


PATIENT

 Ivan Beers
 Emp Pet

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8.5 years

WEIGHT

14 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jennifer Todd

HOSPITAL NAME

Lambs Gap AH

REFERRING VET

Dr. Laura Campbell

INVOICE

12314

DATE

9/28/21

PRESENTING CLINICAL SIGNS

Ivan is an eight year old, MN, DSH cat owned by one of our veterinary technicians. History of renal disease, proteinuria, IBD, heart murmur (stable), vaccine reactions, obsessive eating of food and non-food items, episode of fever/anorexia/constipation last year. Presented on Saturday for constipation with megacolon strongly suspected, but he passed stool before other treatments needed to be administered. Owner changed his diet to Royal Canin Fiber Response and continued other chronic treatments. Sunday evening he had a fever of 103.8, wouldn't eat dinner, and had diarrhea; after the episode of diarrhea he perked up, ate and temperature was 101.0. Monday he seemed normal except for diarrhea in the morning. This morning, his temperature was 103.1, vomited a large amount after eating at 4am, diarrhea overnight and wouldn't eat his canned food at 5am. On exam this morning, temperature 102.2, HR 174, Grade II/VI systolic murmur, breathing regularly, much quieter and compliant than normal for him. Current medications: Cisapride 2.5mg BID Miralax (started last week but discontinued now that he started Fiber Response) Fluoxetine 5mg SID Benazepril 2.5mg SID Prednisolone 2.5mg EOD Renakare (potassium gluconate) 2mEq BID Aluminum hydroxide 900mg BID Provable 1 capsule SID Blood work today: renal values stable for him with creatinine of 1.8mg/dL, no other significant findings on chemistry, CBC showed mild anemia (HCT 30.1%) without reticulocytosis, lymphocytosis (WBC 33.66K/uL, range 2.87-17.02), neutrophilia (24.35 K/uL, range 2.30-10.29), bands suspected, lymphocytosis (6.90 K/uL, range 0.92-6.88), and monocytosis (1.40K/uL, range 0.05-0.67) Diet: recently changed to Royal Canin Fiber Response 2-3 days ago (was feeding Purina OM due to history of diarrhea, and diarrhea resolved on this)

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. Moderate, nondependent, particulate 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.

The area of the aortic trifurcation was free of pathology.

Asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. The left kidney was mildly enlarged in size, measuring 5.2 cm in length. The right kidney was borderline subnormal in size, measuring 3.2 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 0.45 cm diameter. The right adrenal gland was mildly prominent in size with normal contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.70 cm diameter.



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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 intestinal walls demonstrated intact yet segmental to generalized prominent muscularis layer. No evidence of loss of intestinal wall layering or intestinal masses, nor evidence of mechanical obstruction. The jejunum wall width measured 0.27-0.28 cm.

The colon exhibited mild generalized distention with semi-formed to soft feces.

Pancreas

The pancreas was mildly prominent in size with asymmetrical contour. Heterogeneous to subtly hypoechoic parenchyma compared to adjacent omentum was present.

Free Abdomen

Regional mid abdominal reactive to inflamed mesentery with focal scant pocket of peri intestinal free fluid was present. Associated regional 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 0.44 cm diameter.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Urinary bladder sediment
- Bilateral chronic interstitial nephrosis renal pattern with borderline subnormal right kidney and suspect left kidney compensatory hypertrophy
- Prominent right adrenal gland - nonspecific
- Chronic inflammatory enteropathy with associated mid abdominal regional reactive to inflamed omentum and associated lymphadenitis
- Suspect chronic active pancreatitis



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

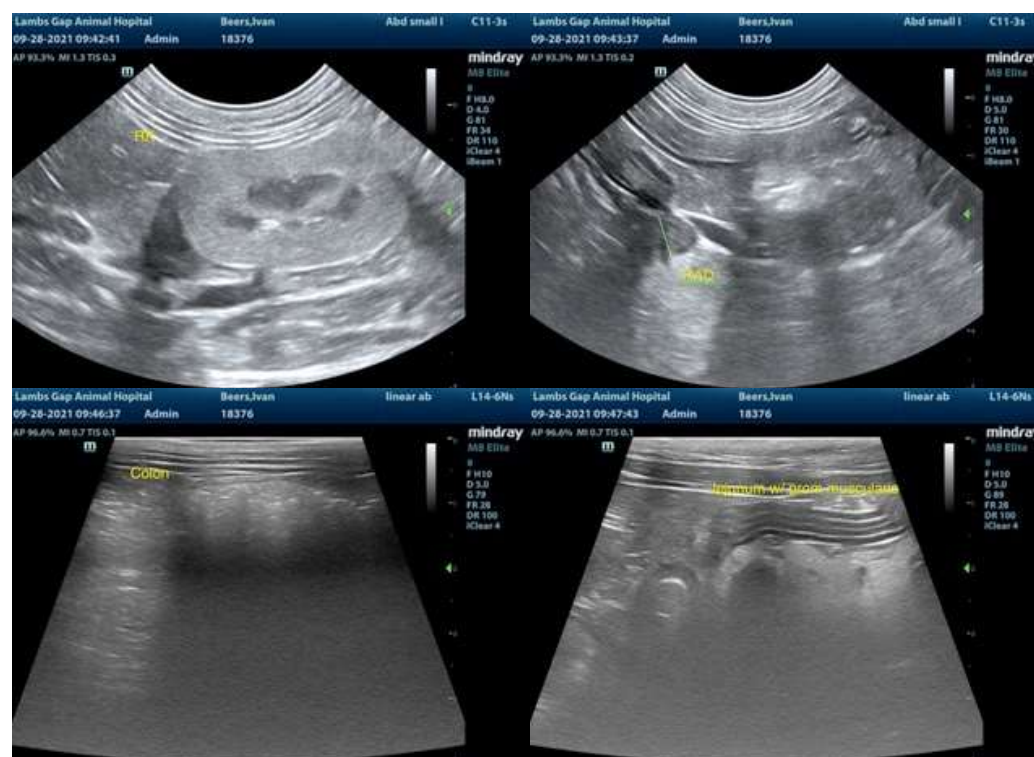
Potentially, the use of Prednisolone may be masking intestinal mural changes. However, the intestine exhibited changes which are suggestive of chronic inflammatory enteropathy / IBD. Minor potential for early neoplastic infiltrative enteropathy with round cells such as lymphoma with emerging associated neoplastic lymphadenopathy is possible yet considered a less likely differential diagnosis.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate.

The prominent right adrenal gland is nonspecific and may be a normal patient variant. Screening blood pressure and monitoring of potassium levels are suggested.

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

In addition to dietary therapy, empirical cobalamin supplementation, continued high colony count probiotic, +/- Increasing Prednisolone frequency may be indicated if evidence of weight loss or continued gastrointestinal signs. Metronidazole / Zithromax combination, given the fever, elevated WBC count, may prove beneficial In light of suspected lymphadenitis.





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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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