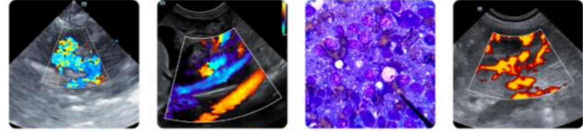
Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath FOSTERING THE ART OF VETERINARY MEDICINE™
www.charlestonmobile.net
info@charlestonmobile.net 800.403.5408

PATIENT
Chakra Surch

SPECIES
Feline

BREED
DSH

SEX
Female Spayed

AGE
07/12/2017

WEIGHT
5.8

INTERPRETED BY
Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY
Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME
Long Point AH

REFERRING VET
Dr Brett Burton

INVOICE
22709

DATE
3-19-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Patient presented on March 16th. Had been vomiting for about a week. Also regurgitating. Losing wt. Eats small meals because if she eats too much, she will vomit. She has been very vocal in the morning. Patient had foreign body surgery at 11 months of age. Had approximately 80% of the jejunum and 20% of the duodenum removed. Had multiple bowel perforations at the time of surgery. (SOAP being emailed to Dr. Nicastro).

Abnormal lab-work values: ALT 224. Hematocrit normal (31%). USG 1.034. Trace proteinuria. T4 normal. Heartworm negative. (Blood work emailed to Dr. Nicastro).
Current Medications: None
Radiographic Findings: N/A

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System
The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.70 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. One- to two cortical infarcts are suspected. There is no obvious evidence of pyelectasia or hydroureter. Renal vasculature is normal.

The right kidney is small-in-size (2.71 cm in length) with a normal shape, architecture and smooth peripheral contours. There is a normal 1:3 cortex to medulla ratio with minimal- to mild 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 (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
The spleen is normal in size (0.56 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 curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

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

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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 an overall retention of the normal layering pattern. In one segment of jejunum, a 1.3 cm heterogenous slightly shadowing structure/lesion appears to be attached to/+/- arising from the serosal surface. The bowel is mildly plicated in this region. The ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas
The pancreas is diffusely visible/prominent, with minimal deviation from the normal peripheral contours The parenchyma is subtly heterogenous in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic effusion.

Lymph Nodes
A few prominent mesenteric lymph nodes are visualized (one measuring 2.49 x 0.49 cm).

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The heterogenous structure attached to (+/- arising from) the segment of jejunum could be consistent with an adhesion from the patient's previous surgery, sponge foreign body (less likely), tumor, granuloma, other. It is unclear whether this lesion is associated with the patient's current clinical signs.

- Mild small intestinal wall thickening. This may be a normal variant for this patient or could be consistent with enteritis, or less likely, emerging neoplasia.

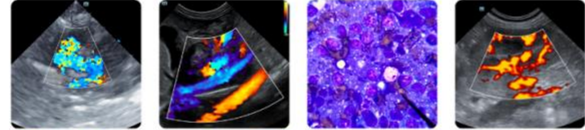
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

Secondary Findings

- Mild bilateral nonspecific age-related renal changes with possible left cortical infarcts

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

- An obvious cause for the patient's weight loss and vomiting is not definitively identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease, emerging neoplasia), underlying metabolic issue, orthopedic or neurologic (less likely given the patient is vomiting), other.



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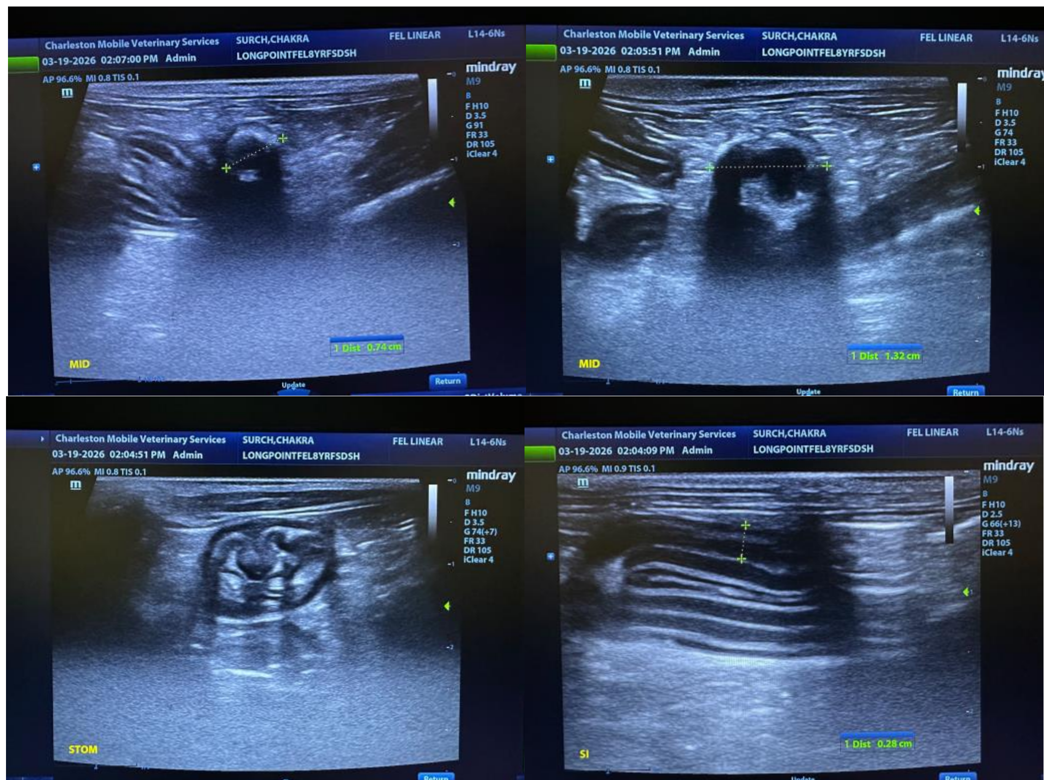
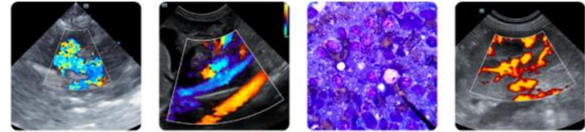
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia
- GI panel including serum cobalamin and folate, TLI and PLI
- Three-view thoracic radiographs to assess for occult pathology in the chest
- +/- pre- and postprandial serum bile acids to assess hepatic function
- Depending on the results of the above diagnostics, consider an abdominal exploratory with GI biopsies and evaluation +/- excisional biopsy of the lesion attached to the jejunum.
- While awaiting test results, symptomatic care (including nutritional support as needed) is recommended.





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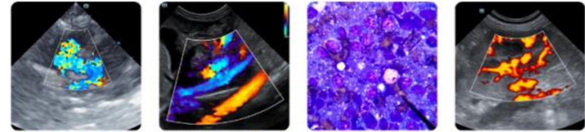

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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