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Clinical Sonography & Telecytology
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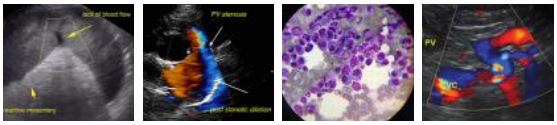


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Freckles Pride

SPECIES

Feline

BREED

DLH

SEX

Neutered male

AGE

12 years

WEIGHT

9 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Ark Animal Hospital

REFERRING VET

Dr. Parker

INVOICE

10109ag

DATE

03/02/2022

PRESENTING CLINICAL SIGNS

History: presenting concern: chronic nasal discharge, weight loss, low energy, halitosis, recent increased vomiting, defecating outside the litterbox.
Abnormal PE/Chem/CBC/UA Results: 2/12/2022-Complete Blood Count NSF ~ 38 platelets/hpf w/ clumping on manual count by RLE See in house lab CBC, mild anemia; mild thrombocytopenia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Mild bilateral pyelectasia was observed. The left kidney measured 4.3 cm in length. The right kidney measured 4.6 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.53 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.58 cm width at the caudal pole.

Spleen

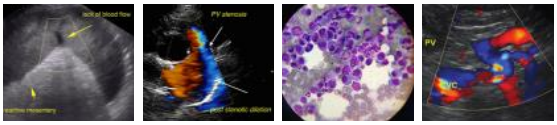
The spleen exhibited subjective to borderline enlarged in size with a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 1.0 cm in width at the level of the hilus.

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 in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and very minor debris in the cranial lumen. 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.



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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. The jejunum wall measured 0.23 cm. The duodenum wall measured 0.36 cm.

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

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 reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

No omental masses, lymphadenopathy or peritoneal effusion noted.

ULTRASONOGRAPHIC FINDINGS

- Moderate nonspecific chronic renal changes with mild pyelectasia.
- Pancreatitis.
- Overtly normal gastrointestinal tract.
- Very mild gallbladder debris-incidental, potentially suggestive of mild nonclinical cholestasis.

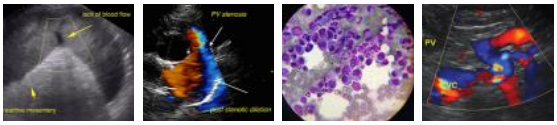
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bilateral pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.

Potential for structurally insignificant gastroenteropathy given the patient's weight loss may be possible and cannot be definitively excluded. Assessment for subxiphoid or cranial abdominal discomfort on palpation associated with the pancreas is recommended. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended for further assessment.

If not recently done, assessment of full chemistry panel is recommended to rule out potential for concurrent hepatopathy. Empirically as needed gastrointestinal support and conservative pancreatitis/triad disease protocol may prove beneficial pending GI panel results.

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 (Cyanocobalamin 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



