

PATIENT

Pip De Anda/Gill

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

13 years

WEIGHT

5.0 lbs.

PRESENTING CLINICAL SIGNS

P has a chronic history of inflammatory bowel disease, megacolon and chronic pancreatitis diagnosed at a different clinic (Banfield) which has been ongoing for many years. She has recently been losing weight and feces looks just like undigested food. P has been having trouble swallowing and acts like it's difficult; won't eat voluntarily so O has been syringe feeding wet food this week. P has lost 0.8lbs since last exam on 4/21/23 (was 5.8lbs; now 5.0lbs). Ongoing issues with urinary tract infections (last urine culture done 03/07/2023 positive for E. Coli and sensitive to Clavamox). UTI seemed to clear up but then this week P has been having hematuria/stranguria again (UA pending). On physical exam P is very thin (BCS 2/9) with oily/unkempt and dull colored hair coat, HR: 210, RR: 30 brpm, T: 100.9°F. No lesions of the oral cavity or neck are easily seen. P is taking prednisolone, gabapentin cisapride and cerenia PO at home. Current Medications Prednisolone 2.5mg PO BID, gabapentin 12.5 - 25mg PO BID - TID, cisapride 2.5mg PO BID - TID and cerenia 4 - 8mg PO SID; got first injection of vitamin B12 0.3mls SQ on 4/21/23 Radiographic Findings Marked gas accumulation all throughout small intestines, mottled material in stomach and colon which appear similar (ingesta), normal silhouettes of the kidneys, bladder, liver. Good serosal detail. Chest cavity appears normally. Primary Question/Differential to Be Answered in This Exam How does P's pancreas appear? Is there a mass present from chronic pancreatitis/suspected EPI or is this purely inflammatory/functional in nature? Are there signs of neoplasia or other abnormalities in any other area? How does the bladder appear and does it show a cause for P's chronic UTIs/hematuria?

INTERPRETED BY

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

Abnormal PE/Chem/CBC/UA Results: - GI panel from Idexx - Suspicious for EPI, but TLI portion is still pending. SpfPL 50 (H; ref range 0.0 - 3.5); cobalamin very low at <150 (ref range 276 - 1,425); folate very high at >24.0 (ref range 8.9 - 19.9) - CBC/CHEM17 and UA pending (will send to ASNW e-mail once completed today)

IMAGING PERFORMED BY

Jenna Walsh, CVT

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.

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The left kidney was subnormal in size exhibiting discernable corticomedullary architecture with uniform increased cortex echogenicity and mildly enhanced corticomedullary border demarcation. No left kidney pyelectasia was noted. The left kidney measured 1.7 cm in length.

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The right kidney was mildly prominent in size yet within normal renal parameters for cats measuring 4.2 cm in length. Mild asymmetrical capsule contour was present in the right kidney. Suspect cortical microinfarction was noted in the right kidney. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of



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corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Mild right kidney pyelectasia was noted.

Adrenal Glands

The adrenal glands were not visualized owing to likely suppression secondary to prednisolone therapy.

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. A moderately sized nonhomogeneous to cystic intraparenchymal mass was present in the mid liver measuring 3.4 cm in diameter. The gallbladder was subnormal in size with thin walls and primarily anechoic luminal content. The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction. The proximal common bile duct measured 0.18 cm diameter.

Gastrointestinal

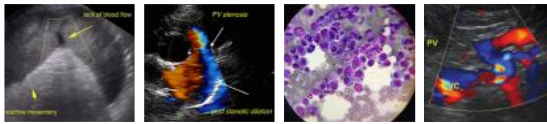
The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material.

The 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 small intestine exhibited segmental to generalized intestinal gas pattern. The duodenum wall measured 0.22 cm width. The jejunum wall measured 0.18-0.20 cm width.

Normal visible colon wall layers were present with subjective formed to semi-formed fecal matter in lumen.

Pancreas

The left and right pancreatic limb exhibited variable prominent size with capsule asymmetry and nonhomogeneous to mild hypoechoic parenchyma. Multiple, variably sized pancreatic cysts were present in the left pancreatic limb with an example measuring 1.0 cm in diameter.



