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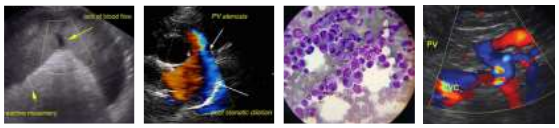


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Gabriel Winther

SPECIES

Feline

BREED

Persian

SEX

MN

AGE

14 years

WEIGHT

8.1 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Albany AH

REFERRING VET

Dr. Spangler

INVOICE

12475

DATE

10/28/21

PRESENTING CLINICAL SIGNS

Weight loss despite polyphagia - 1lb weight loss over past 4 months Mild dental disease Cardiac gallop rhythm
Abnormal PE/Chem/CBC/UA Results: Most significant findings from lab work over past 4 months - CBC - mild microcytic, hyperchromic, nonregenerative anemia; monocytosis, eosinophilia Chem - ALT 348, ALKP 170, cholesterol 243, NOSF TT4 - 3.8, free T4 by ED 1.5ng/dL (ref 1.2-4.3) UA - USG 1.039, trace proteinuria, Will email all most recent labs

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction 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.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. Both kidneys exhibited subtle cortical hypertrophy with mild uniform Increased cortex echogenicity. Mild loss of corticomedullary border demarcation was noted. No evidence of pyelectasia was present. The left kidney measured 4.2 cm in length. The right kidney measured 4.7 cm in length.

Adrenal Glands

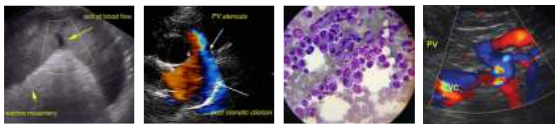
No overt pathology was noted in the area of the left adrenal gland. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.53 cm width.

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.

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 mild gallbladder debris. 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 0.25 cm.

The small intestine presented intact wall layering with generalized propensity for mildly prominent muscularis layer, yet without overt evidence of mural hypertrophy, loss of intestinal wall layering, or Intestinal masses. The jejunum wall width measured 0.26 cm.

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

Pancreas

The left limb of the pancreas was mildly prominent in size with asymmetrical contour and heterogeneous to subtle hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

No omental masses, lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Probable IBD
- Concurrent low-grade to chronic active pancreatitis
- Hepatopathy - subjectively benign
- Mild gallbladder debris
- Bilateral mild chronic renal changes

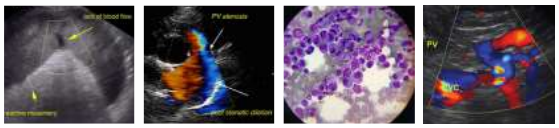
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine exhibited subtle mural changes suggestive of chronic inflammatory enteropathy / IBD. A minor potential for low-grade neoplastic Infiltrative enteropathy with round cells i.e., low-grade lymphoma is possible yet thought less likely.

Given the strong possibility of concurrent hepatobiliary inflammation and pancreatitis, a primary concern for chronic Triad Disease is warranted. Further assessment may include A GI panel to include PLI/TLI/Cobalamin/Folate. Definitive diagnosis would require full-thickness intestinal biopsies as well as pancreatic and hepatica biopsies. Three view chest radiographs are suggested to rule out occult thoracic pathology which may account for weight loss in geriatric patients.

Empirically, some or all of the following protocol may be considered.

