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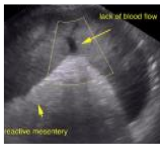
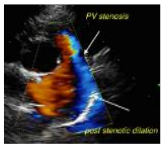
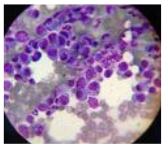
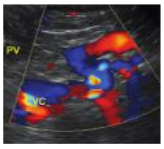





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Simba Powell

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

11 years

WEIGHT

4.25 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield DVM

HOSPITAL NAME

La Pine AH

REFERRING VET

Julee Pickering DVM

INVOICE

16881

DATE

8/16/22

PRESENTING CLINICAL SIGNS

Presenting for AUS w/ Dr. Mayfield. Per rDVM records, P has a multiple year Hx of V+. Was recently prescribed Metronidazole in June 2022 and started on a Purina ProPlan EN DRY diet in July 2022. P V+ upon intake. Patient has long history of episodes of vomiting, in which he will vomit typically once per day; episodes typically last 4-5 days. Usually doesn't have diarrhea. This has been on-going for several years. He will typically have episodes every 3-6 months.

Abnormal PE/Chem/CBC/UA Results: PE: Growling, hissing. Moderate dental tartar/calculus. Abdomen is tense, palpation limited due to growling/hissing. NSF. Blood work performed in June 2022 (Senior Screen): CBC: WNL CHEM: - BG: 239 mg/dL (70-130) - ALT: 152 U/L (0-100) - BUN: 33 mg/dL (15-32) UA: - USG: 1.075 - 3+ proteinuria - 11-20 fat droplets T4: WNL RADS in June: - Gas and stool in colon; resolved radiographically following enema

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.

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. The left kidney measured 3.6 cm in length. The right kidney measured 3.9 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 0.34 cm.

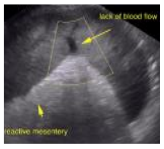
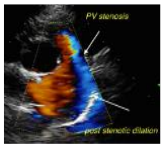
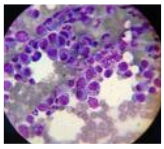
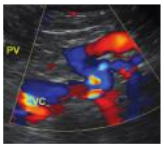
The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.33 cm.

Spleen

The spleen was normal to borderline enlarged in size, measuring 0.75 cm- up to approximately 1.0 cm in width. Minor areas of medial capsule asymmetry with generalized subtle splenic parenchyma heterogeneity. No masses or nodules were evident. Splenic vascularity was normal.

Liver/ Gallbladder

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.

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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 presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained minor retained anechoic pyloric fluid. The pylorus wall measured 0.21 cm.

The small intestine presented intact wall layering with segmental maintained 1:3 muscularis/mucosa ratio, as well as areas of mildly prominent yet intact small intestinal wall layering owing to propensity for mildly prominent mucosa and muscularis layer. The duodenum wall measured 0.24 cm. The jejunum wall measured up to 0.35 cm in areas of prominent jejunal wall layering. The ileocolic wall measured 0.32 cm.

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

Pancreas

The pancreas exhibited regional mild prominent size with areas of capsule asymmetry. Subtle mild hypoechoic yet variably hypoechoic parenchyma. Subtle evidence of peripancreatic reactive mesentery adjacent to the left pancreatic limb.

Free Abdomen

Intermittent enlarged mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 3.0 cm x 0.38 cm. No omental masses were present.

A small pocket of scant peritoneal free fluid was present adjacent to the mid lateral spleen.

ULTRASONOGRAPHIC FINDINGS

- Intact yet subjective segmentally prominent small bowel walls
- Intermittent generally mild to hypoechoic mesenteric lymphadenopathy- probable lymphoid hyperplasia or mild reactive lymphadenitis, emerging neoplastic lymphatic criteria is considered unlikely.
- Chronic to chronic active pancreatitis pattern
- Low grade hepatopathy- subjectively benign
- Borderline splenomegaly- incidental hyperplasia, hematopoiesis or reactive splenitis are all possible. Infiltrative disease is considered unlikely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although potential for patient variant, the small intestine exhibited subtle segmental mural changes, which may suggest underlying inflammatory disease. Based on this finding, as well as suspect concurrent chronic to chronic active pancreatitis pattern, IBD or other chronic inflammatory enteropathy and triaditis given the ALT elevation are considered most likely.

