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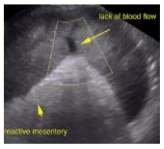

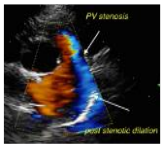

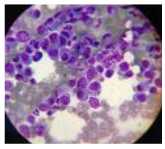
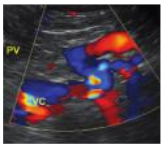

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Nora Troutman

SPECIES

Feline

BREED

DSH

SEX

SF

AGE

11 yr

WEIGHT

8 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Robyn Lantz

HOSPITAL NAME

Eastgate VC

REFERRING VET

Dr. Lindsey Franz

INVOICE

15362

DATE

11/3/22

PRESENTING CLINICAL SIGNS

Not eating well for the past 1-2 months. Will lick the gravy off the food but not willing to eat the chunks of meat. No dry kibble O unsure able litterbox habits- Pt has v+ a few times being very uncommon- last time being 1 week ago. Pt has been retreating more away from the O recently over the past week Had BW done at VCA in Salem O looking for a second opinion. On canned/wet food Started yesterday (on 11/2/2022) Prednisolone 5mg Tablets each Give 1/4 tab by mouth twice daily for 3 days, then 1/4 tablet by mouth once daily for 7 days, then 1/4 tablet by mouth every other day until gone. Do not give with NSAIDs. Watch for dark tarry stools, diarrhea, vomiting; call if noted.

Abnormal PE/Chem/CBC/UA Results: Diffuse muscle atrophy of the epaxial muscles and the muscles comprising the thighs and shoulders 2-3/4 tartar molars 0.6/6 cardiac murmur 1. Grade 2-3/4 Periodontal Disease 2. Grade 0.6/6 Systolic Murmur, Parasternal 3. Periodic vomiting. 4. Anorexia. Differentials include: systemic (cancer, pain), alimentary tract, endocrine/metabolic, neurological, other. 5. Weight loss. Differentials include: neoplasia, infectious, inflammatory, loss of nutrients, maldigestion, malabsorption. ALBUMIN 2.5 2.5 - 3.9 g/dL GLOBULIN 5.3 2.3 - 5.3 g/dL SODIUM 151 145 - 158 mEq/L POTASSIUM 5.0 3.4 - 5.6 mEq/L NA/K RATIO 30 32 - 41 RBC 6.2 5.92 - 9.93 10^12/L HGB 9.1 9.3 - 15.9 g/dL HCT 28 29 - 48 % Platelet Count 115 200 - 500 10^3/uL Platelet count reflects the minimum number due to platelet clumping. Platelet Estimate Adequate Absolute Neutrophils 10788 2500 - 8500 /uL Absolute Lymphocytes 1116 1200 - 8000 /uL Occult Blood 3+ Negative RBC 11-20 0-3 /HPF Appearance CLOUDY Specific Gravity 1.054 pH 6.5 Protein 2+ SDMA 11.4 (<15 ug/dL) 14-Oct-2022 ANTECH US Guided Cystocentesis

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. 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. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. A hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. The left kidney measured 3.5 cm length. The right kidney measured 3.8 cm length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized potentially owing to suppression secondary to Prednisolone therapy.

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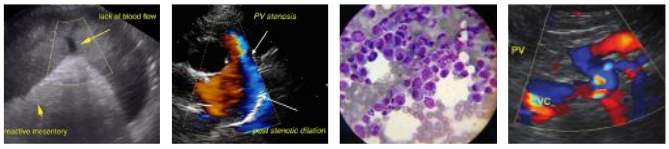

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Spleen

The spleen exhibited borderline to mild enlargement yet maintained a symmetrical capsule contour and a finely textured homogeneous parenchyma. No splenic masses or nodules were noted. Normal splenic vascularity was noted. The spleen measured 1.1-1.2 cm width at the level of the hilus.

Liver/ Gallbladder

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 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

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 0.28 cm.

The small intestine exhibited intact wall layering and subjective maintained 1:3 muscularis/mucosa ratio in the visualized intestinal segments. The duodenum wall measured 0.26 cm width. The jejunum wall measured 0.25 cm width. The ileocolic wall measured 0.36 cm width.

