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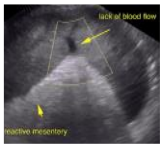
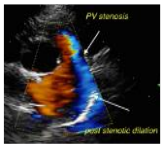
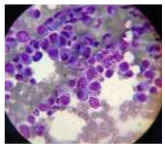
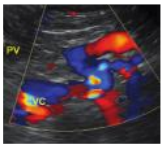




SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Xena Anthony

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

6 years

WEIGHT

5.8 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Robyn Lantz

HOSPITAL NAME

Eastgate Veterinary Clinic

REFERRING VET

Krisy Kelley

INVOICE

16236

DATE

2/21/23

PRESENTING CLINICAL SIGNS

1/6/23 - _P is eating cat litter, O is wondering about Pica. O noticed a week ago. P threw up cat litter a couple nights ago. P likes to eat other things and lick plastic. Using clumping litter. P will occasionally have diarrhea for the past few days. But P will occasionally have constipation or diarrhea. Very noisy GI tract P drinks and pees a lot. Eating cat litter. On gabapentin as needed.

1/26/23 - Eats RC GI diet recheck cbc, since last time she was here, food was switched, wasn't eating as much of it and was having constant diarrhea, switched to old food earlier this week, still eating the same amount but more enthusiastically. Eating 1/8 cup less a day. Got anxiety med before today but threw it up. Has a history of some diarrhea and constipation, hasn't had an issue like that for months. O mightve caught her eating litter, hard to tell, hasn't V+ litter. Finished abx without issue

1/30/23 - Energy has been a bit higher, P is still not eating as much, P was very active and ate after appetite stimulant. P didnt eat as much the second time, P had some loose stool. P is still having a lot of gas_ Currently on: Revolution, Mirtazapine 1/4 SID, Lactulose BID, Orbax_ Start P on 1 U glargine (U-100) BID today >>>Spot BG in 3-5d after start tx, place Libra at time of spot glucose >>>Glucose curve in 2 weeks post starting this dose Leukocytosis: Continue course of Orbax >>>Recheck CBC/Chem at time of glucose curve GI Clinical Signs: Mix wet and dry food together in meals (rather than free feed both options) to encourage appetite Change Mirtazapine and Lactulose to PRN Continue Revolution Plus

2/6/23 - _P was doing well initially after starting insulin. P is now starting to go down hill. P is not wanting to eat as much. Does well after mirtazapine Currently on Insulin, Lactulose, Mirtazapine

Abnormal PE/Chem/CBC/UA Results: Specific Gravity 1.076 (HIGH) 1.015-1.060 Protein 1+ (HIGH) NEGATIVE Bilirubin 1+ (HIGH) NEGATIVE Calcium Oxalate Dihydrate Crystals 11-20_ Culture NO GROWTH ON SOLID MEDIA IN 72 HRS. Increased albumin (1.9 g/dL; reference range 2.3-3.9 g/dL) Decreased BUN (13 mg/dL; reference range 14-36 mg/dL)_ Increased glucose (359 mg/dL; reference range 64-170 mg/dL) Decreased calcium (7.8 mg/dL; reference range 8.2-10.8 mg/dL) Decreased CPK (51 IU/L; reference range 56-529 IU/L) Complete Blood Count NSF Increased WBC count (38.0 x 10^3/UL; reference range 3.5-16.0 x 10^3/uL)__ Increased neutrophils (31,920/uL; 2,500-8,500/uL) Increased monocytes (760/uL; reference range 0-600/uL) Total T4 WNL 1/27/2023 blood work 2/10/23 urinalysis/culture

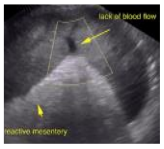
ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

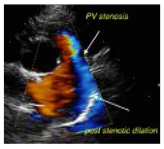
Urinary System

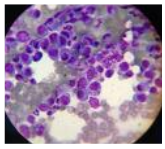
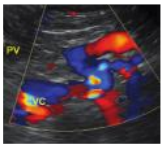
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

No evidence of significant medial iliac or sublumbar lymphadenopathy was noted.

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





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with no evidence of pelvic dilation or pyelectasia. The left kidney measured 4.0 cm in length. The right kidney measured 4.3 cm in length.

Adrenal Glands

No overt pathology was noted in the area of the left or right adrenal glands.

Spleen

The spleen exhibited normal to borderline enlargement, maintained symmetrical capsule contour and a finely textured and homogenous parenchyma. The spleen measured 0.94 cm width at the level of the hilus.

Liver/ Gallbladder

The liver exhibited subjective borderline to mild enlargement. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended to mildly contracted in appearance containing primarily anechoic content. The cystic and common bile ducts were normal. No evidence of post hepatic stasis was noted.

