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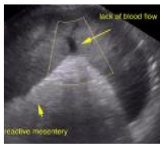
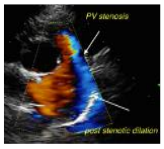
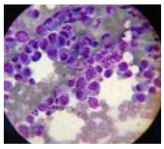
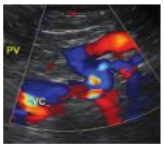





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Mya Massey

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

2.7 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Shannon Heintz

HOSPITAL NAME

Pennsauken AH & UC

REFERRING VET

Shannon Heintz

INVOICE

15245

DATE

5/17/22

PRESENTING CLINICAL SIGNS

History: For ultrasound blurb: P presented in April for weight loss noted at home per owners for the last month along with a ravenous increase in appetite. P has lost 2 lbs in the last couple months, and appetite has increased tremendously. When P is not monitored, she will go lick counters or kitchen sink for pieces of food left over because she is so hungry. O also reports that P has also started vomiting and having diarrhea. O reports the vomit is small amount bile/foam overnight. This is occuring now 3-5 times a week. She is having diarrhea once a day or every other day in small amounts. No new changes in her diet. She is currently on Tastefuls by Blue Buffalo. She has not gained any weight even when the owners doubled the amount of wet food they were feeding twice a day. Previous medical history includes spay when P was young, a previous dental in December, and a minor creatinine elevation at this time (1.9mg/dL). On physical exam, P has minimal muscle wasting, a BCS of 4/9, and minor tartar diffusely. Intial CBC/chemistry/thyroid was largely unremarkable except for an azotemia (see below). Non-invasive systolic blood pressure was noted to be 130-140mmHg repeatedly.
Abnormal PE/Chem/CBC/UA Results: SDMA 16 crt 2.4 TT4 2.6 USG from free catch urine was 1.022 Free T4 by ED was 29.6pmol/L (normal)

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 were noted. Aortic trifurcation was normal.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.4 cm in length. The right kidney measured 3.2 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 0.29 cm.

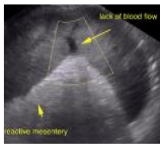
The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.31 cm.

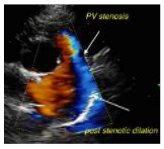
Spleen

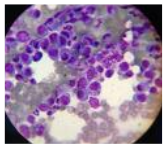
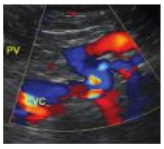
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.56 cm.

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. No evidence of hepatic neoplastic criteria.





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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 exhibited overtly normal wall layering with moderate gastric distention, secondary to retained non-shadowing ingesta/chyme. No overt evidence of mechanical pyloric outflow obstruction.

The small intestine presented intact wall layering with subjective maintained 1:3 muscularis/mucosa ratio and without evidence of loss of intestinal wall layering, masses or mechanical obstruction. The ileocolic wall measured 0.25 cm. The duodenum wall measured 0.29 cm. The jejunum wall measured 0.20 cm.

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

Pancreas

The pancreas exhibited normal size and contour with mild nonhomogeneous to hypoechoic parenchyma compared to adjacent nonreactive or inflamed peripancreatic omentum.

Free Abdomen

Very small pocket of scant free fluid was noted between the cranial pylorus and caudal liver margin.

Intermittent mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example measured 0.54 cm in diameter.

ULTRASONOGRAPHIC FINDINGS

- Moderate gastric distention with retained ingesta/chyme
- Overtly normal small bowel
- Suspect mild pancreatitis
- Mild chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The finding of moderate gastric distention with retained ingesta/chyme is nonspecific and may correlate with postprandial presentation. However, if documented NPO, some degree of metabolic gastric hypomotility or nonobstructive delayed gastric emptying could be considered. Given the normal T4 levels in this patient, and even without evidence of structural gastrointestinal pathology, underlying structurally insignificant gastroenteropathy, some contribution owing to suspected mild pancreatitis, is suspected.

A GI panel to include PLI/TLI/Cobalamin/Folate, as well as three view chest radiographs and neurological / musculoskeletal examination are recommended to assess for or rule out occult disease which may cause weight loss. A fresh fecal analysis, to assess for parasitic ova and/or empirical deworming, even if fecal testing is negative, or if clinically indicated, could be considered. No obvious evidence of intraabdominal neoplastic criteria.

