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Clinical Sonography & Telecytology
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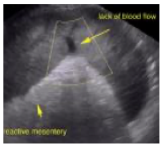
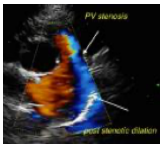
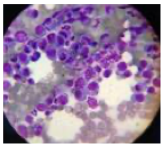
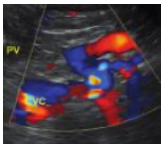

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Coco Rodriguez

SPECIES

Feline

BREED

Siamese

SEX

Neutered Male

AGE

2 years

WEIGHT

16.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ferrer DVM

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. Blanca Colon

INVOICE

12796

DATE

4.19.23

PRESENTING CLINICAL SIGNS

History: The patient presented as a referral for an abdominal ultrasound to evaluate the GI tract. The patient had mucoid discharge on the left eye for the last couple of days and the owner gave Benadryl 3ml PO. Pet vomited yellow fluid and had 2 episodes of bloody diarrhea. Since then, the patient has not eaten, has not suffered a change in diet, and is an indoor-only cat.

Abnormal PE/Chem/CBC/UA Results: PE: the pet is QAR, vital parameters wnl, mm pink & moist, CRT < 2 sec. Chest auscultation was unremarkable. Abdominal palpation showed pain and discomfort in the cranial abdomen. Difficult to assess for thickness or organomegaly as P is obese and has a large amount of abdominal fat. BCS 8/9. Approximately 6% dehydration. Abdominal radiographs showed stacking of GI segments, gastric content with a caudal displacement of the gastric axis, and somewhat distended loops of the small intestine. CBC/Chem Panel - increased TP and globulins (9.1 g/dl and 5.8 g/dl respectively)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 1-2 cm, are normal.

The left kidney is prominent in size (4.98 cm in length) with normal curvilinear peripheral contours. The cortex is hyperechoic relative to the spleen. 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.

The right kidney is prominent in size (4.43 cm in length) with normal curvilinear peripheral contours. The cortex is hyperechoic relative to the spleen. 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.

Adrenal Glands

The left adrenal gland is normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature appear normal.

The right adrenal gland is normal size (0.29 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The spleen is normal in size (0.64 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 appears 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.

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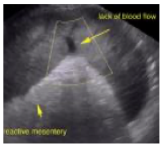
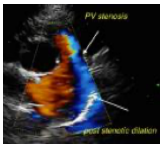
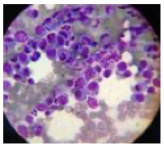
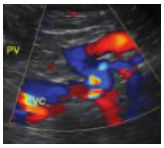

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Gastrointestinal
The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is diffusely thickened (up to 0.42 cm) with retention of the normal layering pattern. There is disruption in the normal 1:3 muscularis: mucosal ratio, with a >1:1 ratio in some segments. Discreet masses are not identified. The ileocecocolic junction is normal. The colonic wall is diffusely thickened (up to 0.51 cm). The proximal colonic lumen appears to be fluid-distended. There is no obvious evidence of an obstructive pattern.

Pancreas
The right limb of the pancreas is normal in size with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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
There is no obvious evidence of free fluid. A few prominent lymph nodes are observed at the aortic trifurcation (the largest measuring 0.79 cm in diameter). A few prominent mesenteric lymph nodes are seen (the largest measuring 1.26 cm in length). A few prominent lymph nodeS are also seen in the right cranial quadrant. The mesentery surrounding the nodes is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The bowel changes could be consistent with emerging lymphoma or inflammatory bowel disease.
- The prominent abdominal lymph nodes could be consistent with reactive lymphadenitis, lymphoid hyperplasia, or emerging neoplasia (i.e., lymphoma).