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

Pancreas

The pancreas was normal to mildly prominent in size exhibiting subtle hypoechoic to nonhomogeneous parenchyma compared to adjacent omentum. Evidence of minor pancreatic duct dilation was noted.

Free Abdomen

Multiple midabdominal mesenteric lymph nodes were present. 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. An example of lymph node size was 2.9 cm x 0.82 cm. No free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- Bilateral nonspecific medullary rim sign
- Borderline to mild splenomegaly - nonspecific, mild splenomegaly owing to sedation if clinically applicable, patient variant, benign incidental hyperplasia, hematopoiesis, splenitis, possible emerging round cell neoplasia cannot be definitively excluded
- Subjective chronic enteropathy
- Associated hypoechoic to variably sized mesenteric lymphadenopathy - hyperplasia, lymphadenitis secondary to chronic enteropathy, neoplastic lymphadenopathy, all potentials
- Possible low-grade pancreatitis

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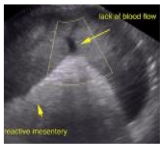
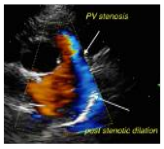
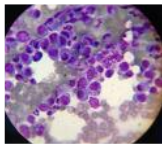
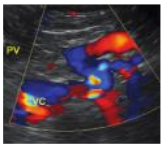

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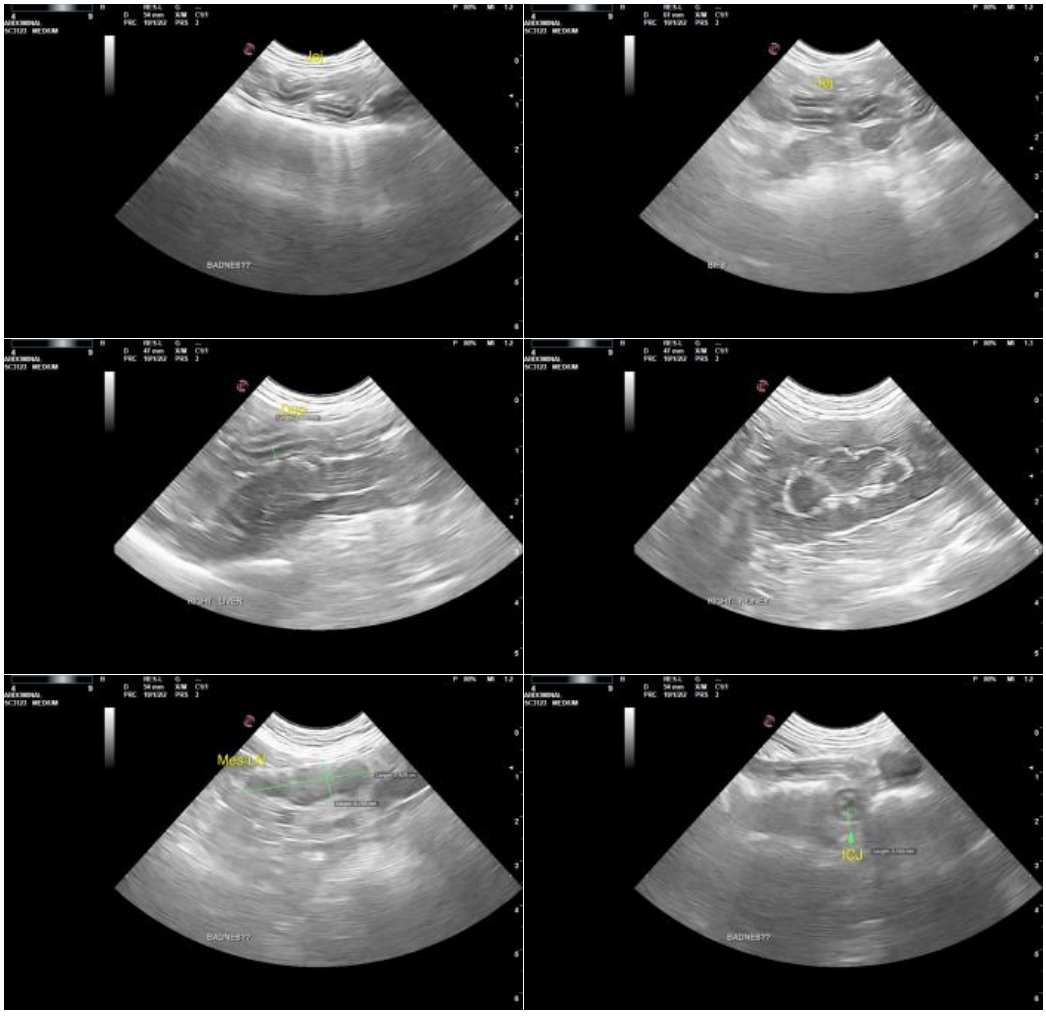
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although no evidence of overt gastrointestinal mural pathology with possible suppression of gastrointestinal mural changes owing to Prednisolone, underlying chronic intestinal disease is suspected given the clinical signs, weight loss, as well as loss of muscle mass. Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate, screening FNA lymph node cytology, assuming normal clotting status, is warranted.

