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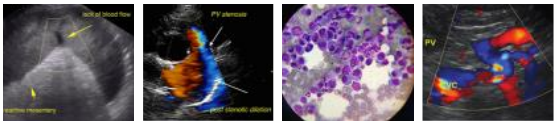


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Tiger Bolesky

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

16 Years

WEIGHT

9.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

East Gate VC

REFERRING VET

Dr. Tsuchida and Dr. Franz

INVOICE

23872

DATE

8/11/23

PRESENTING CLINICAL SIGNS

Historically hyperthyroid (refer to ABNORMAL laboratory findings) - on 8/7, vomited undigested food and water couple times a day. P is historically known to vomit if P eats food too quickly - P received Cerenia on 8/8 and vomited a hairball right after eating cheese (has not vomited since) - visited Wilamette Veterinary Hospital (WVH) for overnight ER service on 8/8 and 8/9 (abdominal radiographs were taken on 8/8) - P defecated regular amount (dry) on 8/7 and a small amount (dry) on 8/10 - O reports tenesmus - P received lactulose on 8/9 evening at WVH - Enema performed with warm water and lubricant at 3:30pm on 8/10 PE on 8/10: - Grade 2/6 right parasternal heart murmur - Dry, hard fecal material felt on rectal palpation; tenesmus - Limited ROM of bilateral hips Current Medications Methimazole 7.5mg SID (starting on 8/8, previously BID), Cerenia 16mg once evening of 8/10, Gabapentin 100mg once prior to visit on 8/11, Solensia injection on 8/8 Primary Question/Differential to Be Answered in This Exam - Any signs of foreign body/ obstruction in gastrointestinal tract - Abnormalities of colon/rectum wall - Signs of IBD/lymphoma - Perforation of gastrointestinal tract - Signs of chronic (pancreatitis)

Abnormal PE/Chem/CBC/UA Results: Chemistry: on 8/8 - SDMA: 17.6UG/dL (<15.0) - Amylase: 1,3681 (100-1200) - PrecisionPSL: 25U/L (8-26) CBC: on 8/8 - Eosinophils: 1584/UL (0-1000) T4: on 8/8 (re-ran by Antech lab and confirmed) - 0.5UG/DL (0.8-4.0) - Methimazole 7.5mg BID at this time

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 to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.8 cm in length. The right kidney measured 4.1 cm in length.

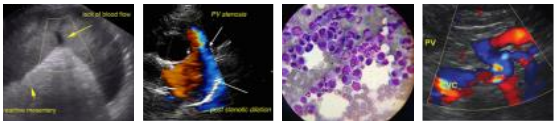
Adrenal Glands

Both adrenal glands were overtly normal in size, position and shape. The left adrenal gland measured 0.31 cm. The right adrenal gland measured 0.26 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.

Liver



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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.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with mild lumen gas.

The small intestine presented generalized intact variably thickened wall layering with mild altered wall layer ratio owing to propensity for segmental prominent muscularis layer. The duodenum wall measured 0.29 cm. The jejunum wall measured up to 0.35 cm. The ileocolic wall measured 0.35 cm.

The colon exhibited normal wall layering with formed to shadowing fecal matter in lumen. No obvious evidence of distal colon distention.

Pancreas

The left pancreatic limb was normal in size and contour with nonhomogenous isoechoic mildly hypoechoic parenchyma compared to adjacent nonreactive omentum. Mild left limb pancreatic duct dilation was noted.

Free Abdomen

No evidence of overt lymphadenopathy, peritoneal effusion or omental masses.

ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable stomach/colon
- Chronic enteropathy- suspect chronic inflammatory infiltrative enteropathy, i.e., IBD/eosinophilic enteritis. Potential for neoplastic infiltrative enteropathy with round cells, such as lymphoma or mast cell neoplasia.
- Mild left limb chronic pancreatitis pattern
- Mild chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of gastrointestinal mechanical obstruction, foreign material or definitive evidence of intrabdominal or gastrointestinal neoplastic criteria. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Full thickness intestinal biopsies would be required for a definitive diagnosis.

Empirically, as needed gastrointestinal support and as needed therapy for constipation, empirical IBD protocol, pending additional diagnostics, which may include dietary therapy +/- Prednisolone trial at lowest effective dose to control clinical signs, and clinical monitoring would be reasonable, if biopsies are not possible. Sonographic monitoring of the gastrointestinal tract is suggested if progressive clinical signs or evidence of weight loss.

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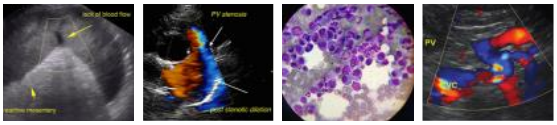

