



PATIENT PRESENTING CLINICAL SIGNS

Toby Chuss History: Recheck, worsening clinical signs, continued weight loss, decreased appetite, vomiting, diarrhea Metronidazole, Methimazole, Prednisone

SPECIES ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Feline **Urinary System**

BREED The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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.

DSH

SEX Normal size and margination was 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. Pinpoint areas of medullary mineral were present bilaterally. The left kidney measured 3.9 cm in length. The right kidney measured 4.4 cm in length.

MN

AGE The area of the aortic trifurcation was free of pathology.

2011

Adrenal Glands

WEIGHT The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.39 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.32 cm width.

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Spleen

INTERPRETED BY 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 0.69 cm in width at the level of the hilus.

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

Liver

IMAGING PERFORMED BY 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.

Rebekah Jakum, CVT ARDMS/RVT

Gastrointestinal

HOSPITAL NAME 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.

Lehigh Valley AH

REFERRING VET 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.

Dr. Meyer

INVOICE The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. The jejunum wall 0.30 cm in width. The ileocolic wall measured 0.46 cm in width.

11203ag Normal visible colon wall layers were present with apparent soft feces in lumen.

Pancreas

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 07/26/2022



PATIENT Toby Chuss
 The pancreas exhibited normal size and contour with subtle hypoechoic homogeneous parenchyma compared to adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

SPECIES *Free Abdomen*

Feline No peritoneal effusion was present.

BREED DSH
 Focally enlarged mesenteric lymph nodes were present adjacent to the small intestine and the ileocolic junction. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic to peri intestinal inflammation was evident. An example of lymph node size was 0.65 cm in width.

SEX

ULTRASONOGRAPHIC FINDINGS

- MN
- Diffuse progressive thickened small intestine-consistent with infiltrative enteropathy
 - Associated variably sized hypoechoic mesenteric lymph nodes
 - Mild perilymphatic to peri intestinal reactive mesentery
 - Potential concurrent low grade pancreatitis
 - Static mild chronic renal changes

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The SI presentation exhibited progressive mural changes, increased muscularis layer thickening compared to the previous study and consistent with infiltrative enteropathy. Inflammatory enteropathy (IBD/eosinophilic enteritis) vs neoplastic enteropathy are possible. The progressive SI thickening was more definitive as was associated lymphadenopathy from the previous study. The potential for early neoplastic lymphadenopathy cannot be excluded. Assuming normal clotting status a lymph node FNA for screening cytology if accessible could be considered. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

INTERPRETED BY

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

Full thickness intestinal biopsies are likely required for a definitive diagnosis. Given the progression of intestinal changes despite corticosteroid therapy, higher potential for neoplastic infiltrative enteropathy could be possible. Continued prednisolone use with potential increased dose if clinically applicable and empirical cobalamin supplementation with as needed GI support would be reasonable. Three view chest radiographs suggested if not recently done to rule out occult thoracic pathology.

HOSPITAL NAME

Lehigh Valley AH

Pending GI panel and lab results, if persistent elevated ALT or evidence of pancreatitis, triad disease could be a consideration in this patient. Some or all of the following protocol could be considered.

REFERRING VET

Dr. Meyer

Part or all of this protocol may be considered based on your clinical impression of the patient:

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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 (Cyanobalamine 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

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then endoscopy would be warranted and/or recheck sonogram to assess more emerging 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.