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Free Abdomen

No omental masses, lymphadenopathy, or evidence of peritoneal effusion were noted. Subtle evidence of peripancreatic hyperechoic omentum was noted.

ULTRASONOGRAPHIC FINDINGS

- Normal urinary bladder / visible proximal urethra
- Left kidney subnormal size with moderate chronic degenerative changes
- Right kidney moderate chronic renal changes with mild pyelectasia, subjective borderline compensatory hypertrophy
- Cystic nonhomogeneous liver mass - suspect benign biliary cyst adenoma
- Nonobstructive proximal common bile duct dilation - age-related common bile duct changes, possible low-grade cholangitis
- Chronic pancreatitis with multiple variably sized pancreatic cysts
- Structurally unremarkable gastrointestinal tract / colon

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potentially, Prednisolone use may be masking gastroenterocolic mural changes.

Assessment for evidence of cranial abdominal or subxiphoid discomfort on palpation, which may correlate with chronic pancreatitis, is suggested.

The decreased cobalamin level is consistent with distal small intestinal disease, while the elevated folate level, although nonspecific, may suggest proximal small intestinal disease or dysbiosis.

Assessment of gastrointestinal response to supplemented cobalamin going forward is suggested. Chronic Triad Disease may be a consideration in this patient, given possible low-grade cholangitis or if previous or future hepatic enzyme elevations.

