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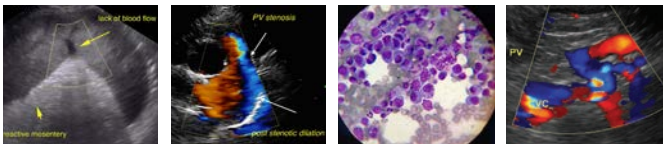

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1-800-838-4268 info@sonopath.com

PATIENT

Leela Navab

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7 Years

WEIGHT

6.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jessica Bailes

HOSPITAL NAME

All Creatures Great & Small Corvallis

REFERRING VET

Dr. Jessica Bailes

INVOICE

24610

DATE

8/12/21

PRESENTING CLINICAL SIGNS

Hx of intermittent vomiting/chronic constipation since 11/2020. Significant weight loss noted recently. Vomitus may have some blood in it. Per male owner patient didn't eat anything since last night. Abnormal PE/Chem/CBC/UA Results: Generalized sarcopenia, dental disease, otherwise NSF On exam. BW/UA done 8/10: CHEM: increased ALT (165), increased amylase (1982), hypochloridemia (103), Azotemia (BUN = 46/CREAT = 2.7); phosphorus WNL@ 5.4, increased total calcium (12.9) CBC: Leukocytosis (19.4) w/ neutrophilia (11,446), increased EOS (1746), thrombocytopenia (195K)w/ adequate estimate TT4: WNL @ 1.9 UA: USG = 1.025; 1+ proteinuria (UPC WNL @ 0.2): pyuria 21-50/hpf; rod bacteriuria >100/hpf Started on orbax 8/10/21 .

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.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. Mild to moderate loss of corticomedullary distinction noted in both kidneys. A focal lateral cortical infarct was present in the left kidney. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. A hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is likely an idiopathic finding. The right kidney measured 3.5 cm. The left kidney measured 3.6 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.38 cm. The left adrenal gland measured 0.37 cm in width.

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 0.67 cm in width.

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 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 contained echogenic ingesta with progressive distal acoustic shadowing, most consistent with post prandial presentation without signs of ileus, obstruction or foreign material. Gastric body wall measured 0.25 cm.

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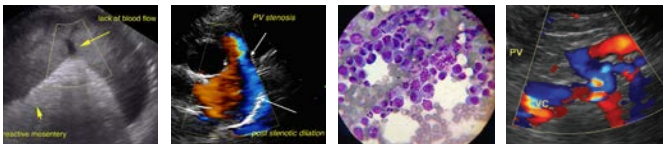

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained echogenic, nonshadowing ingesta consistent with normal food without signs of ileus, obstruction or foreign material. Jejunum wall measured 0.20 cm. Duodenum wall measured 0.26 cm.

Ileocolic wall measured 0.36 cm. The colon walls presented intact yet mildly prominent wall layering with mild thickened to echogenic submucosa. The colon was non-distended, containing subjective soft to semiformed feces. Colon wall measured 0.25 cm.

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 inflammation. No overt evidence of neoplasia.

Free Abdomen

No effusion. No evidence of significant lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic nephropathy with non-specific medullary rim sign and left kidney cortical infarct
- Chronic active pancreatitis
- Mild hepatopathy – subjectively benign, low-grade hepatic parenchymal or hepatobiliary inflammatory process suspected given the elevated ALT.
- Gastrointestinal ingesta
- Mild chronic colitis

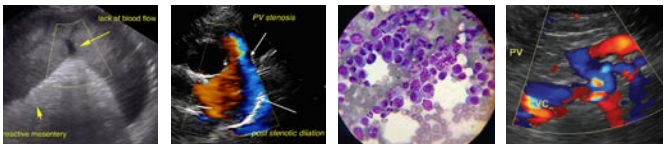
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of gastrointestinal ingesta is non-specific. Post-prandial presentation is possible. However, given the reported fasting prior to the ultrasound, some degree of gastrointestinal hypomotility may be considered. Potential for triad disease may be considered in this patient, although overt evidence of structural gastrointestinal mural changes was not overtly evident. Further assessment may include a GI panel to include PLI, TLI, cobalamin and folate. Recheck urine culture and sensitivity on sterile urine sample suggested 7 days post completion of current antibiotics. Empirically, as-needed gastrointestinal support/gastroprotectants with some or all of the following protocol may be considered. Intestinal, pancreatic and hepatic biopsies are likely required for definitive diagnosis.