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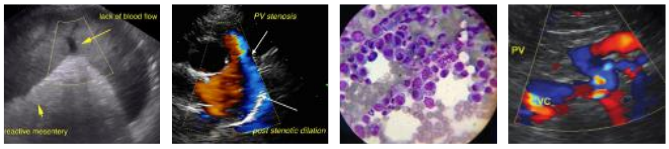

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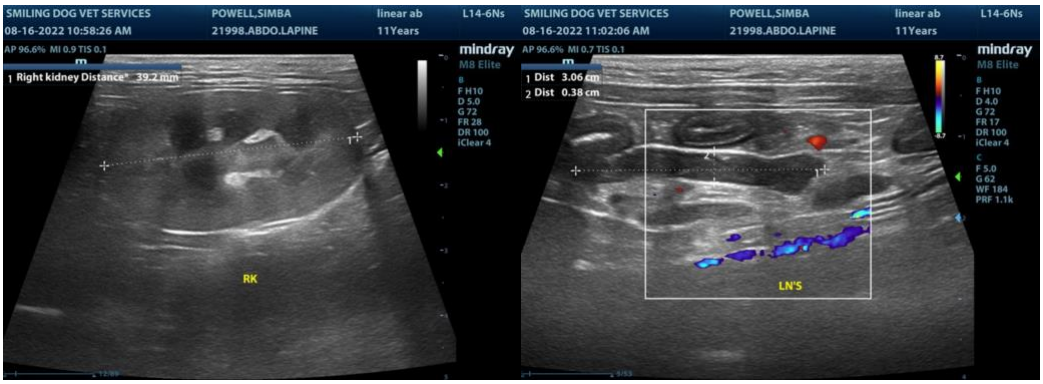
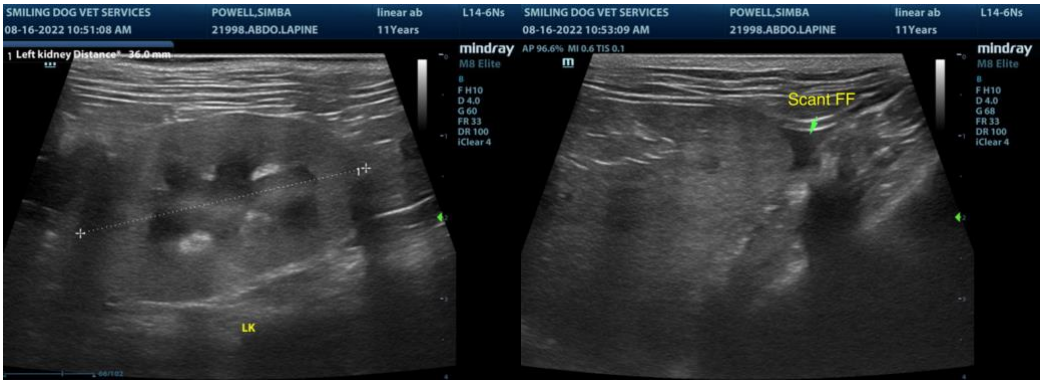
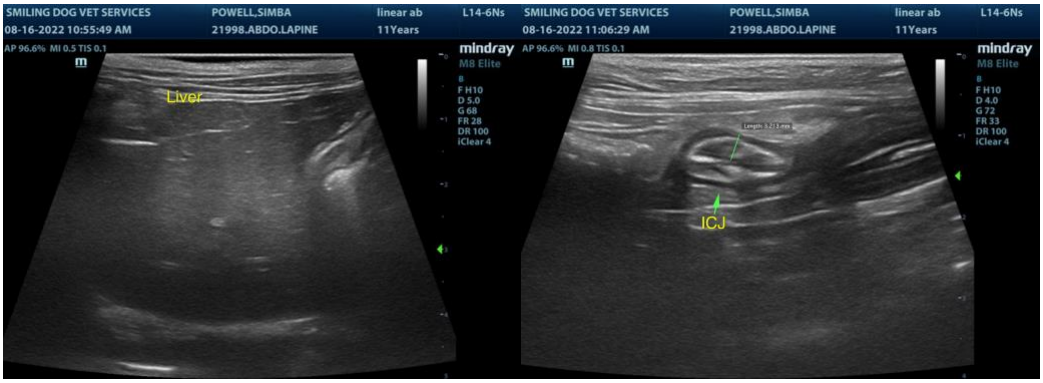
Hepatic FNA, using a 25-guage needle and assuming normal clotting status could be considered for screening cytology, primarily to assess for evidence of inflammatory cells. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Full thickness intestinal biopsies +/- hepatopancreatic biopsies are likely required for a definitive diagnosis. Potentially, dietary intolerance/food allergy and/or occult parasitism if the patient is indoor/outdoor could be playing a role in the patients vomiting. A hydrolyzed diet trial, empirical deworming, +/- cobalamin supplementation pending GI panel and/or additional therapy for triaditis could be considered with assessment of clinical response.







