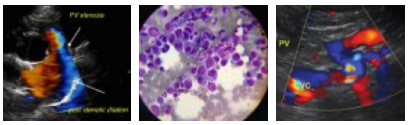
IMAGING PERFORMED BY

IntraPet.com



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DATE

10/3/22

PATIENT

Mango Vinci

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

10/1/2009

WEIGHT

14.3 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. King

INVOICE

14039

PRESENTING CLINICAL SIGNS

13 y/o MN DSH. DM since January, Last curve 2 months ago. Currently 3 units Prozinc BID (5a/5p). Gets Proviable and Gaba daily --Chronic intermittent diarrhea. Hx of intermittent Kidney elevations; Hx of sibling indoor cat with same mother developing FELV at age 12. He has been tested several times negative after other pet passed; not recent. PC anorexia, diarrhea-worse.

Current Medications: Famotidine, Cerenia, Buprenorphine, Ondansetron, Unasyn, Metronidazole, Mirtazapine.
Lab Results: Normal Kidney Values, Increase Monocytes, Negative Ketones, Hematuria, but NO pyuria NO bacteria, USG 1.032
Radiographs: misshapen Left Kidney with Renolith (likely cause of intermittent changes in past).
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

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 debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2-3 cm, are normal.

The left kidney is normal size (3.04 cm in length) with an irregular shape. There is a normal 1:3 cortex to medulla ratio with poor corticomedullary distinction. Cortical infarcts are visualized at both poles. No nephroliths are seen. Moderate to severe pyelectasia is present (0.84 cm in the transverse plane). The proximal urethra is mildly dilated (up to 0.31 cm in diameter). It is no longer visible a few cm distal to the renal pelvis.

The right kidney is normal size (5.04 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with poor corticomedullary distinction. No nephroliths are seen. Severe pyelectasia is present (0.92 cm in the transverse plane). The proximal ureter is dilated (up to 0.38 cm) but is not visualized a few cm distal to the renal pelvis.

Adrenal Glands

The region of the adrenal glands is evaluated. No obvious pathology is observed.

Spleen

The spleen is normal in size (0.82 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. 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 portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are visible/tortuous but not overtly dilated. The distal common bile duct measures 0.32 cm in diameter. The duodenal papilla is normal (0.41 cm in width).

Gastrointestinal

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 not dilated. The small intestinal wall is normal to mildly thickened (up to 0.29 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The colonic wall is normal. No 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

There is no evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.76 cm in length. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Intestinal wall pattern consistent with inflammatory bowel disease with some potential for emerging lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

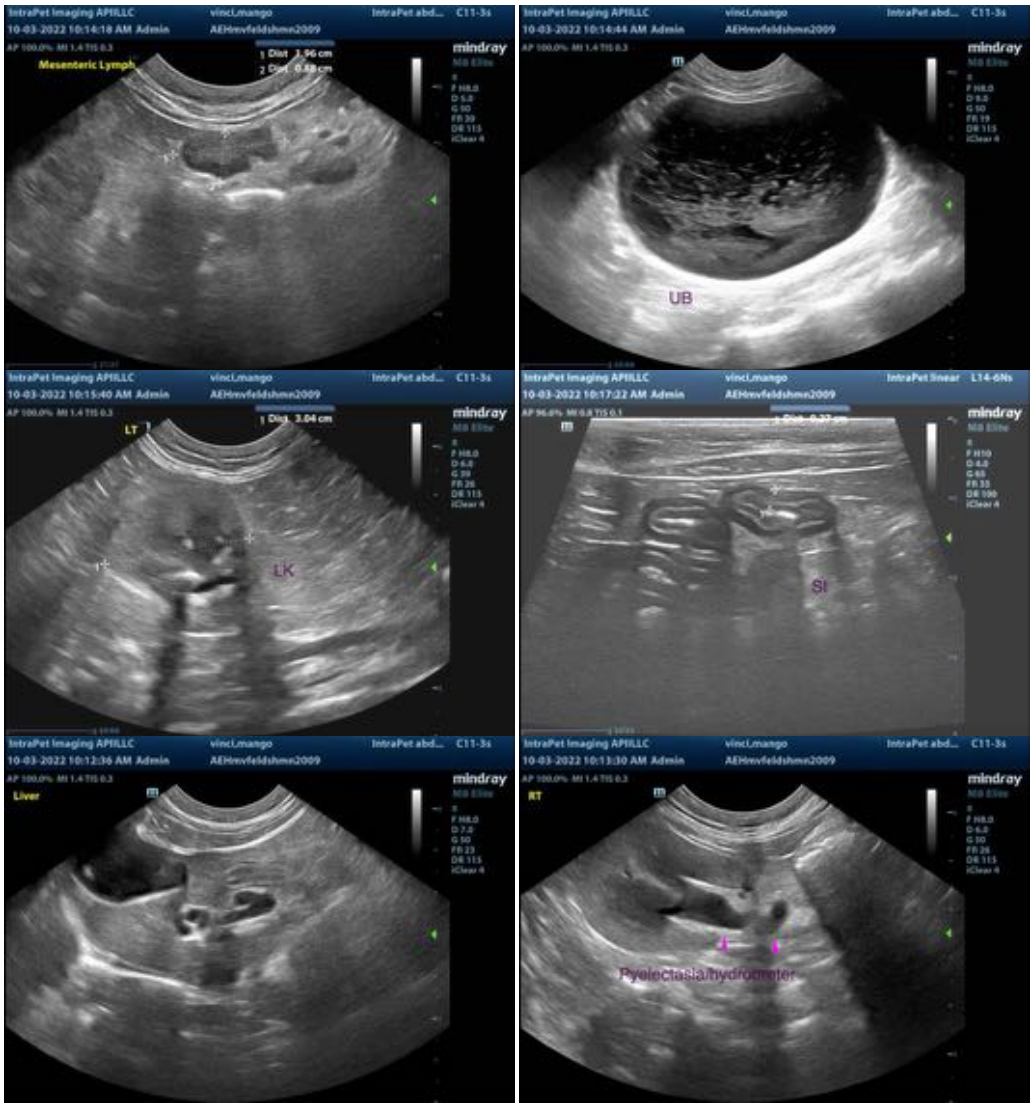
Secondary Findings:

- Bilateral, degenerative renal changes with left cortical infarcts. Bilateral pyelectasia and hydroureter is present, possibly secondary to ureteral strictures or less likely, ureteroliths or tumors.
- The urinary bladder debris could be consistent with cells, crystals, lipid droplets and/or exfoliated material.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the renal changes, a urine culture and sensitivity is recommended to assess for occult infection.
- Regarding the bowel changes and history of diarrhea, consider the following:
    1. GI panel including serum cobalamin, folate, TLI and PLI (send to Texas A&M).
    2. A fecal evaluation for ova/Giardia.
    3. 6-week hydrolyzed protein or limited antigen diet trial.
    4. Consider initiation of a probiotic with a high colony count (i.e., Proviable Forte).
    5. Also consider empirical treatment for small intestinal bacterial overgrowth with a 4-week course of Tylosin (in lieu of Metronidazole).

6. Depending on the results of the above diagnostics and therapeutics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.



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.

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

info@SonoPath.com