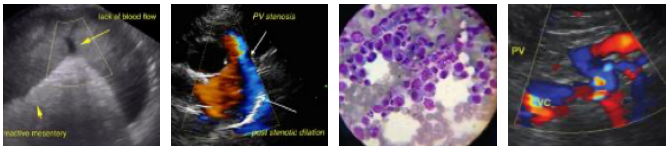
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Milo Robertson

SPECIES
Feline

BREED
Domestic longhair

SEX
Male, neutered

AGE
10 Yrs. 3 Months

WEIGHT
7.21 kg.

INTERPRETED BY
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY
Dr. Barnes

HOSPITAL NAME
Westivew VH

REFERRING VET
Dr. Barnes

INVOICE
14448

DATE
1/16/23

PRESENTING CLINICAL SIGNS

History: Lethargic, anorexia 2 days. Usually is a good eater. Slight Pyrexia 39.3 C
Abnormal PE/Chem/CBC/UA Results: CBC: WNL, just low Lym Chem slight low Urea, Phos, Ca TT4 40 (N 10-60), SDMA 12 (N 0-14) Snap fPl Abnormal, Pancreatitis Xrays": 1. Suspect enteritis due to nonspecific etiologies. Systemic disease such as pancreatitis can cause bowel atony resulting in a similar radiographic change. 2. Constipation. 3. Otherwise unremarkable abdomen. 4. Unremarkable geriatric thorax.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended. A moderate amount of suspended echogenic is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1-2 cm, are normal.

The left kidney is normal size (4.55 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.95 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size 0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

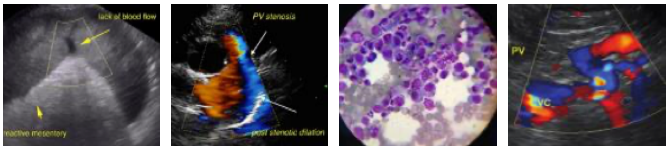
Spleen

The spleen is prominent in size (1.18 cm in width at the level of the hilus) with normal curvilinear peripheral contours. There is appropriate echogenicity and echotexture. A 0.34 cm hyperechoic nodule is observed near the cranial aspect. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

Gastrointestinal



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The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is segmentally fluid dilated (mild). The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The colonic wall is normal. The lumen of the transverse colon is fluid distended. The descending colonic lumen contains gas. No obvious obstructive disease is noted.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes are suggestive of inflammatory bowel disease. However, correlation with patient's clinical history is recommended. Diarrheic stool is present in the ascending colon. Mild ileus is suspected.
- The mild splenomegaly may be a normal variant for this large breed cat. Other differentials include lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic simulation and less likely, emerging neoplasia (i.e., round cell tumor).

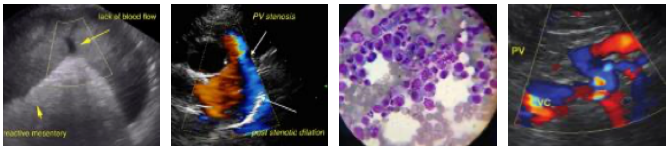
Secondary Findings:

- The urinary bladder debris could be consistent with cells, crystals, exfoliated materials and/or lipid droplets.
- The hyperechoic splenic nodule trends toward the benign (i.e., myelolipoma) with a lower possibility of emerging neoplasia (i.e., mast cell tumor).

* An obvious cause for the patient's fever is not identified in this study. Considerations include enteritis, low-grade pancreatitis, infectious disease, occult neoplasia, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the history of fever, consider the following:
  1. Three-view thoracic radiographs to assess for occult pathology in the chest.
  2. Infectious disease testing (i.e., feline leukemia, FIV, toxoplasmosis +/- FIP).
  3. Also consider an fPLI +/- a full malabsorption panel to evaluate for pancreatitis and maldigestion/malabsorption.