Empirical therapy could include a hydrolyzed diet trial with increased caloric intake, empirical cobalamin supplementation, high colony count probiotics, as needed gastrointestinal support +/-

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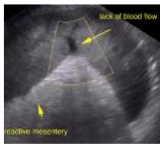
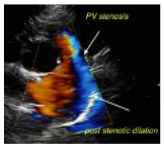
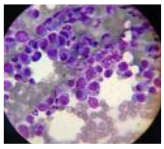
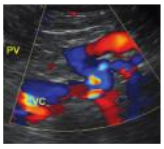

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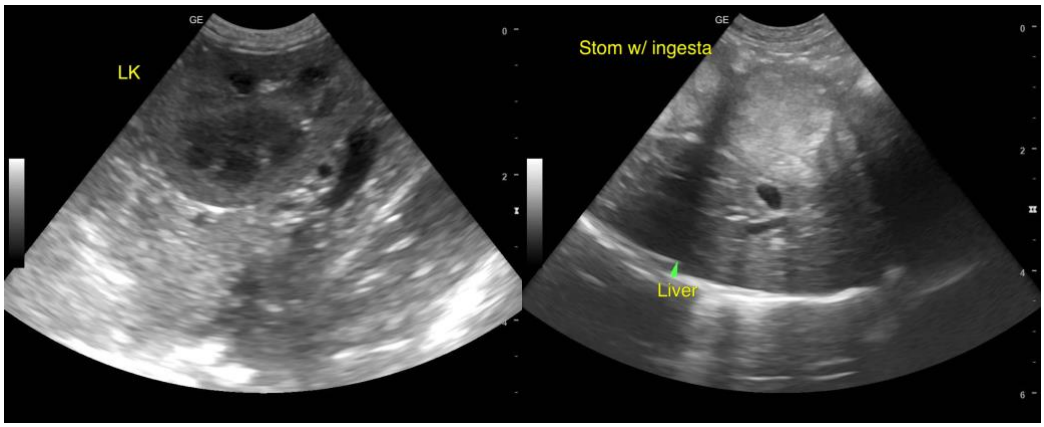
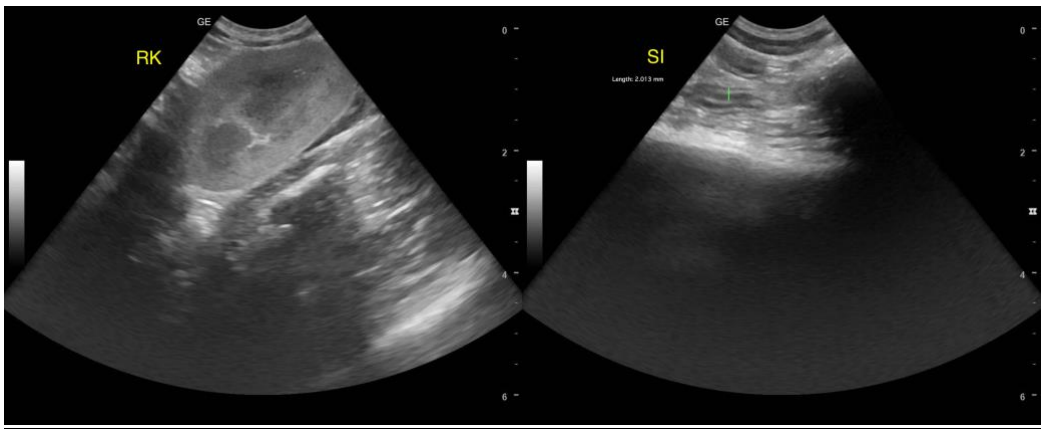
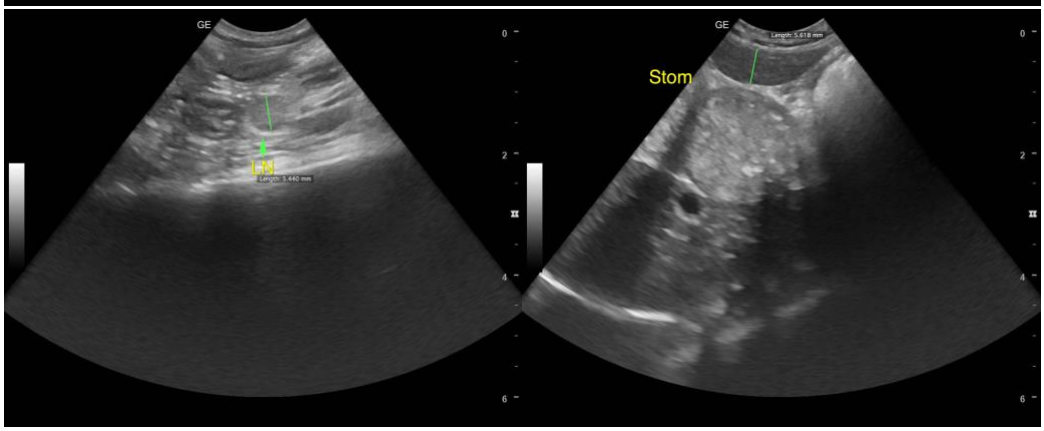
Prednisolone trial (at lowest effective dose to control clinical signs with assessment of clinical response) and gastrointestinal biopsies, likely required for a definitive diagnosis.