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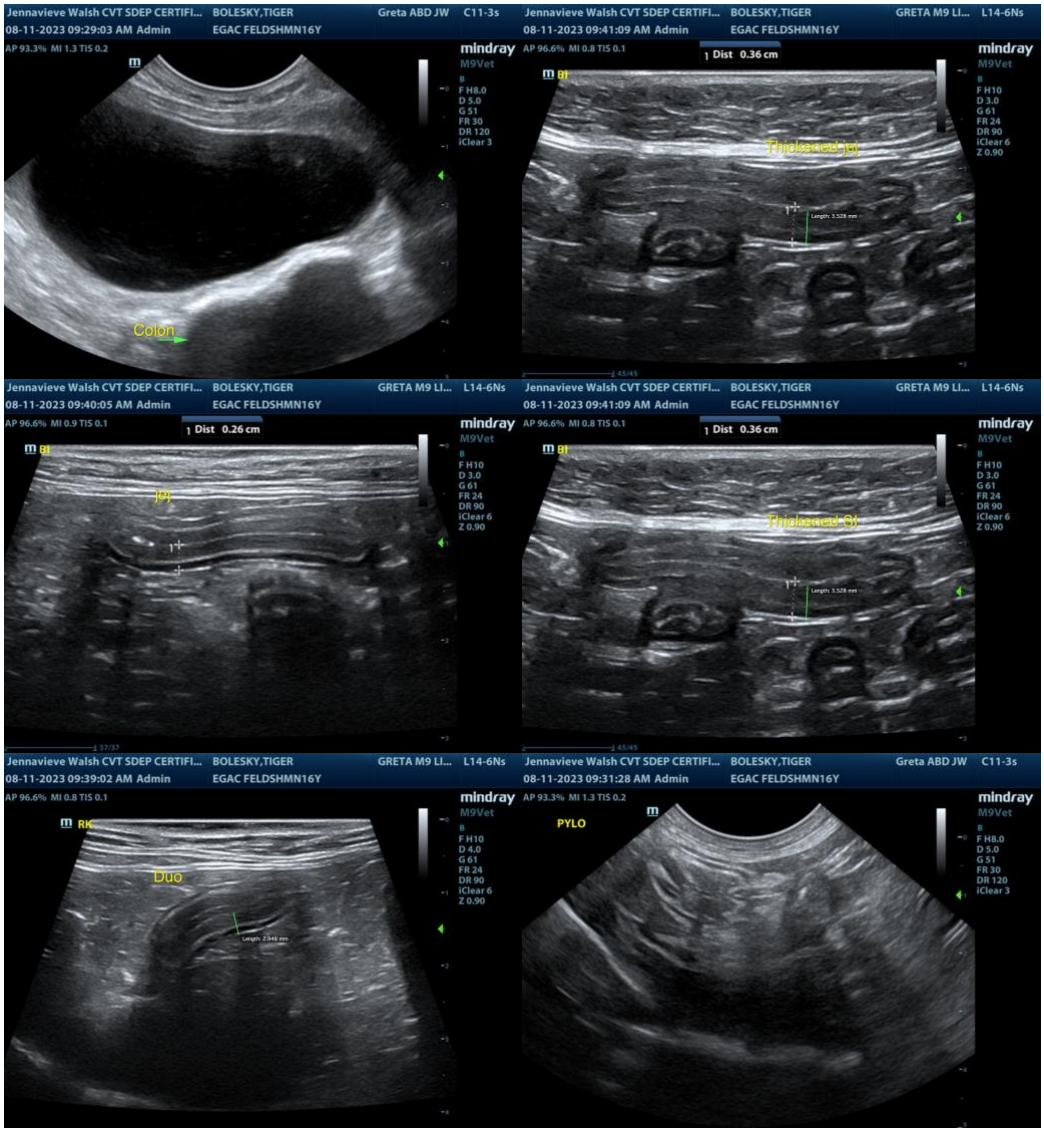

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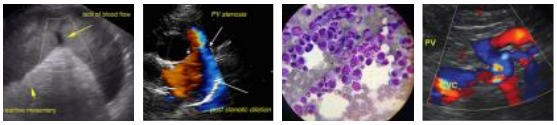

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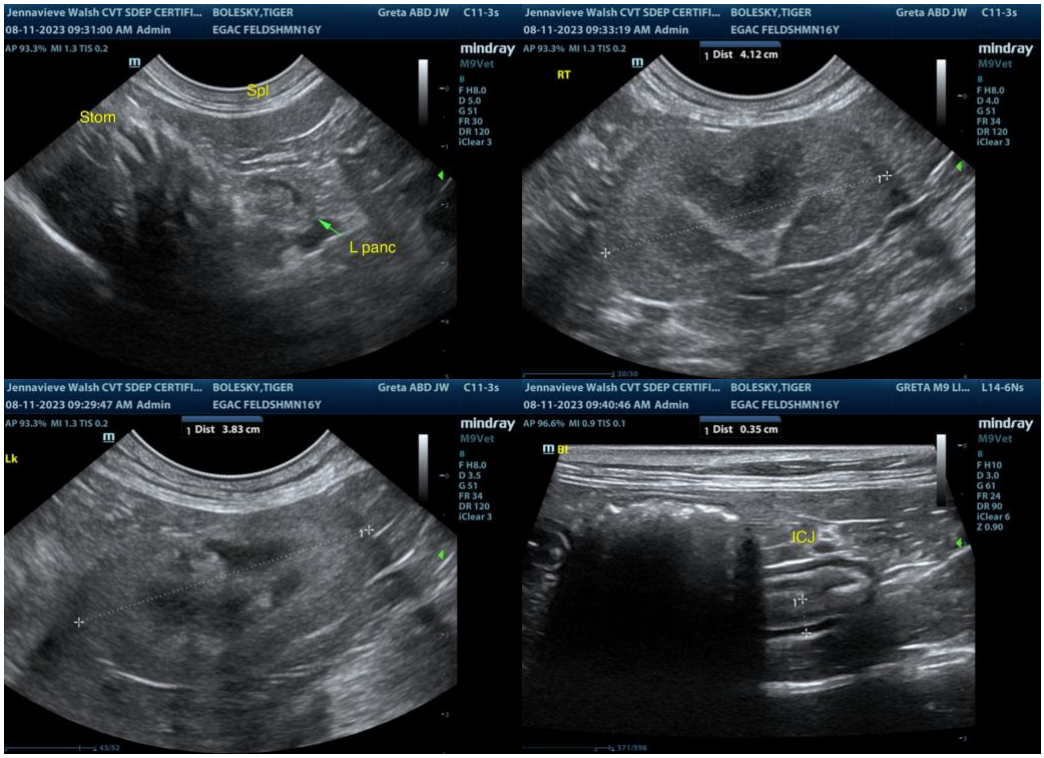

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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