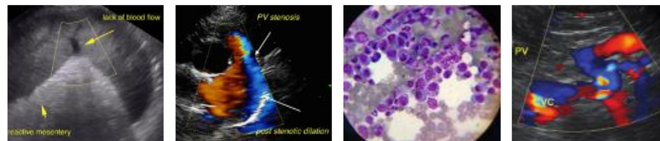
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Indie Stonecipher

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

10 Years

WEIGHT

10.5 Lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jasimine Palacios (SDEP Attendee)

HOSPITAL NAME

Rivers Edge PMC

REFERRING VET

Dr. Laura Archer

INVOICE

13263

DATE

12/30/21

PRESENTING CLINICAL SIGNS

History: Primary presenting complaint to rDVM : continued and unexplained weight loss. Patient has a history of chronic pancreatitis with suspect IBD. Treated with repeat depomedrol and convenia injections. Currently on daily prednisolone 5mg SID-BID. Diagnosed hyperthyroid in 2018. Currently maintained on methimazole 5mg BID. Diagnosed diabetic in 2020. Treated with vetsulin. Patient determined to be in remission (clinical signs resolved and fructosamine WNL) and vetsulin discontinued 11/2021. Patient currently having diarrhea but otherwise BAR, eating well. Fecal parasite testing negative 12/30/21 Current Medications: Prednisolone 5mg SID-BID liquid Methimazole 5mg BID transdermal

Abnormal PE/Chem/CBC/UA Results: Historically elevated amylase and lipase during pancreatitis flare-ups. Most recent CBC/Chem/T4/fructosamine all WNL. Radiographic Findings: Possible mass effect in abdomen and haziness in area of pancreas on radiographs taken 2/2021 Abdominal ultrasound performed at Willamette Vet Hospital on 9/16/19 (see attached report) findings: "regional pancreatitis, nephritis presentation"

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 lumen is moderately distended with mostly anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (3.82 cm in length); with a slightly irregular shape. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A cortical infarct is observed at the cranial lateral aspect. Trace pyelectasia is present. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.80 cm in length); with a normal shape, smooth peripheral margins and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

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

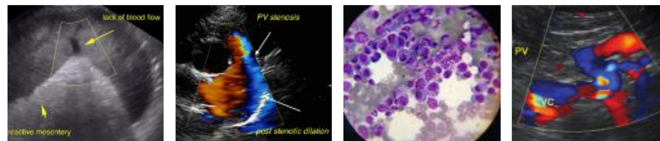
The right adrenal gland is normal size (0.35 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively normal in size (0.74 cm in width at the level of the hilus) with normal curvilinear peripheral contours and a folded conformation. 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



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regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The gall bladder is of normal contours and contains some gravity dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The tissue at the gastroesophageal inlet is prominent/thickened. The gastric wall is normal in thickness with a normal layering pattern. The gastric lumen is not dilated. The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with has and chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely prominent in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and slightly mottled in appearance. NO distinct focal lesions are observed. The pancreatic duct (0.18 cm in diameter) is visible but not overtly dilated. There is no evidence of peripancreatic effusion.

Free Abdomen

There is no evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are consistent with pancreatic remodeling +/- fibrosis. Low grade inflammation may also be present, particularly if the patient is exhibiting cranial abdominal pain.
- The thickened tissue at the gastroesophageal inlet may represent an inflamed distal esophageal sphincter, normal variation or less likely, emerging neoplasia.

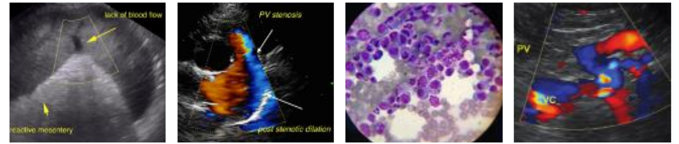
Secondary Findings

- Bilateral age-related changes with a left cortical infarct

*An obvious cause for the patient's weight loss and ongoing diarrhea is not identified in the study. Considerations include primary gastrointestinal disease (i.e., inflammatory bowel disease, intestinal dysbiosis, food allergy), chronic pancreatitis, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the weight loss, three-view thoracic radiographs are recommended to assess for occult neoplasia in the chest.
- Other diagnostic considerations include the following:
    1. Malabsorption panel, including serum cobalamin, folate, TLI and PLI