Triaditis/Pancreatitis protocol

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 (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 then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. One diet does not work for all



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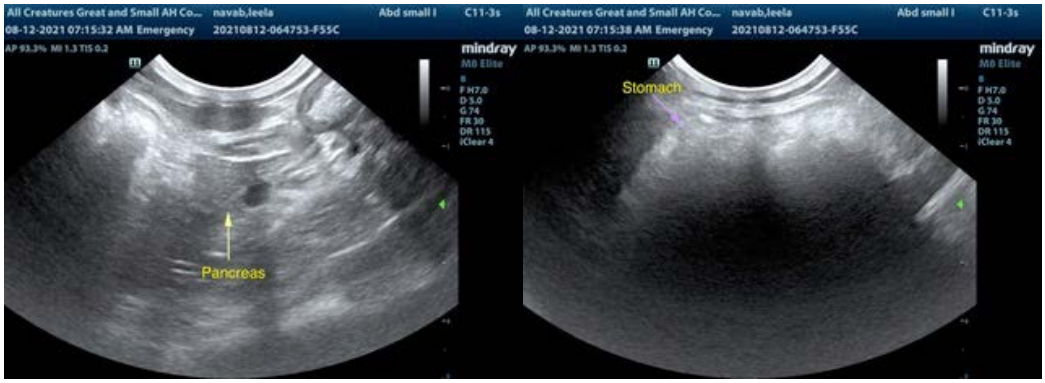
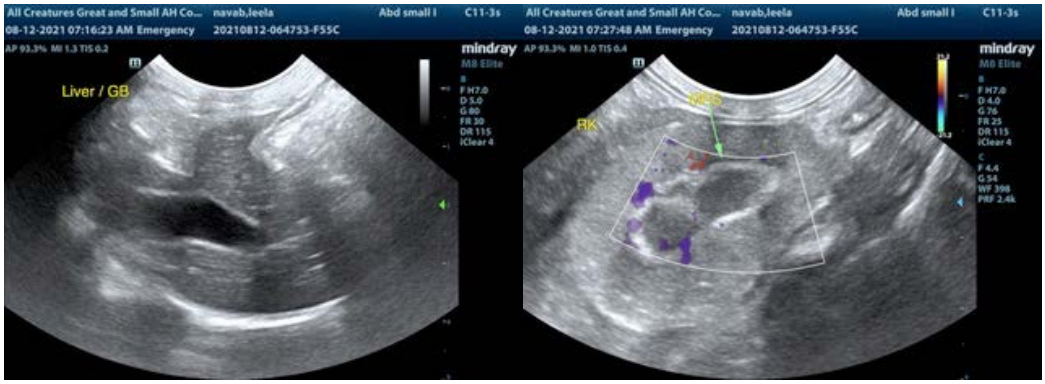
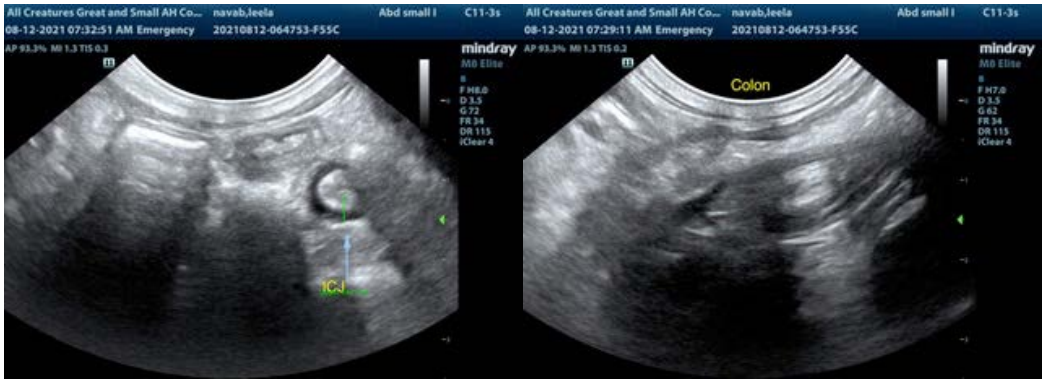
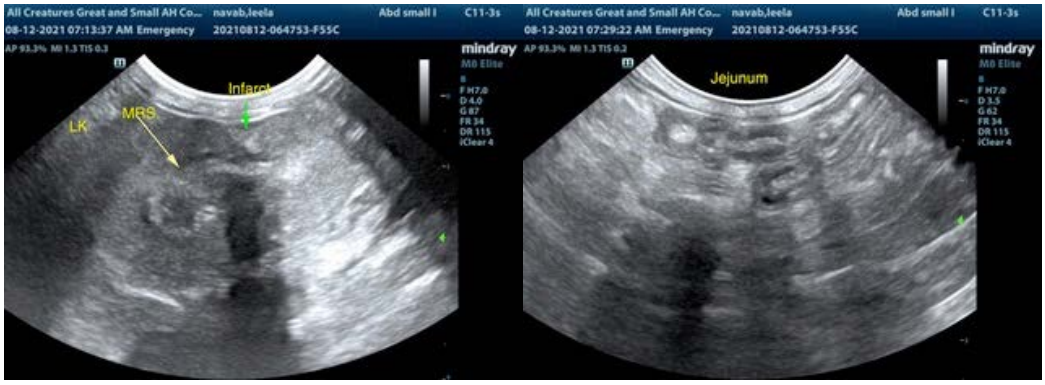
patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.









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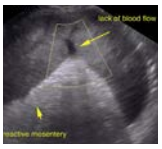
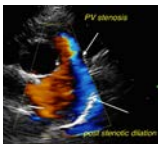
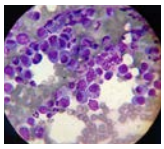
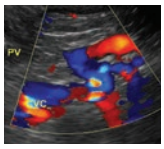

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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