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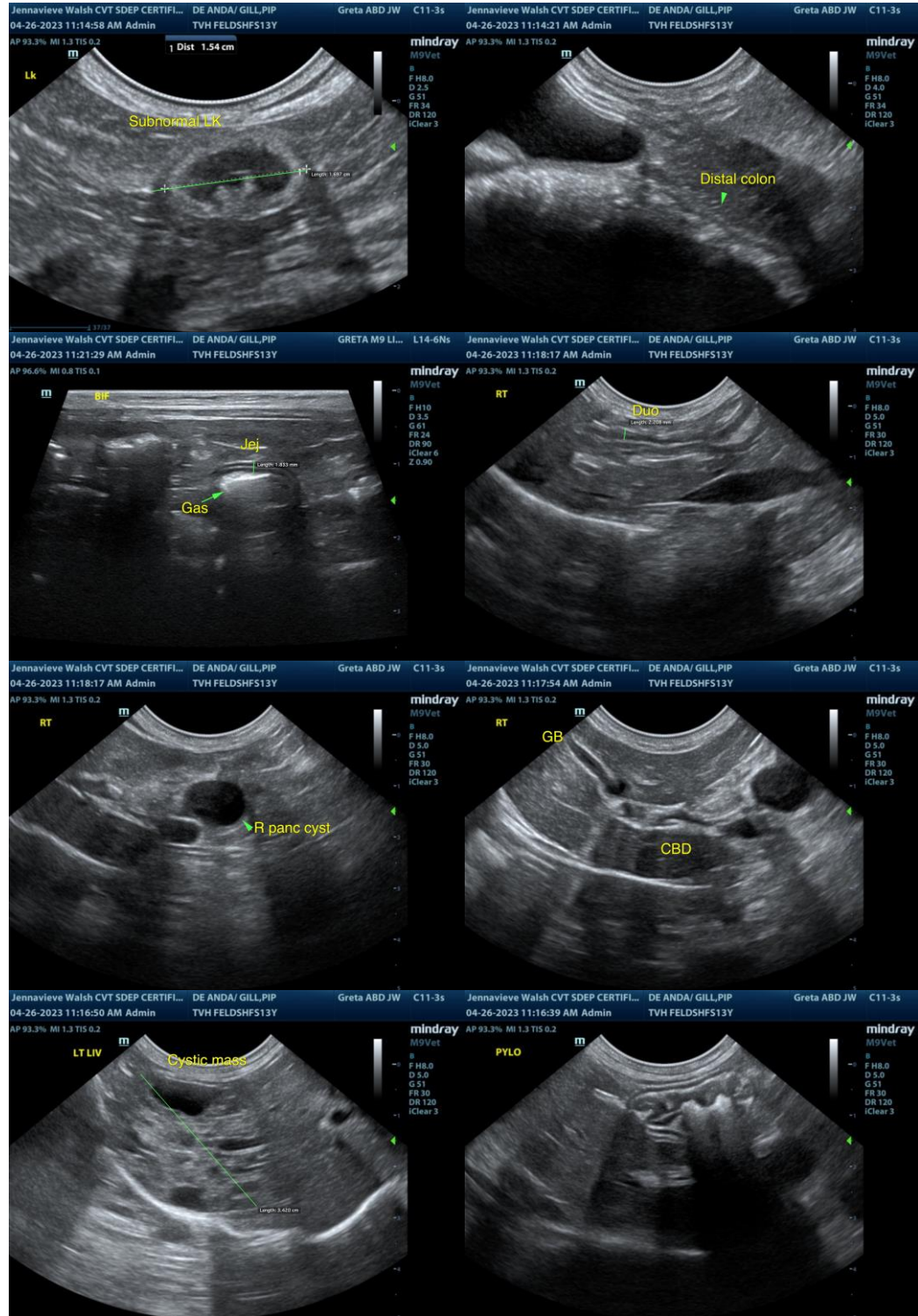
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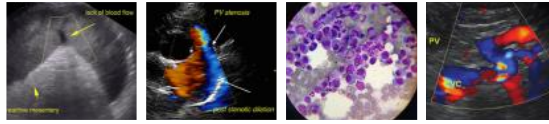
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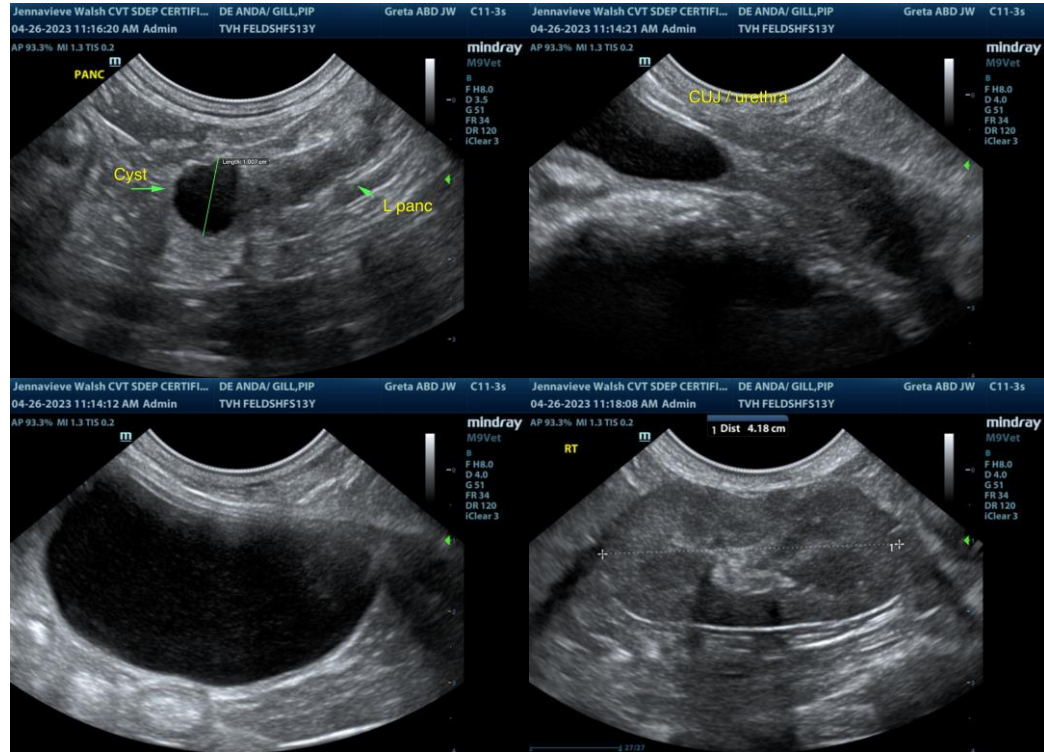
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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