



**PATIENT**

Ollie Fathallah

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

10 Years 11 Months

**WEIGHT**

9 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Michaleen

**HOSPITAL NAME**

DPC Vet Hospital

**REFERRING VET**

Dr. Feldt

**INVOICE**

26347

**DATE**

10/16/21

**PRESENTING CLINICAL SIGNS**

Chief Complaint: LOSING WEIGHT History: P IS A 10Y9M OLD M/N DSH PRESENTING TODAY FOR LOSING WEIGHT. O STATES GRADUALLY LOSING WEIGHT OVER PAST FEW MONTHS. O STATES P HAS RAVENOUS APPETITE O STATES HAS ALWAYS BEEN THAT WAY. P HAS BEEN PRETTY HEALTHY NOT SEEN VET SINCE LAST HERE IN 2018. NOT PU/PD. NO OTHER PROBLEMS/CONCERNS. HAS BEEN DRINKING MORE LATELY

Abnormal PE/Chem/CBC/UA Results: 9/4 exam Hydration: N Mentation: N EENT: NO PALPABLE THYROID NODULE Oral Cavity: MISSING SEVERAL TEETH, VERY DIFFICULT TO DO ORAL EXAM Lymph Nodes: N Skin: 3RD AND 4TH DIGITS LEFT REAR HAVE EXPOSED QUICKS, SMALL AMT BLOOD IN ADJACENT FUR...MR NEVER NOTICED. VERY NICE HAIRCOAT CV/Respiratory: TACHYCARDIC, NO MURMUR. Abd/GI: N Uro/Perineum: N Musculoskeletal: N Neurological: N comprehensive senior panel -WNL other than HCT low end of normal (29) and 2+ protein w/1.063 USG 10/9 notes Date: 10/9/2021 Time: 15:14 Notes: FECAL NPS CONTINUING TO LOSE WEIGHT DESPITE INCREASING AMT FED. ONE OF THE CATS IS VOMITING ALOT IN THE HOUSE....I SUSPECT IT'S OLLIE SINCE HE IS THE ONLY ONE LOSING WEIGHT MY BIG CONCERN IS IBD BUT COULD BE LSA OR A CHRONIC GI FB CAUSING A PARTIAL OBSTRUCTION. IDEALLY AB US +/- REFER TO DR TOLL FOR SCOPING/GI BIOPSIES GAVE OWNER ALTERNATIVE OPTION OF STARTING CERENIA 24MG 1/4 SID LONG TERM IF NOT BETTER IT'S EITHER WORKUP OR TRY EMPIRICAL TX FOR IBD WITH BUDESONIDE OR PREDNISOLONE ALONG WITH HYPOALLERGENIC DIET WHICH MAY NOT BE REALISTIC IN MULTI-CAT HOUSEHOLD

**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 were noted. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction.

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 pelvic dilation was present. The kidneys measured 4.0 cm each.

The area of the aortic trifurcation was free of pathology.

**Adrenal Glands**

No overt pathology in the area of the left and right adrenal glands.

**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 0.69 cm in width.

**Liver**

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



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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**

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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 0.24 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. Jejunum wall measured 0.25-0.26 cm wall width.

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Normal visible colon wall layers were present with apparent formed feces in lumen.

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**Pancreas**

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

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**Free Abdomen**

Intermittent, mildly enlarged mesenteric lymph nodes were present. Example measured 1.7 cm x 0.8 cm and 2.5 cm x 1.1 cm. 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.

**WEIGHT**

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**ULTRASONOGRAPHIC FINDINGS**

**INTERPRETED BY**

R. McKenzie Daniel,  
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- Sonographically unremarkable gastrointestinal tract
- Intermittent mesenteric lymphadenopathy – probable lymphoid hyperplasia or mild reactive lymphadenitis.
- Mild age related kidneys

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

If hyperthyroidism is ruled out, structurally insignificant inflammatory bowel (given the presence of mesenteric lymphadenopathy and weight loss) would be a primary differential diagnosis. The mesenteric lymphadenopathy was not overtly consistent with neoplastic criteria, which is considered unlikely.

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Assuming normal clotting status, ultrasound guided FNA of an enlarged mesenteric lymph node could be considered for screening cytology. Further assessment may include T4 levels if not done. GI panel to include PLI, TLI, cobalamin and folate, and 3-view chest radiographs to rule out occult thoracic pathology as a potential cause of weight loss. Baseline UPC may be considered given the 2+ proteinuria and quiet urinary bladder sediment.

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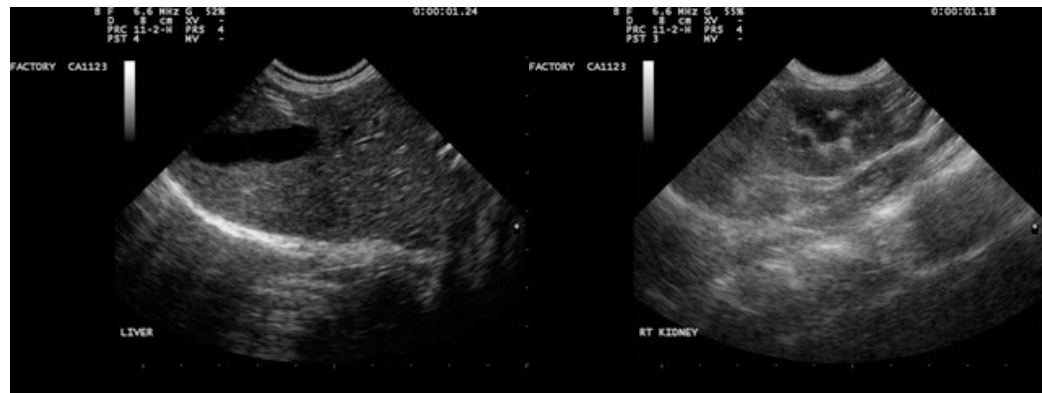
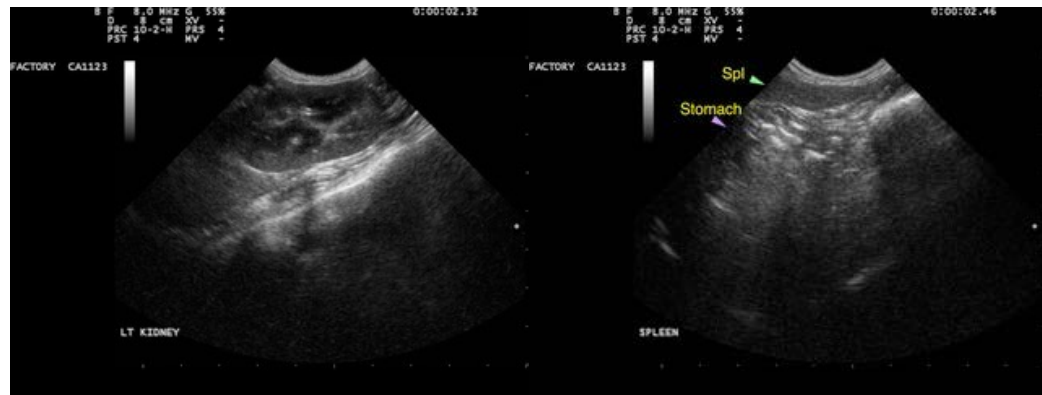
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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info@SonoPath.com

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