Secondary Findings

- Mild bilateral chronic renal changes
- 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

- Fecal evaluation for ova and Giardia
- Prophylactic deworming with Fenbendazole
- Malabsorption panel, including serum cobalamin and folate, TLI and PLI
- Consider transitioning to a hydrolyzed protein or limited antigen diet (when the patient will tolerate it).
- Also consider initiation of a probiotic as well as a fiber supplement (i.e., Metamucil or Konsyl).
- If lymph node cytology results are inconclusive, consider endoscopic or surgical GI biopsies. Three-view thoracic radiographs should be performed prior to anesthesia.

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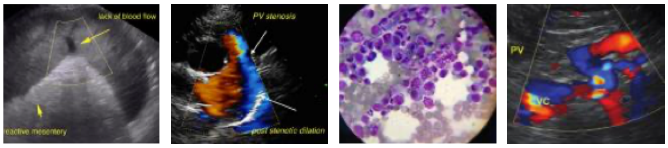

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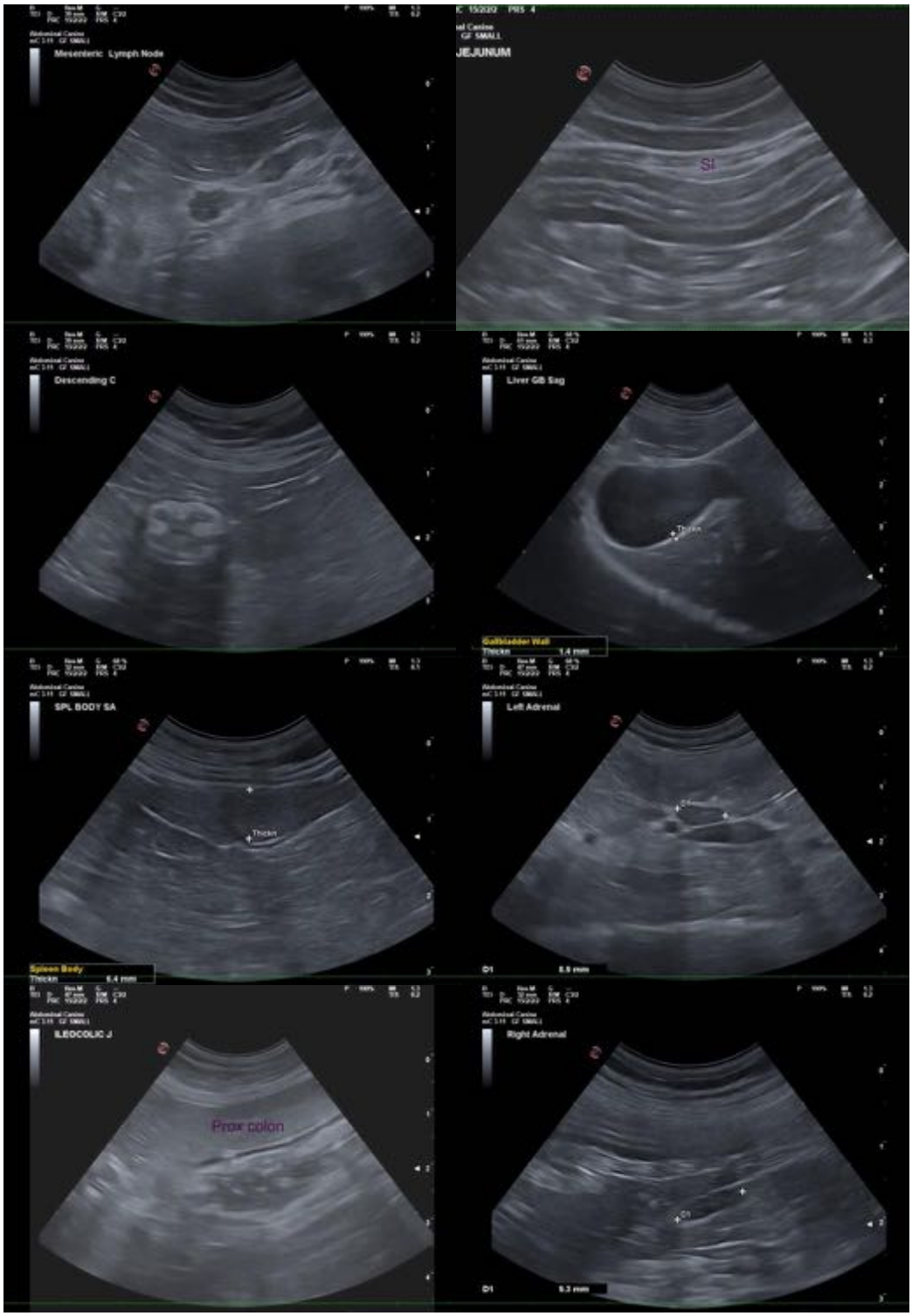