Baseline UPC level for further renal staging, given the mild proteinuria and quiet urinary bladder sediment, is suggested. Full-thickness intestinal and lymphatic biopsies are likely required for a definitive diagnosis. If not done, three-view chest radiographs are suggested to rule out occult thoracic pathology as a contributing factor.



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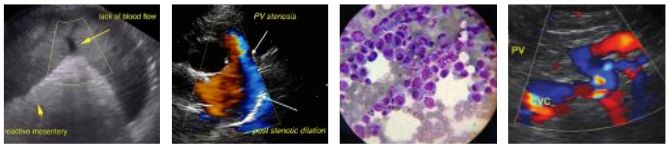

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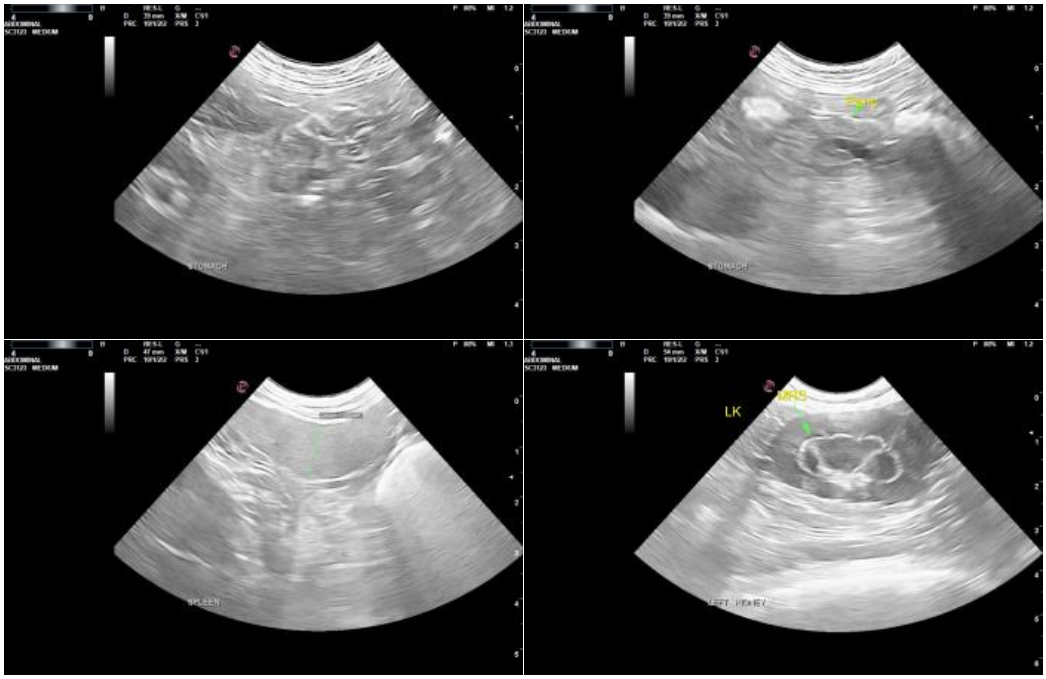

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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