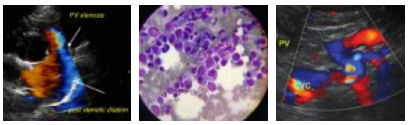
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE
12/6/21

PATIENT
Suki Donis

SPECIES
Feline

BREED
Domestic shorthair

SEX
Female, spayed

AGE
7/11/21

WEIGHT
11 lbs.

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

IMAGING PERFORMED BY
Andi Parkinson RDMS

HOSPITAL NAME
Timonium AH

REFERRING VET
Dr. Stephens

INVOICE
12652

PRESENTING CLINICAL SIGNS

History: Presented with uveitis and hypopyon, general blood panel sent to the lab. Hypoalbuminemia noted, which has persisted. Protein-losing nephropathy suspected. Retaining fluid/limb edema noted on exam 12/3/21.

Current Medications: Omega fatty acid supplement started. Finished topical Flurbiprofen.
Lab Results: Albumin 1.8-2.0, tested 3 different days, 3+ proteinuria on 2 different days, UPC ratio pending. CBC chem WNL except for low albumin. USG 1.050 with proteinuria and an inactive sediment. Feline leukemia/FIV/heartworm negative.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is contracted. The wall is of appropriate thickness for the level of repletion. Luminal contents are anechoic. No cystic calculi are observed.

The left kidney is normal size (4.21 cm in length); normal shape and architecture with smooth peripheral margins. 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.

The right kidney is normal size (4.21 cm in length); normal shape and architecture with smooth peripheral margins. 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.

Adrenal Glands

The left adrenal gland is normal in size (0.45 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.55 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is contracted (0.57 cm in width at the level of the hilus) with normal curvilinear peripheral contours. 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 gall bladder lumen is moderately distended. A bi-lobed confirmation is present. The wall is normal in thickness. A small amount of aggregated echogenic suspended sludge is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pyloric antrum, the wall is thickened (up to 0.93 cm) with apparent loss of the 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 0.33 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. There is also

thickening of the submucosal layer in some regions. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

A small to moderate amount of anechoic free fluid is present. The mesentery throughout the abdomen is hyperechoic. A few prominent lymph nodes are observed at the level of the ileocecal colic junction, the largest measuring 1.38 cm in length. Surrounding mesentery is hyperechoic.

Other

A brief echocardiogram reveals no evidence of pericardial effusion. The cardiac chambers are subjectively normal in size. Pleural effusion is present.

Subcutaneous edema is observed ventrally.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pleural effusion, ascites and subcutaneous edema are likely secondary to low oncotic pressure +/- concurrent increased vascular permeability.
- The pyloric antral wall changes are concerning for infiltrative neoplasia (i.e., lymphoma, adenocarcinoma). However, a severe inflammatory process cannot be excluded. The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma.
- Diffuse peritonitis is present, likely secondary to bowel pathology.

Secondary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Minor chronic renal changes.
- The splenic contraction is likely secondary to dehydration.
- Bi-lobed gallbladder- incidental.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fine needle aspirations of the abdominal fluid and pyloric antral wall (if accessible) are recommended if clotting status is appropriate. If cytologic evaluations are inconclusive, surgical GI biopsies may be necessary to get a definitive diagnosis.

- A GI panel including serum cobalamin, folate, TLI and PLI is also recommended.

- Given the presence of bi-cavitary effusion, the prognosis for this patient is considered guarded.


IntraPet Imaging APIILLC
donis,suki
IntraPet abd... C11-3s
12-06-2021 12:07:47 PM Admin
TAHsdfeldshfs2016
Stomach
Dist 0.93 cm
mindray


IntraPet Imaging APIILLC
donis,suki
IntraPet linear L14-6Ns
12-06-2021 12:09:07 PM Admin
TAHsdfeldshfs2016
SI
Dist 0.21 cm
mindray


IntraPet Imaging APIILLC
donis,suki
IntraPet linear L14-6Ns
12-06-2021 12:09:20 PM Admin
TAHsdfeldshfs2016
mindray


IntraPet Imaging APIILLC
donis,suki
IntraPet abd... C11-3s
12-06-2021 12:04:03 PM Admin
TAHsdfeldshfs2016
Ascites
mindray


IntraPet Imaging APIILLC
donis,suki
IntraPet abd... C11-3s
12-06-2021 12:04:31 PM Admin
TAHsdfeldshfs2016
Liver
Plesrai effusion
mindray


IntraPet Imaging APIILLC
donis,suki
IntraPet abd... C11-3s
12-06-2021 12:07:32 PM Admin
TAHsdfeldshfs2016
Pylorus
mindray


IntraPet Imaging APIILLC
donis,suki
IntraPet linear L14-6Ns
12-06-2021 12:09:04 PM Admin
TAHsdfeldshfs2016
SI
mindray


IntraPet Imaging APIILLC
donis,suki
IntraPet linear L14-6Ns
12-06-2021 12:09:27 PM Admin
TAHsdfeldshfs2016
LN
mindray

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 ACVIM (*Small Animal Internal Medicine*)
Andrea.nicastro@sonopath.com