Transdiaphragmatic view revealed a mild comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Minor retained anechoic pyloric fluid was noted with no signs of ileus, obstruction, or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no overt small intestinal obstructive pattern or definitive foreign material. The jejunum wall measured 0.20 cm width.

The subjective colon appeared to exhibit generalized distention containing formed to semi-formed fecal matter, as well as segmental mildly thickened to indistinct wall layering. The colon wall subjectively measured 0.38 cm in wall width.

Pancreas

The left pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses or overt lymphadenopathy was noted. A very scant pocket of free fluid was noted in the cranial abdomen around the ventral liver.

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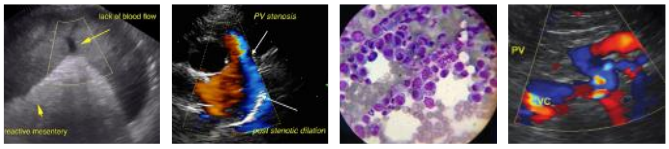

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ULTRASONOGRAPHIC FINDINGS

- Subjective borderline to mild hepatomegaly - overtly benign, possible emerging diabetic hepatopathy
- Sonographically unremarkable to mildly contracted gallbladder
- Heterogeneous left pancreas - not overtly consistent with significant or active pancreatitis, patient variant or low-grade / chronic pancreatitis possible
- Suspect segmentally thickened generalized distended colon containing formed shadowing to semi-formed fecal matter
- Minor retained pyloric fluid, overtly normal visualized small bowel
- Nonspecific mild transdiaphragmatic comet tail artifact

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the history of Pica in this patient, nonspecific generalized gastroenterocolic disease may be of primary concern. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Although the colon appeared to be segmentally thickened and distended with fecal matter, the possibility of segmental intestinal distention with retained ingesta cannot be definitively excluded. Enterocolic biopsies are likely required for a definitive diagnosis.

Continued monitoring of serum glucose levels, as well as periodic urinary C/S if evidence of glucose urea, is indicated. Three-view chest radiographs are recommended to assess for evidence of thoracic pathology.

Empirically, a hydrolyzed diet trial, cobalamin supplementation pending assessment of cobalamin levels, and empirical therapy for constipation if clinically indicated would be reasonable.

For an additional charge, internal medicine consult can be utilized through Sonopath.com. You can select the internal medicine drop down at http://spa.sonopath.com/.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services

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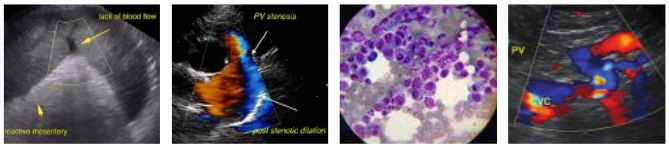

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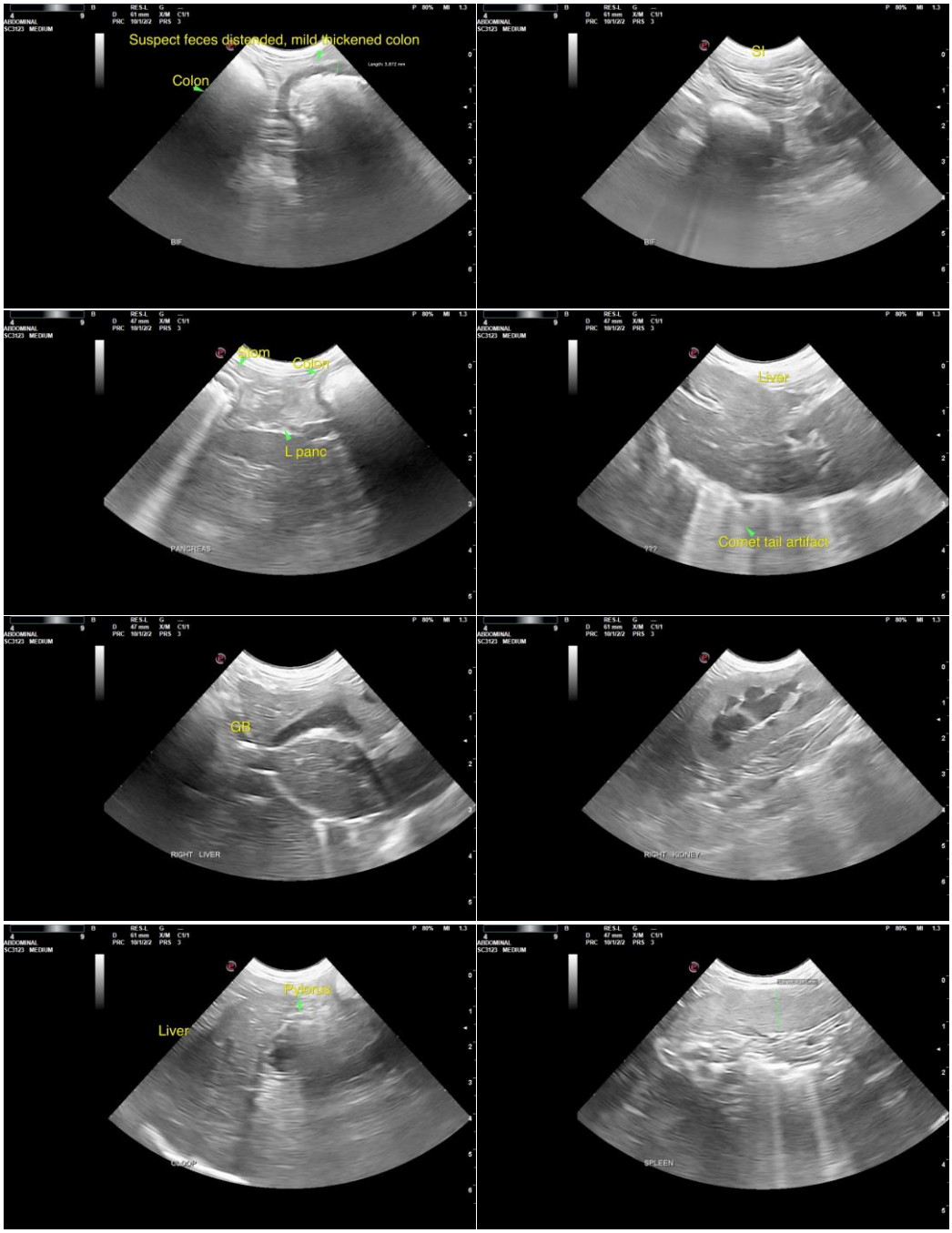