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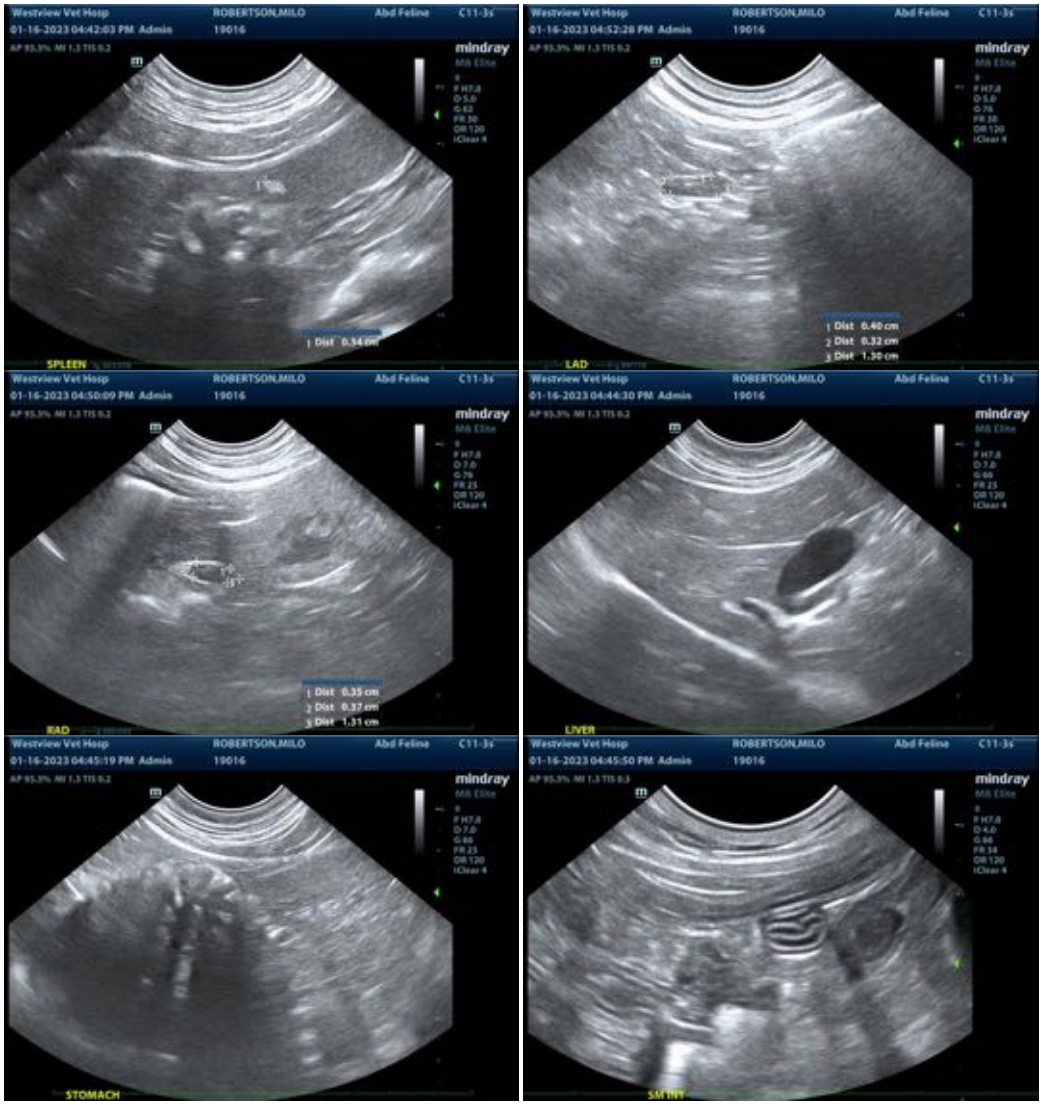
- Given the small intestinal wall changes, the following can be considered:
  1. A fecal evaluation for ova/Giardia.
  2. Hypoallergenic or limited antigen diet trial, particularly if the patient exhibits chronic gastrointestinal signs.
  3. +/- GI biopsies.



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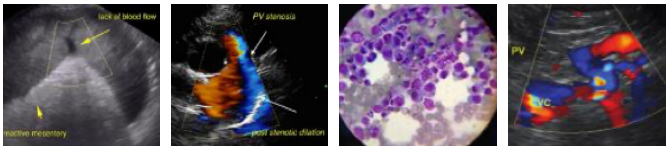

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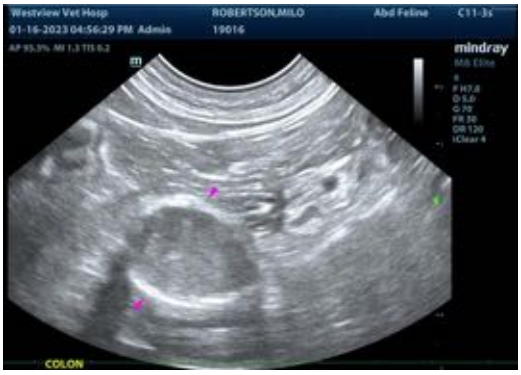

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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