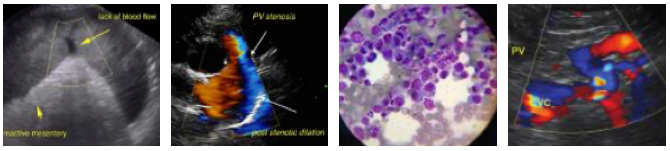
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Beau Hegwood

SPECIES
Feline

BREED
Domestic shorthair

SEX
Male, neutered

AGE
14.5 Yrs.

WEIGHT
5.72 lbs.

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

IMAGING PERFORMED BY
Tracy Lasarge

HOSPITAL NAME
SVS Imaging NW

REFERRING VET
Dr. Patton

INVOICE
14638

DATE
2/27/23

PRESENTING CLINICAL SIGNS

History: Beau presented to the MVS Emergency Service on Feb 25, 2023, at 5:15pm for evaluation of Straining to Defecate and Hyporexia About 2 weeks ago, O noticed that Beau was not interested in eating her typically dry food (IAMs indoor weight and hairball food). O switched Beau to a variety of different wet foods to try to entice him to eat but has not noticed an improvement in his appetite. Beau has lost a significant amount of weight and O says that she thinks that he is also losing muscle. About a 9 days ago, she noticed that Beau was straining to defecate. O is unsure when the last time that Beau defecated. She thought that he may be constipated, so she started given him Miralax 1/4 teaspoon BID for 1 week but discontinued due to not showing improvement. Beau does have a history of playing with rubber/hair ties but has never ingested them. O is unsure if Beau is urinating due to having multiple cats in the house. Beau is drinking water but O is not sure if it is a normal amount. Beau has a past history of back surgery and right limb nerve damage so he frequently bites his toes leading to irritation and bleeding.
Abnormal PE/Chem/CBC/UA Results: Unremarkable labs

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 with 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 size (3.97 cm in length) with an irregular shape. The cortex is hyperechoic relative to the spleen and thickened with moderate loss of corticomedullary distinction. A cortical infarct is observed at the cranial pole. Moderate pyelectasia is present (0.50 cm in the longitudinal plane). Hyperechoic shadowing diverticular foci are seen. The proximal ureter is minimally dilated (0.16 cm in diameter).

The right kidney is normal size (3.94 cm in length) with an irregular shape. The cortex is hyperechoic relative to the spleen and variably thickened with moderate loss of corticomedullary distinction. Cortical infarcts are suspected. Trace pyelectasia is present (0.14 cm in the longitudinal plane). Hyperechoic shadowing diverticular foci are visualized. There is no evidence of hydroureter.

Adrenal Glands

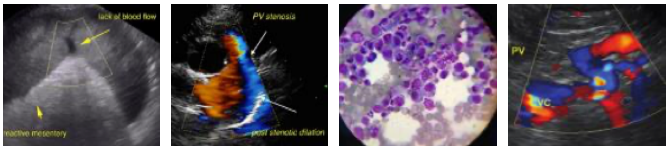
The left adrenal gland is normal in size (0.50 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in 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 (0.77 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



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The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen. Several small hypoechoic nodules are observed throughout the organ. In addition, a 0.86 cm cystic structure is observed deep on the right side, adjacent to the diaphragm. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of echogenic debris 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 minimally fluid 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 thickness is normal with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in a few segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are 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

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

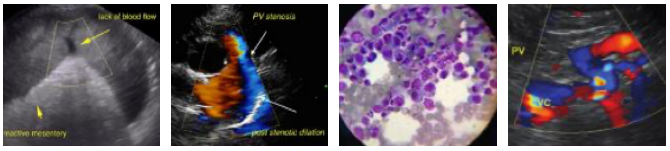
- The hepatic parenchymal changes could be consistent with infiltrative neoplasia (i.e., lymphoma), inflammatory disease, or other hepatopathy.
- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this patient.
- Trace ascites.

Secondary Findings:

- The bilateral renal changes are consistent with chronic interstitial nephrosis/nephritis with cortical infarcts, dystrophic mineralization and pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult disease in the chest.
- Given the hepatic parenchymal changes, consider a fine needle aspirate, if clotting status is appropriate. A 25-gauge needle should be used.
- Regarding the renal changes, a urinalysis with a culture and sensitivity should be considered.
- Given the weight loss and bowel changes, also consider a fecal evaluation for ova and Giardia as well as a GI panel including serum cobalamin, folate, TLI and PLI.