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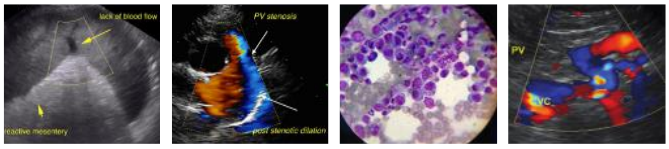

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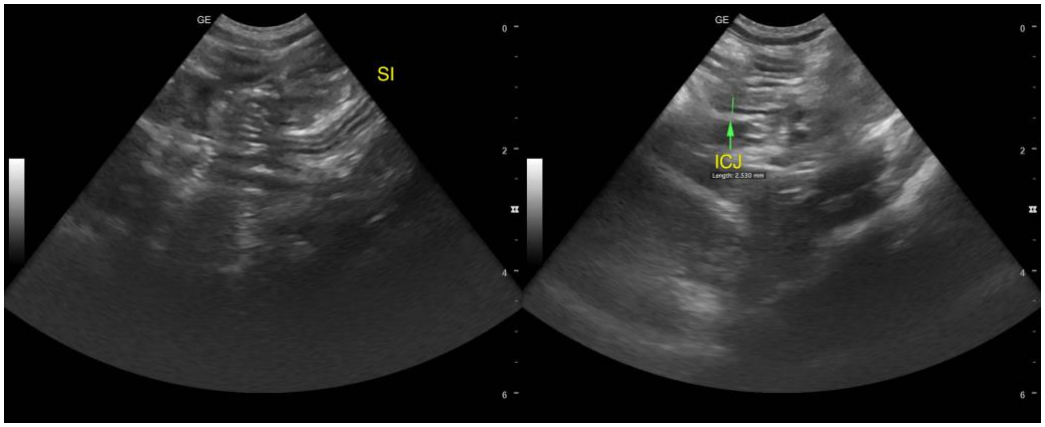

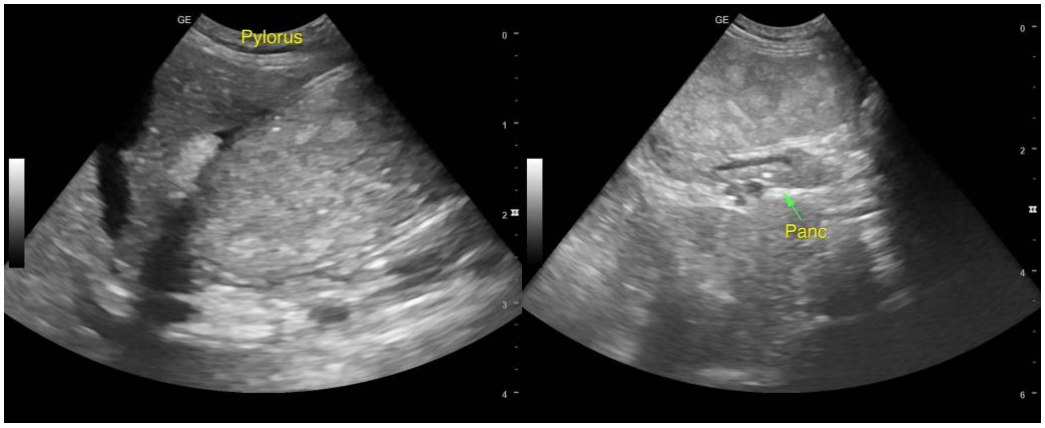

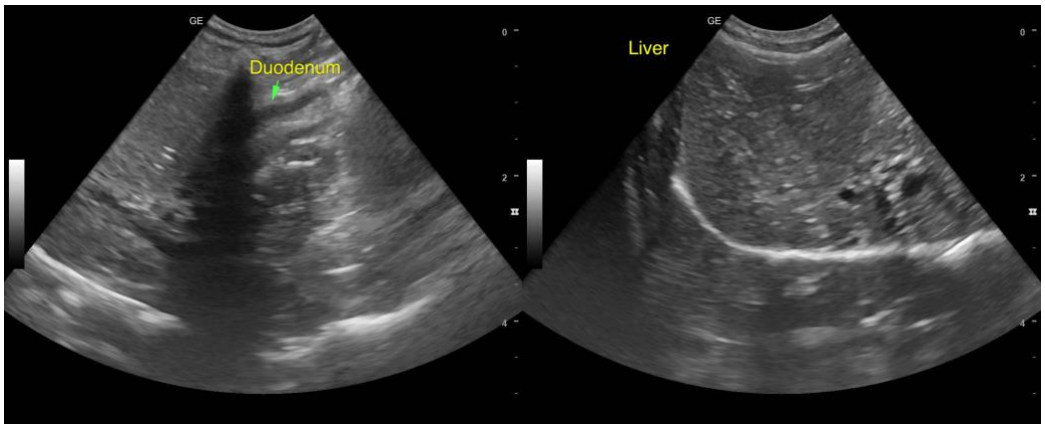

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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info@SonoPath.com

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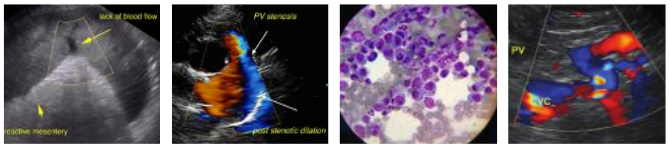

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