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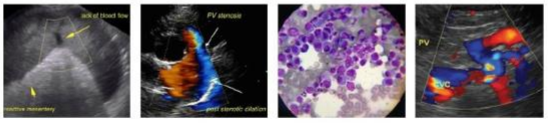


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Pepper Monnet

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

17 Years 4 Months

WEIGHT

6.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Mtn. View AH

REFERRING VET

Dr. Sarah Kalivoda

INVOICE

16898

DATE

8/18/22

PRESENTING CLINICAL SIGNS

History: p. started acutely vomiting 8/14, cannot keep food or water down, not responding to cerenia anorexia~ ~ was dx as hyperthyroid 7/27 and started on methimazole 2.5 mg po bid 7/30, started vomiting 2 weeks later~

Abnormal PE/Chem/CBC/UA Results: LABS Relevant Labratory Results / Abnormalities: ~ ua usg 1.058, pH 6.5, uprot 1+, quiet sediment uprot/creat 0.2 cbc wnl chem: creat 1.9 (2.3) other renal values wnl - iris stage 2, normotensive early borderline proteinuric fpl normal 7/15 CK 1428 proBNP 69 (0-100) T4 4.9 (4.7) felv/hw/fiv neg MEDS cerenia 16 mg 1/2 t po intermittently mirtazipine 7.5 mg 1/4 t po q 3 days~

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. Primarily anechoic urine was present in the lumen. Minor nondependent particulate to hyperechoic sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural 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 3.3 cm in length. The right kidney measured 3.5 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 0.37 cm.

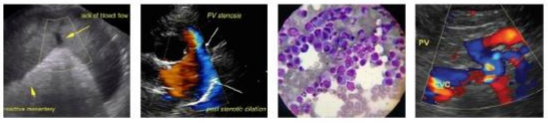
The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.56 cm.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease. The spleen measured 0.84 cm in width at the level of the hilus.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. Intermittent, discreet hypoechoic intraparenchymal nodules were present, likely



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consistent with areas of regenerative hyperplasia or hematopoiesis. No evidence of hepatic neoplastic criteria.

The gallbladder was non distended in size with mild nondependent particulate gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammation. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact yet mildly prominent wall layering. The lumen of the stomach was empty with mild luminal gas. No evidence of gastric distention with retained ingesta, fluid or foreign material. No evidence of mechanical pyloric outflow obstruction. The pylorus wall measured 0.33 cm.

The duodenum exhibited intact yet mildly prominent wall layering with minor areas of upper to mid duodenal corrugation. The duodenum wall measured 0.30 cm. The jejunum and ileum to the level of the colon were sonographically unremarkable, exhibiting intact wall layering and subjective maintained 1:3 muscularis to mucosa ratio. The jejunum wall measured 0.20 cm. The ileocolic wall measured 0.38 cm.

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

Pancreas

The pancreas was mildly prominent in size with mildly nonhomogeneous hypoechoic pancreatic parenchyma with variable pancreatic duct dilation.

Free Abdomen

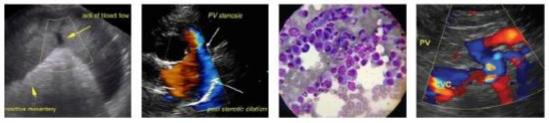
Intermittent, mildly prominent to enlarged mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of lymph node size measured 1.2 cm x 0.4 cm width. No omental masses or evidence of peritoneal free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Minor urinary bladder sediment
- Mild chronic renal changes
- Gastroduodenitis pattern
- Suspect mild chronic to chronic active pancreatitis
- Intermittent mild subjective benign/reactive mesenteric lymph nodes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The overall appearance of the upper GI tract is suggestive of inflammation/gastroduodenitis. Some contribution to the clinical signs may potentially be owing to chronic to chronic active pancreatitis. This possibility maybe considered if evidence of cranial abdominal or subxiphoid discomfort on palpation. A GI panel to include PLI/TLI/Cobalamin/Folate for further assessment of the pancreas, as well as assessment of more generalized small intestinal disease is recommended. Potential for very early



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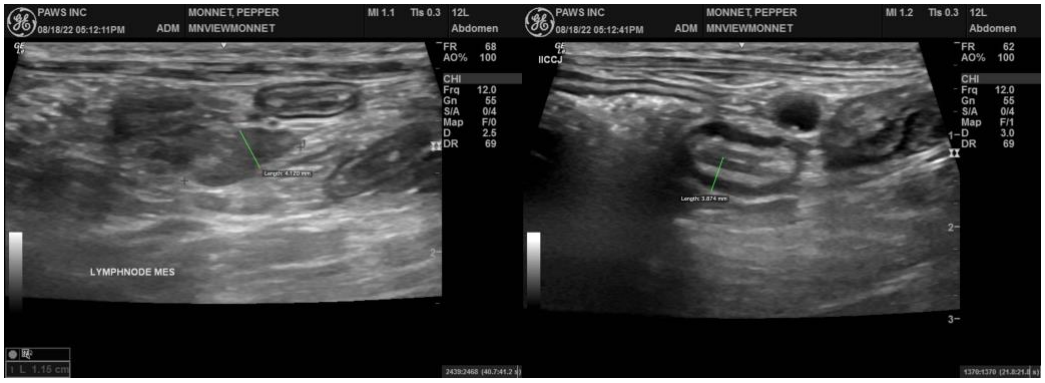
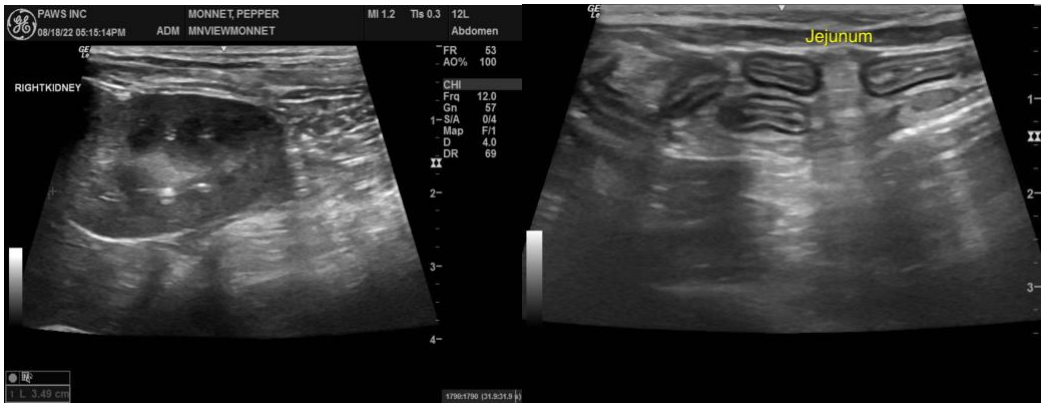
infiltrative upper gastrointestinal neoplasia, although considered less likely, cannot be definitively excluded.