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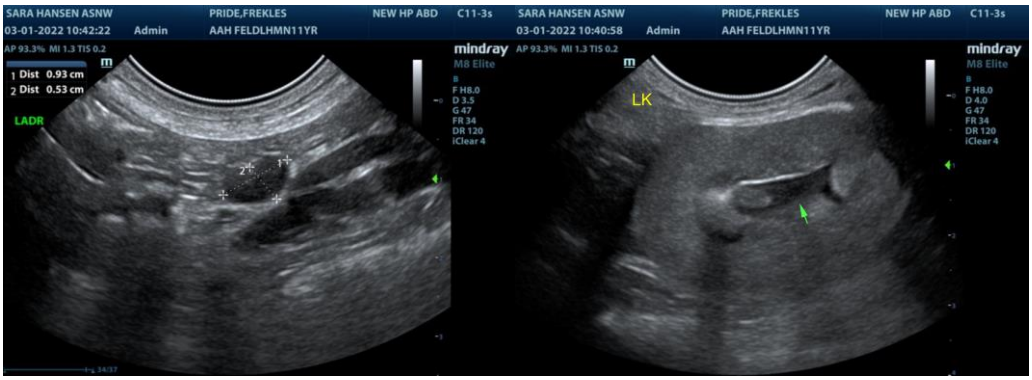
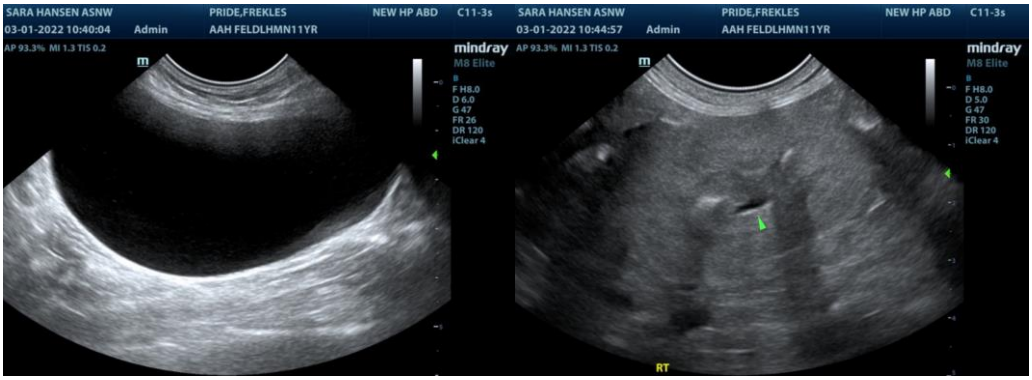
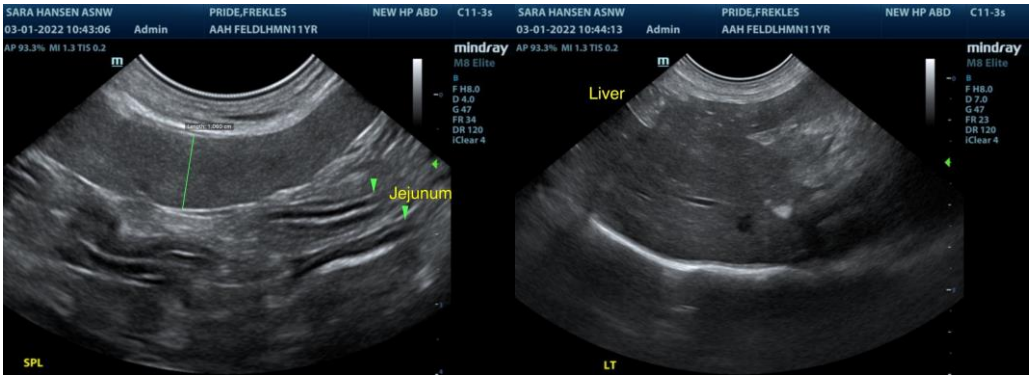
disease. One diet does not work for all patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.







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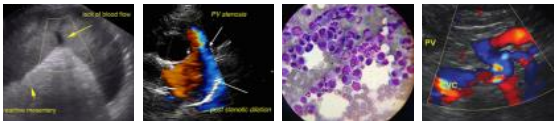

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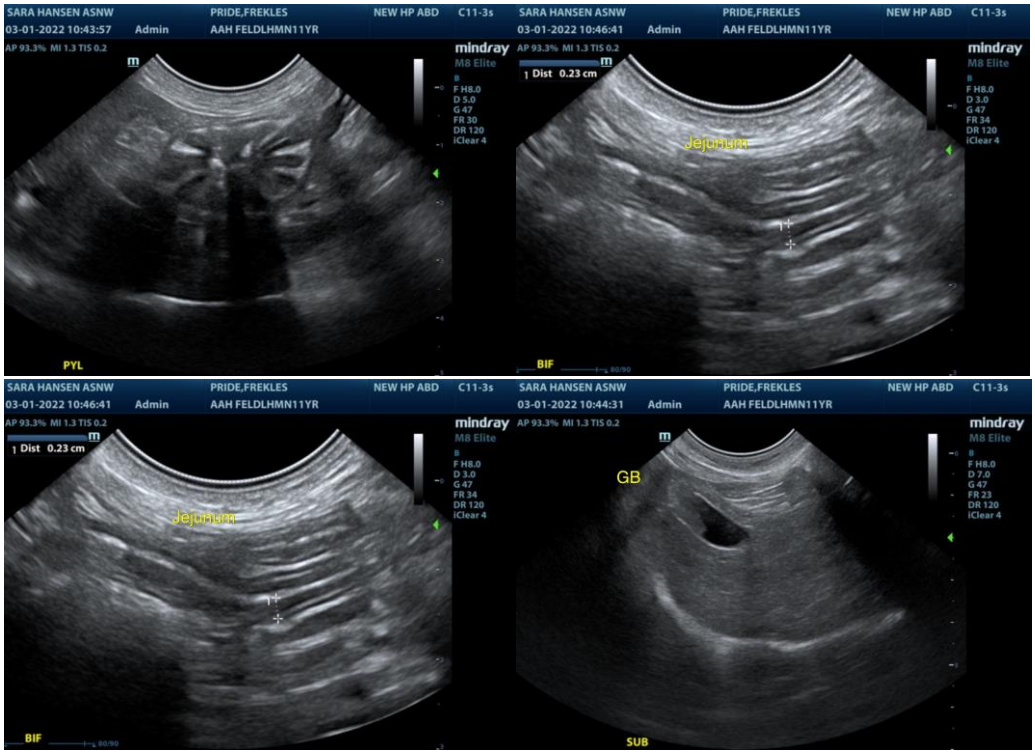

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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