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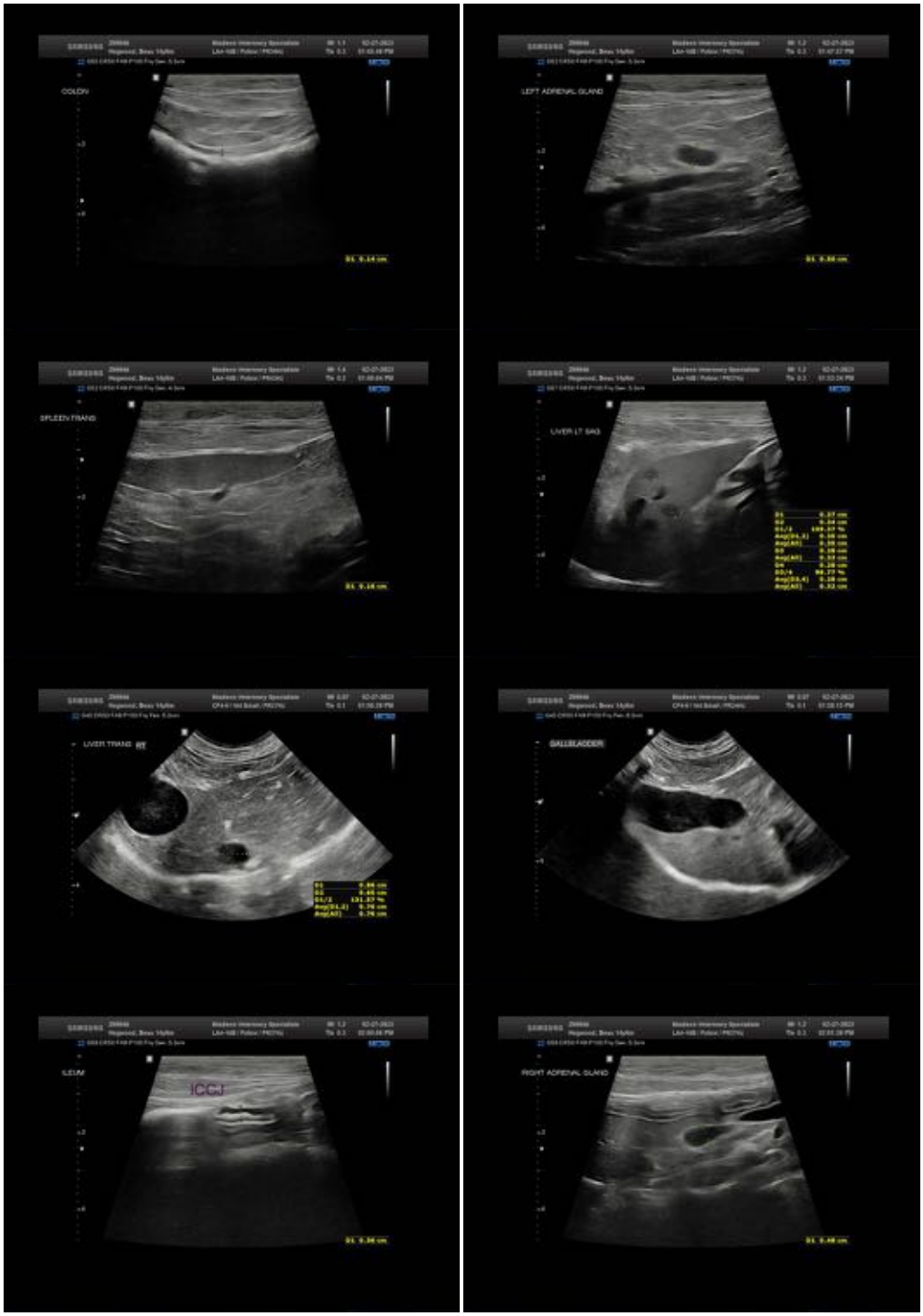
- Depending on the results of the above diagnostics, GI biopsies (i.e., endoscopic or surgical) may be warranted. Given the patient's history of straining to defecate, endoscopy/colonoscopy may be preferable to surgical biopsies.



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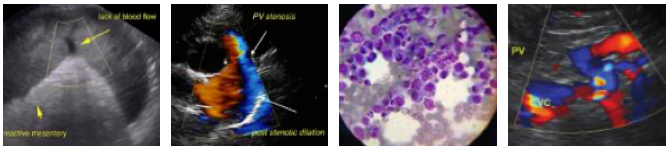

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com