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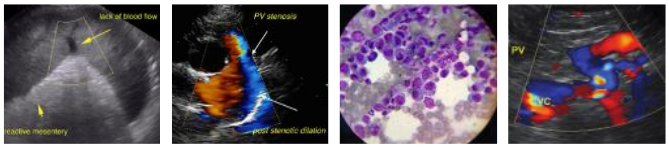

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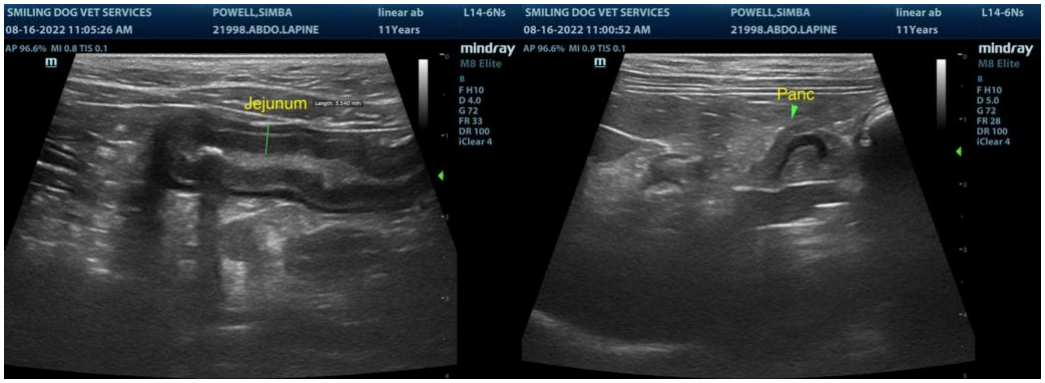

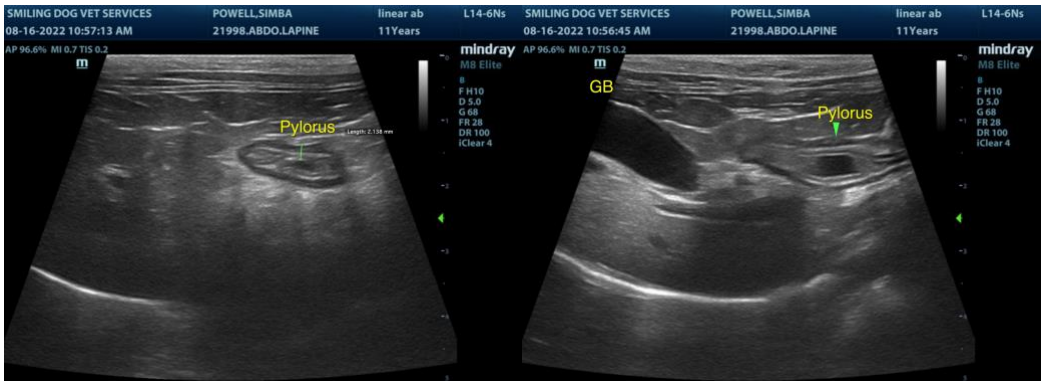

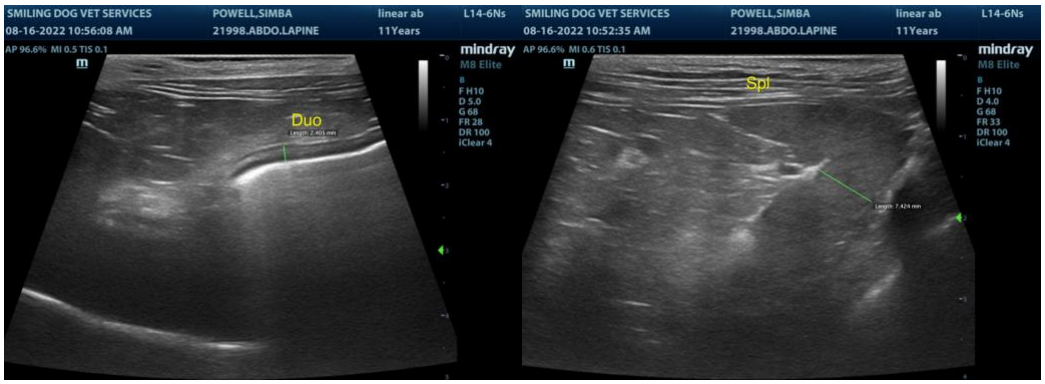

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com