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



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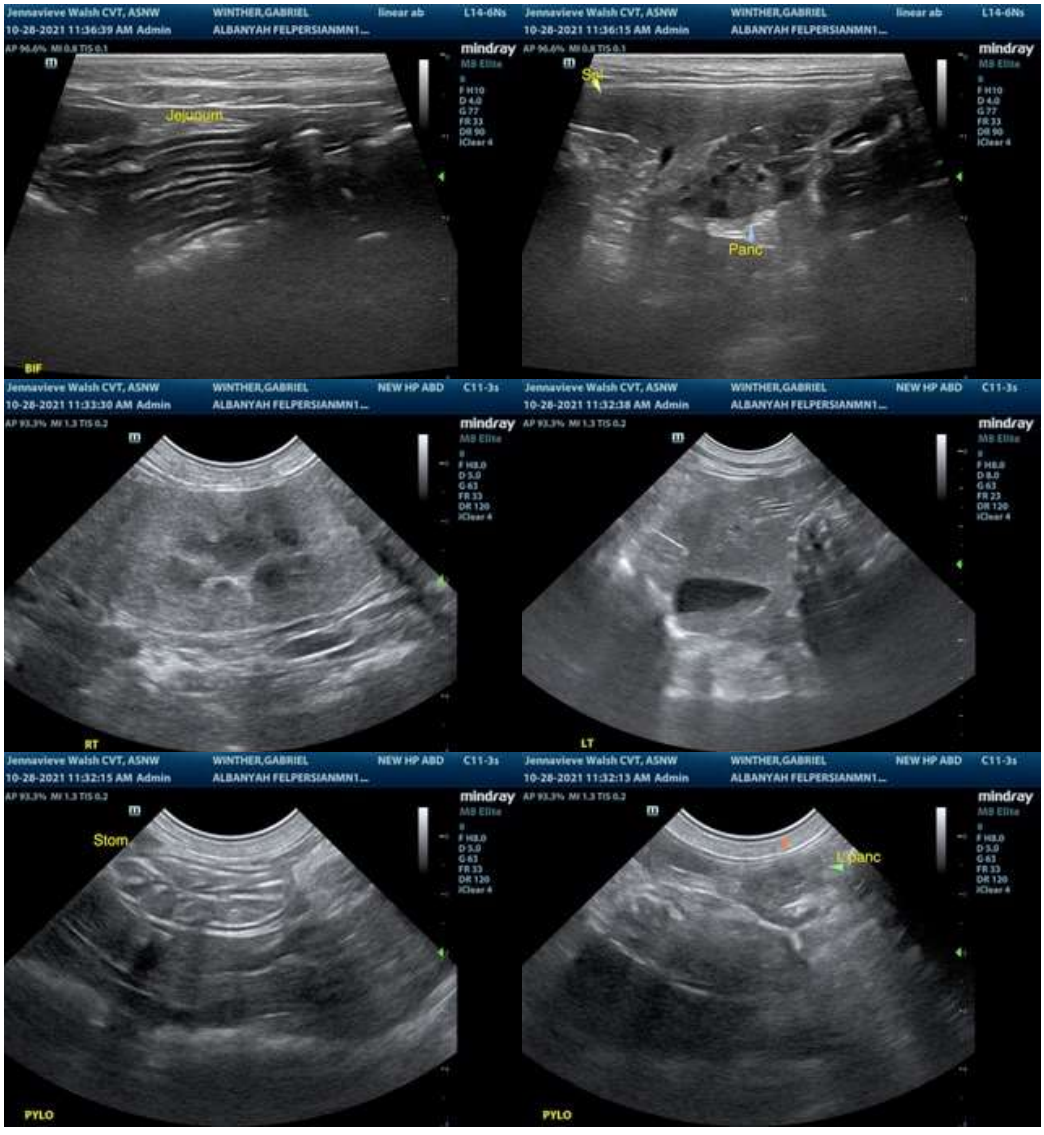
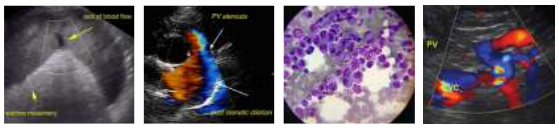
mg/kg tapering over 1 week to minimal effective dose), and **B12 injections** if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet (***Hydrolyzed diets have been shown 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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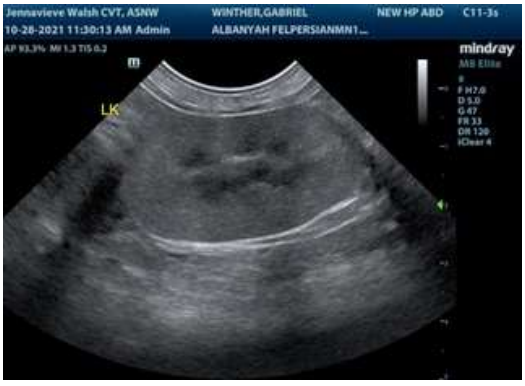

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com