



PATIENT PRESENTING CLINICAL SIGNS

Jake Hackett
History: Patient has a history of chronic intermittent (becoming more continuous) watery blow out diarrhea. Did not respond to diet elimination trial and patient did not respond favorably to metronidazole. Considerable weight loss (11.3 lbs in march to 8.94 currently). Physical exam findings: p/e showed a patient that was QAR, mild delayed skin tent (admin. SQ fluids). Mild chronic denatl disease. Ropey intestines with gas and liquid appreciated with palpation. Abnormal CBC values: Mild monocytosis and neutrophils WNL but possible bands seen. RBC WNL. Abnormal Chemistry Values: Albumin @ 2.4. Mild hypophosphatemia. Cobalamin (B12) < 150, TLI WNL and folate WNL. Abnormal UA Values: Radiograph Findings(email radiographs if available): Reason for Ultrasound: Work up of chronic diarrhea and r/o inflammatory, infectious, autoimmune, neoplasia vs other.

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

10 Years

WEIGHT

8.94 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Alpine Animal Hospital

REFERRING VET

Dr Shane Sheets

INVOICE

47059

DATE

8-20-21

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 residual prostate appeared normal and free of pathology.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination was present in the kidneys. Both kidneys exhibited maintained 1:3 cortex / medulla ratio with subtle uniform increased cortex echogenicity. Mild loss of corticomedullary border demarcation 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 3.6 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 0.42 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.60 cm width.

Spleen

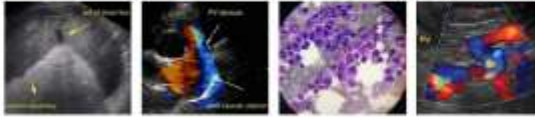
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

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. 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 no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.26 cm width.



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The small intestine presented intact wall layering with primarily maintained 1:3 muscularis/mucosa ratio with subjective propensity for segmentally prominent to echogenic submucosa and subtly prominent muscularis layer. No evidence of loss of intestinal wall layering or intestinal masses. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.26 cm width and the jejunum wall measured 0.29 cm width. The ileocolic wall measured 0.36 cm width.

The colon exhibited intact yet subjective mild prominent descending colon walls with semi-formed to soft feces. The descending colon wall measured 0.27 cm width.

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 reactivity / inflammation. Subtle generalized pancreatic duct dilation was present. The pancreatic duct measured 0.15 cm diameter. No overt evidence of neoplasia.

Free Abdomen

Focally enlarged jejunocolic lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal width: length ratio was maintained (<0.5). An example of a jejunocolic lymph node size was 0.57 cm diameter.

Intermittent small pockets of peri-intestinal to perilymphatic free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- Mild chronic renal changes.
- Chronic enteropathy with associated jejunocolic lymphadenopathy.
- Subjective mild concurrent colitis.
- Pancreatitis.
- Small pockets of scant peri-intestinal to perilymphatic free fluid.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Based on the gastrointestinal presentation and concurrent pancreatitis, IBD or other chronic inflammatory enteropathy and pancreatitis are likely. Suspected concurrent reactive lymphadenitis is probable. Minor potential for emerging to low grade neoplastic infiltrative enteropathy and associated emerging neoplastic lymphadenopathy possible yet considered less likely. The decreased cobalamin levels are consistent with distal small intestinal disease. A definitive diagnosis would require full thickness intestinal +/- pancreatic biopsies. Potential for triad disease may be considered if previous history of hepatic enzyme elevation.

Empirically, cobalamin supplementation, dietary therapy, i.e., hydrolyzed diet or higher fiber diet, high colony count probiotic, +/- continued antibiotic, or prednisolone trial at lowest effective dose to control clinical signs if biopsies are not possible would be warranted. Diarrhea pcr panel may be considered.