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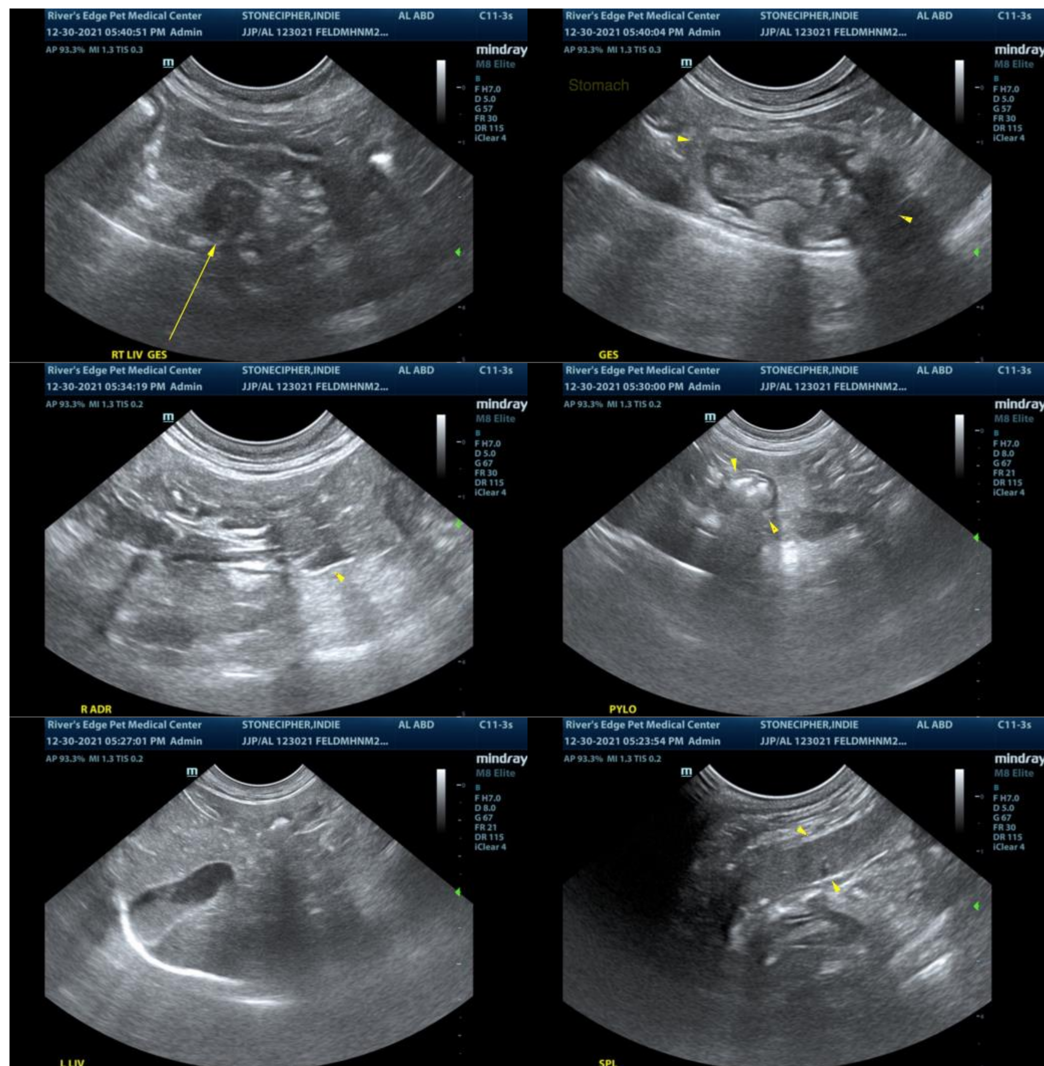
2. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.

3. A 6-week limited antigen diet trial to assess for food allergies

4. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. If biopsies are to be pursued, ideally, the patient would be weaned off corticosteroids to prevent masking of underlying pathology.