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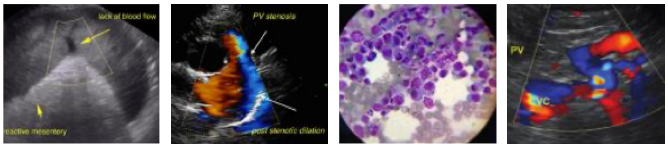

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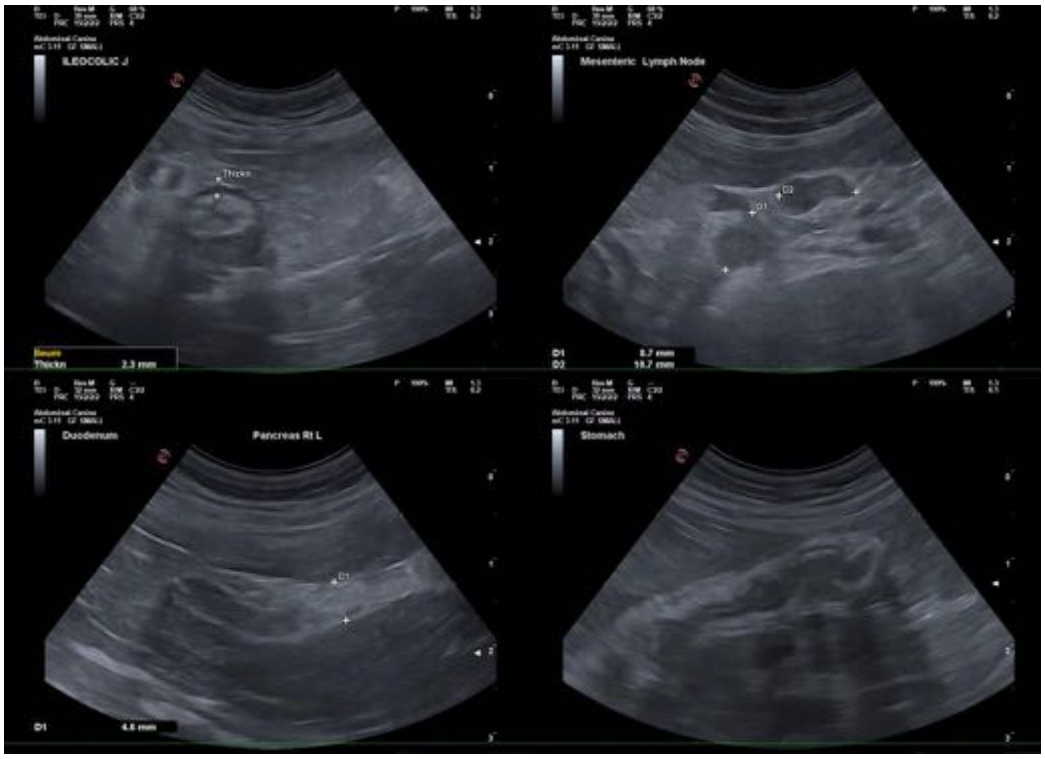

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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