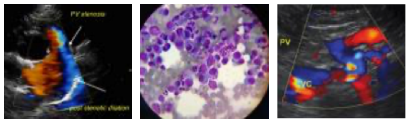
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

12.30.2022

PATIENT

Smokey Crews

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7/31/2012

WEIGHT

13 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Timonium Animal Hospital

REFERRING VET

Dr. Gernhart

INVOICE

11989

PRESENTING CLINICAL SIGNS

Dehydration, anorexia, wants to eat but only licks the food, owner convinced there is a problem with prehension? Has signs of colitis, Treating with Metronidazole, Famotidine, Amp, Mirtaz

Current Medications: Cerenia 6 mg IV started yesterday afternoon.
Famotidine 3 mg IV, Ampicillin 118 mg IV, Metronidazole 11 ml 55 mg IV
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested/Approved.
Imaging Performed By: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is mildly to moderately distended. Luminal contents are mostly anechoic. 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 (4.28 cm in length) with slightly irregular shape. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. A cortical infarct is suspected at the cranial pole. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

The right kidney is normal size (5.24 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with moderate 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 size (0.47 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.74 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 to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is distended with ingesta. 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 minimally to mildly thickened (up to 0.30 cm) with normal layering. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. The colonic wall is diffusely thickened (up to 1.41 cm), irregular and hypoechoic, with a loss of the normal layering pattern. The lumen of the descending colon contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portion of the left limb, the pancreas is normal to slightly prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is subtly hypoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

The mesentery in the cranial abdominal fluid is hyperechoic. Trace free fluid is observed. A few prominent colic lymph nodes are visualized (the largest measuring 0.58 cm in length). Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The colonic wall changes are concerning for infiltrative neoplasia (i.e., lymphoma). However, severe inflammatory disease is also possible.
- The small intestinal wall changes could be consistent with emerging lymphoma or inflammatory bowel disease.
- Peritonitis is present, likely secondary to colon pathology.

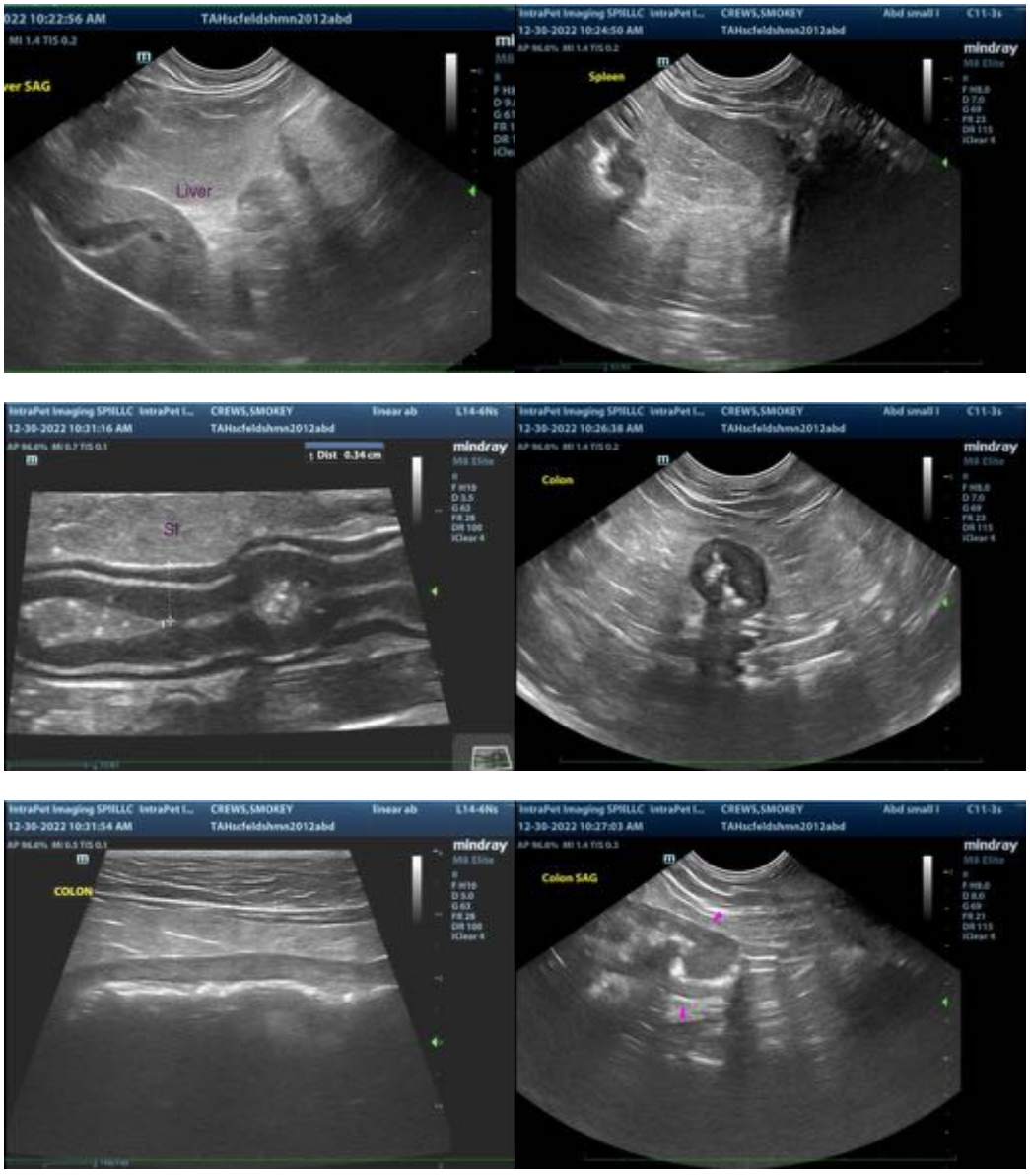
Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral chronic renal changes with left dystrophic mineralization and a suspected cortical infarct.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fine needle aspirate of the colonic wall can be considered if clotting status is appropriate. However, this may prove difficult, and care must be taken to avoid penetration of the colonic lumen. Thus, endoscopic or surgical biopsies may be preferable.
- Given the small intestinal wall changes, a malabsorption panel, including serum cobalamin and folate, TLI and PLI, is also recommended, along with a fecal evaluation for ova and Giardia.

- Thoracic radiographs should also be considered, particularly given the concern for infiltrative neoplasia in the colon.



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.

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