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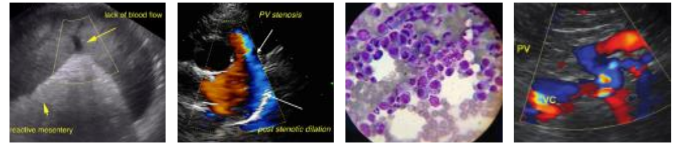

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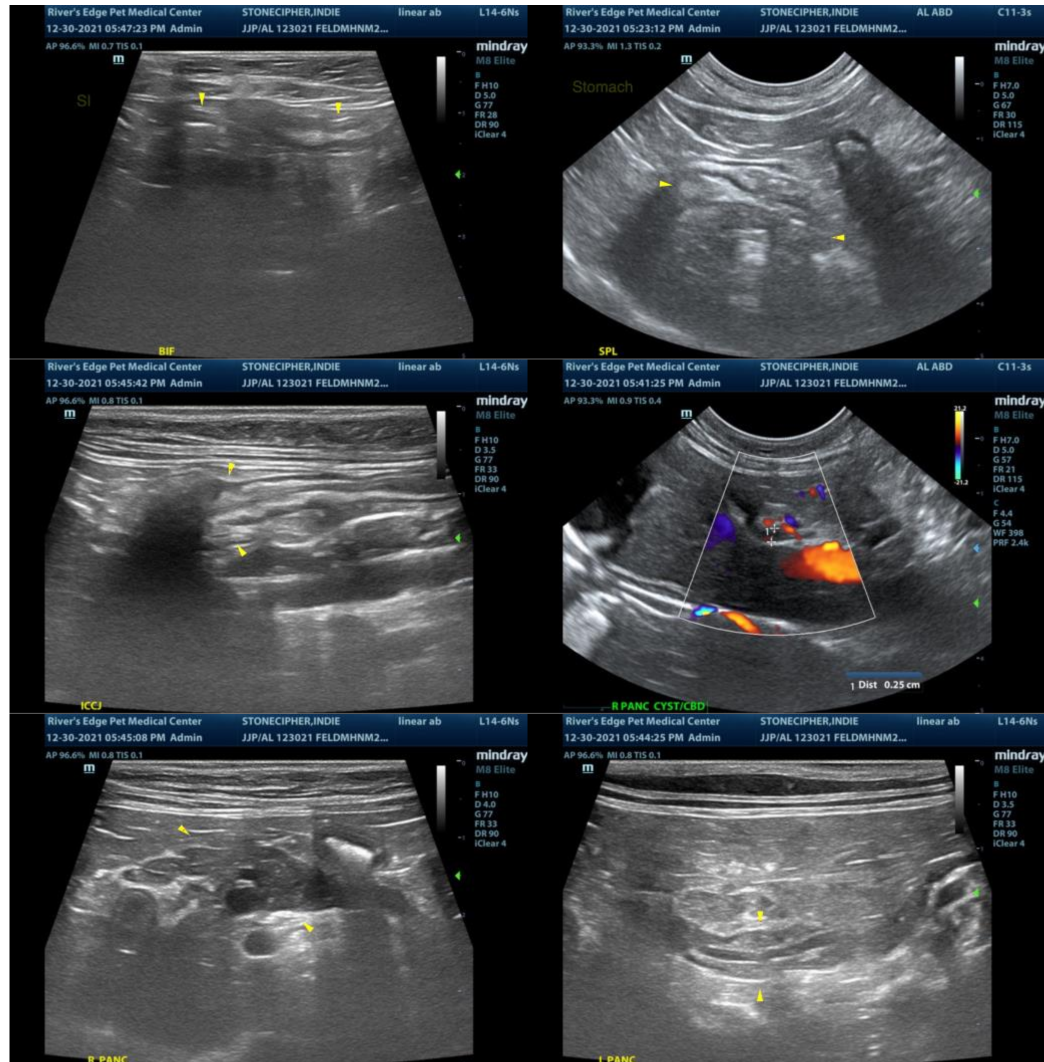

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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