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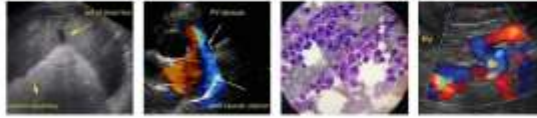
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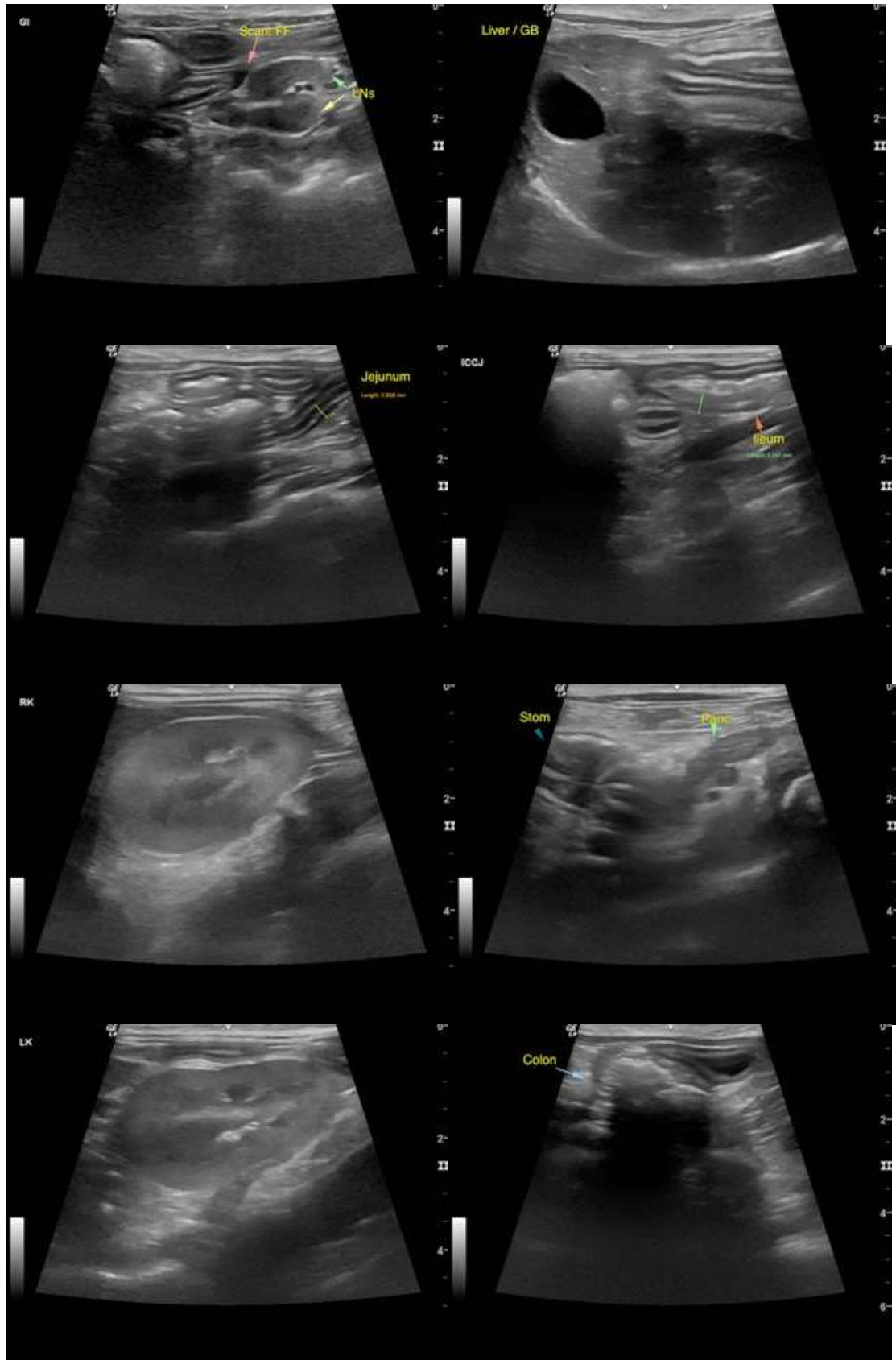
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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