Empirically, continued gastrointestinal support, canned hydrolyzed diet trial and gastroprotectant protocol , such as Omeprazole, would be reasonable. Three-view chest radiographs are suggested to rule out occult thoracic or esophageal pathology as a contributing factor. 24–48-hour hospitalization with IV fluids and as needed gastrointestinal support may be indicated, if continued vomiting or evidence of dehydration. Upper GI endoscopy may ultimately be indicated with potential for biopsies.





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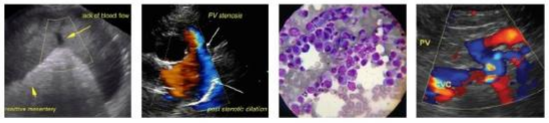

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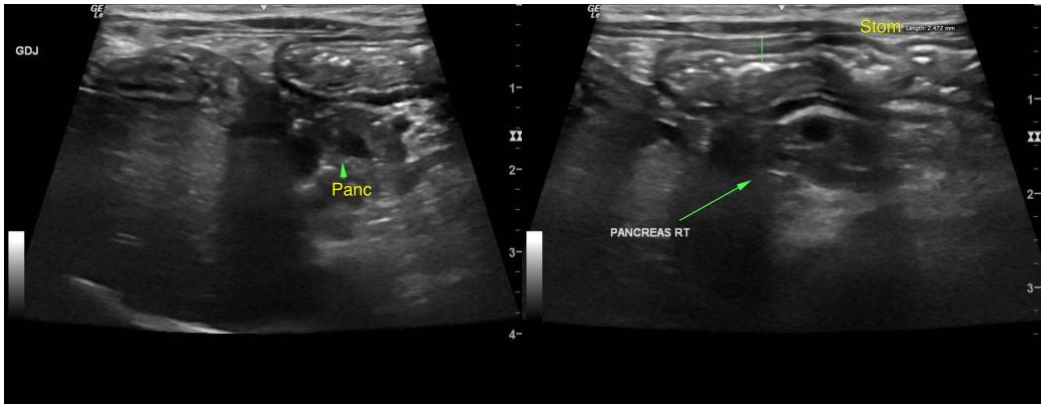

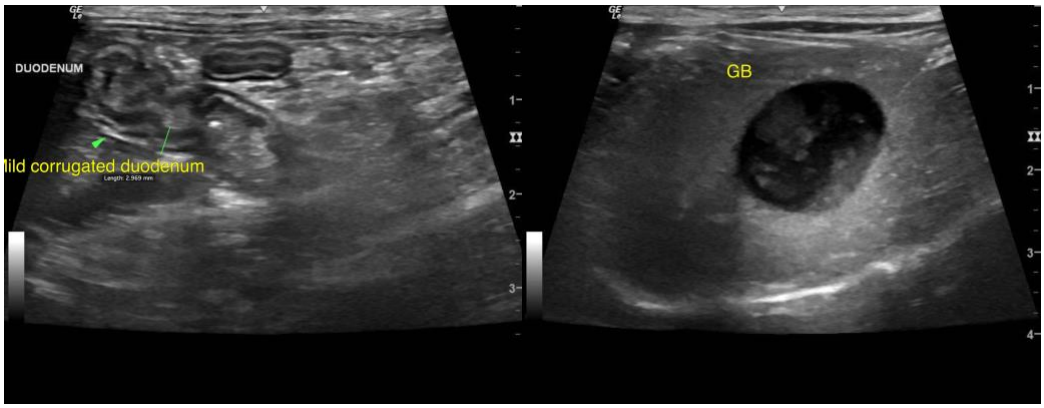

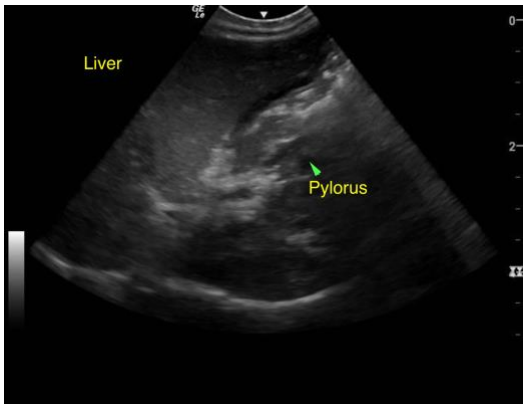

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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