SPECIES

Feline

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IMAGING PERFORMED BY

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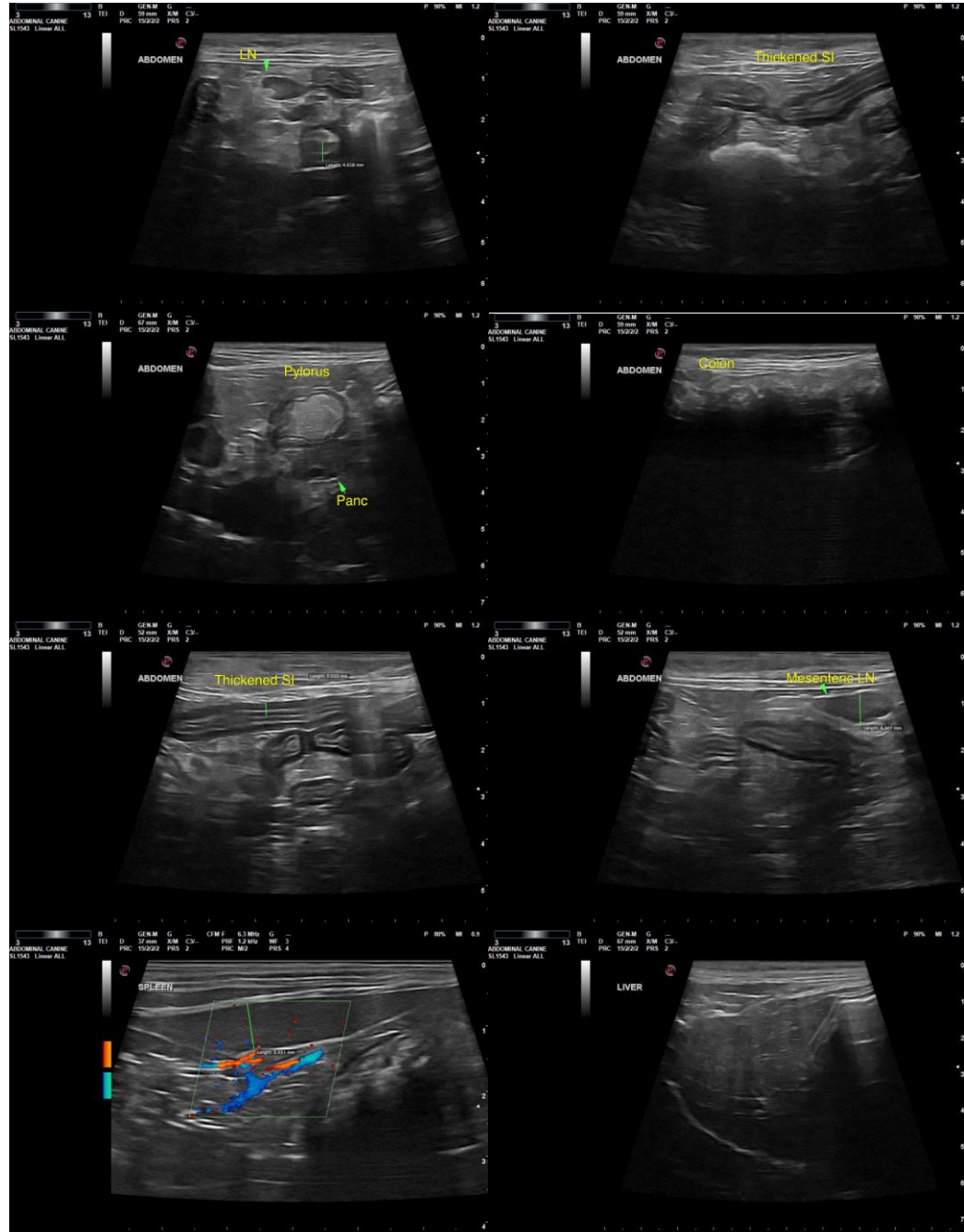
Dr. Meyer

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SPECIES

Feline

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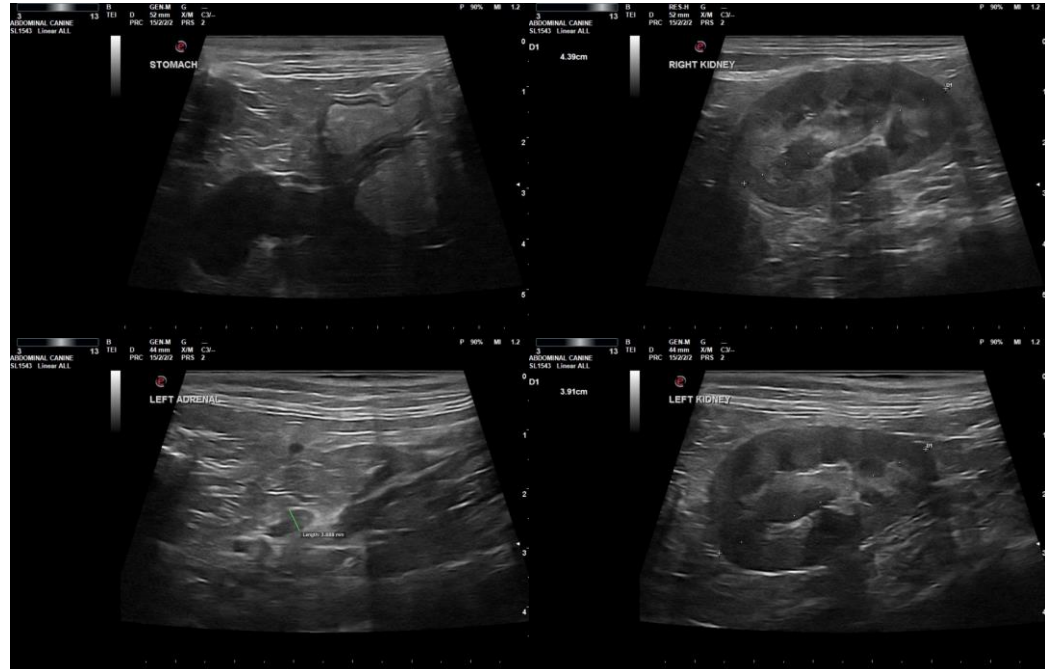
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

INTERPRETED BY

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

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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