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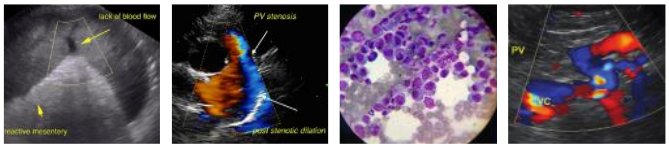

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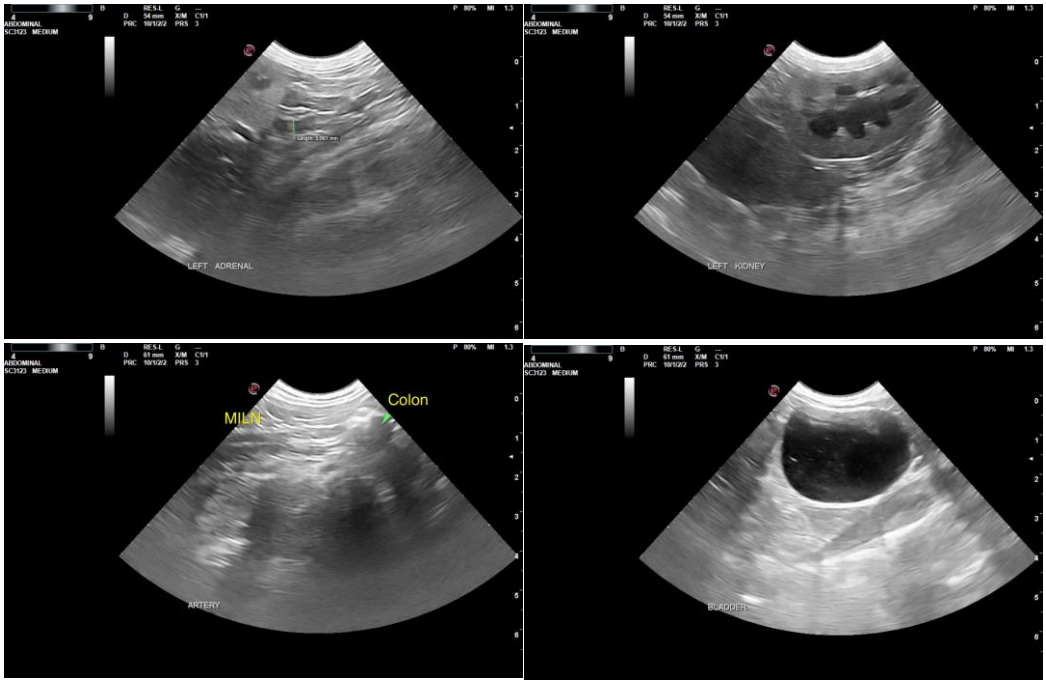

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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