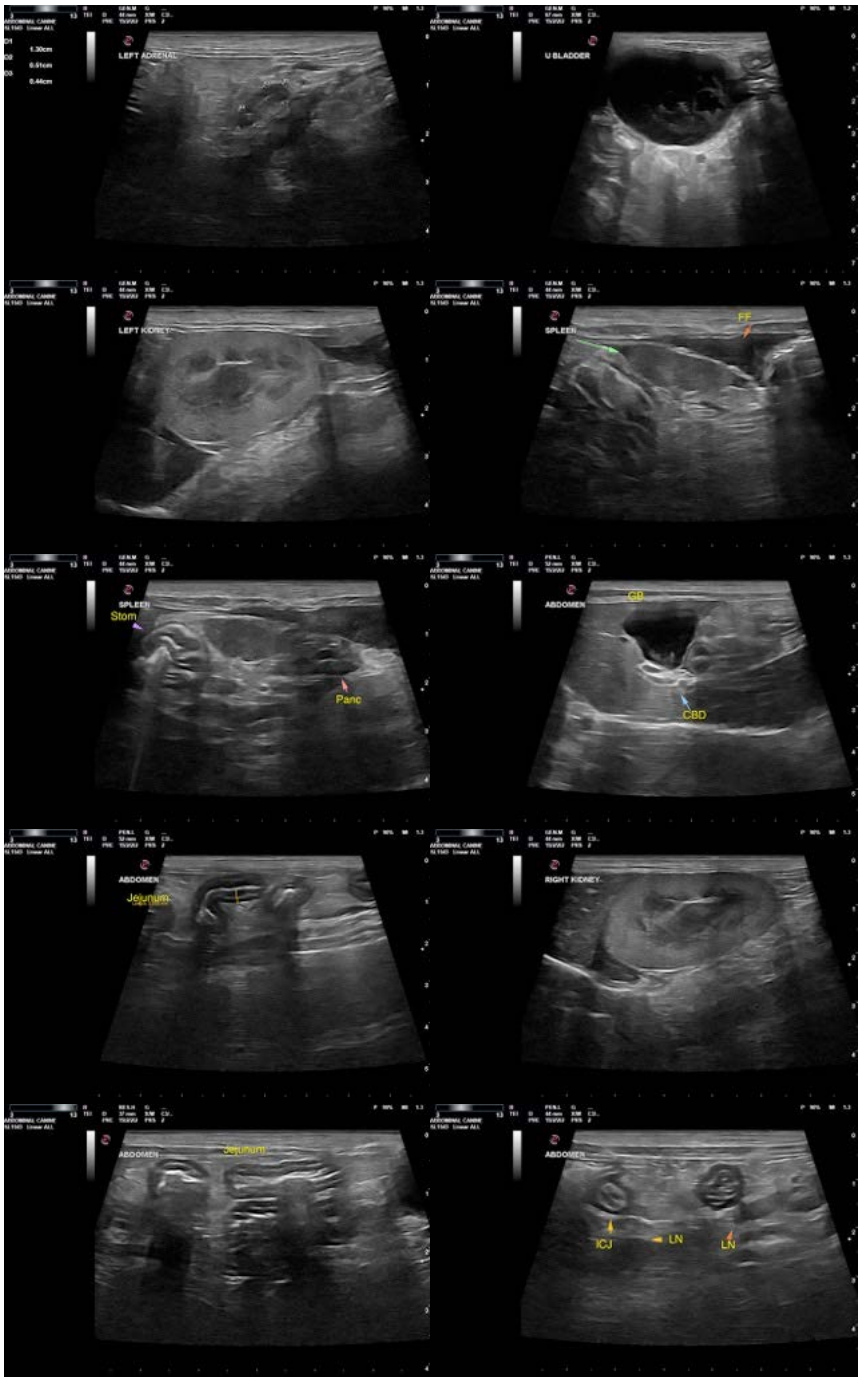

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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