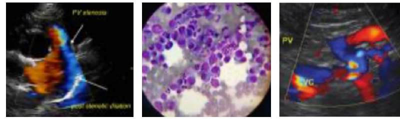
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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DATE

6.21.23

PATIENT

Lulu Miller

SPECIES

Feline

BREED

Burmese

SEX

Female Spayed

AGE

7/1/2020

WEIGHT

6.25 lbs

INTERPRETED BY

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

HOSPITAL NAME

Mt. Airy Vet Assoc

REFERRING VET

Dr. Cormier

INVOICE

13436

PRESENTING CLINICAL SIGNS

Lulu presented for a two-month history of intermittent vomiting. Last week she vomited food, bile, and for the first time lost her appetite. Owner noticed that her husband may have been feeding the incorrect food (kitten instead of adult food), so unsure if this is related. BAR, MM: pink, moist, CRT<2, BCS: 4/9 CV: No murmurs or arrhythmias; strong, synchronous femoral pulses. GI: Abdomen palpates soft, but Lulu vocalizes on palpation of mid-abdomen.

Current Medications: On 6/12/23 Lulu received 20mL/kg of LRS, 3mg of Cerenia, 3mg of famotidine, and vitamin B12 - injectable. No oral medication was dispensed.
Lab Results: CBC and chemistry were unremarkable. No parasites seen on fecal with giardia.
Radiographs: No obvious foreign body seen.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS

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. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is small in size (2.79 cm in length) with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, or hydroureter. Renal vasculature appears normal.

The right kidney is normal in size (2.77 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature appears normal.

Adrenal Glands

The left adrenal gland is normal size (0.33 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature appear normal.

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

Spleen

The spleen is normal in size (0.49 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. There is an increase in portal markings. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. 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/not seen.

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 thickness is normal. There is disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. 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 hypoechoic 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 0.90 cm cranial abdominal lymph node is visualized. In addition, a few prominent lymph nodes are observed at the ileocecocolic junction (the largest measuring 0.67 cm in length). A few prominent mesenteric lymph nodes are also observed (the largest measuring 1.14 cm in length). Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this patient. There is also a potential for emerging lymphoma, although neoplasia is considered unlikely at this time.

- The pancreatic changes are suggestive chronic pancreatitis, with possible parenchymal remodeling.

- The increase in hepatic portal markings is suggestive of an inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis) although normal variation cannot be excluded.

Secondary Findings

- Bilateral chronic age-related renal changes

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

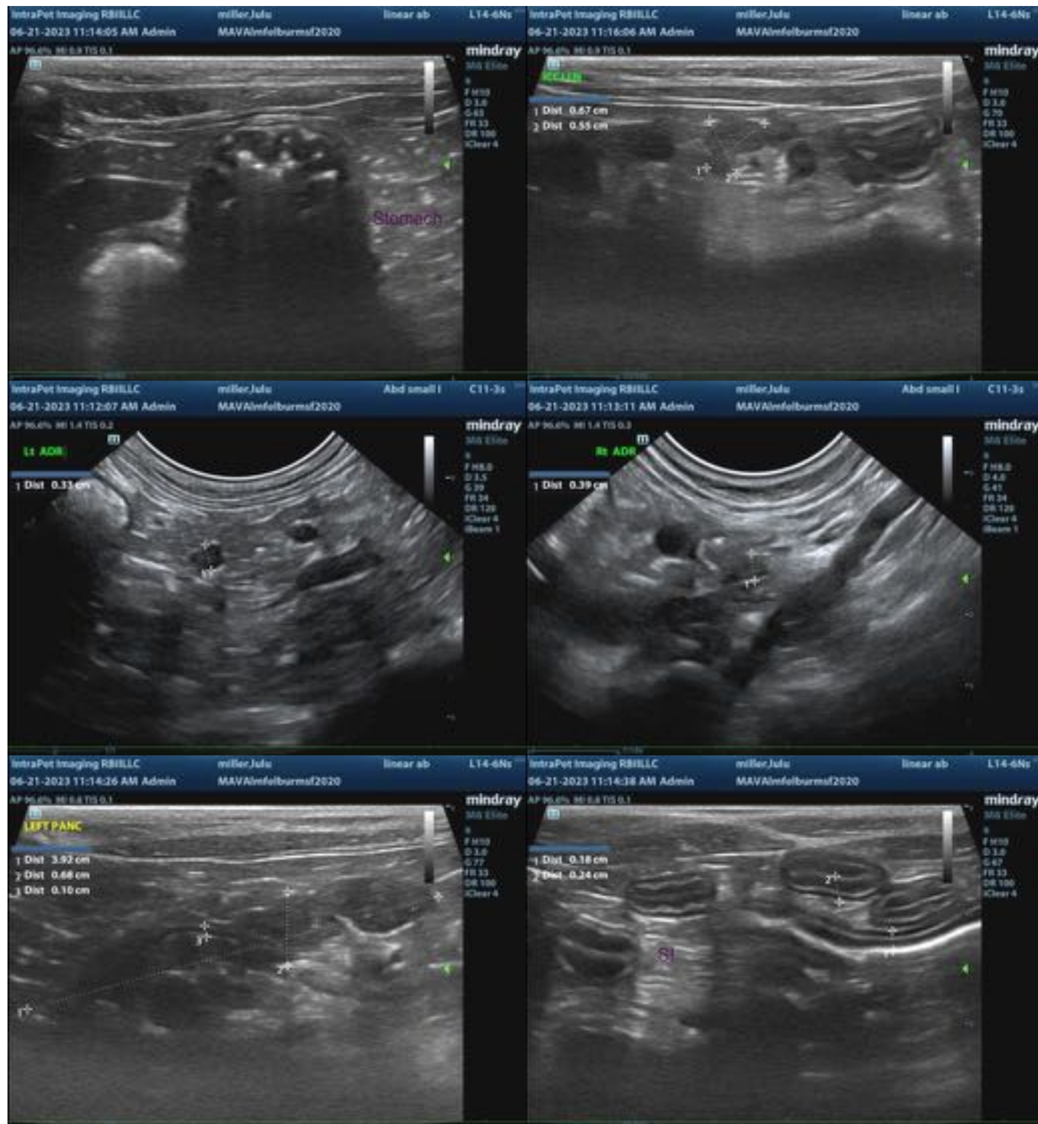
  *Given the patient’s sonographic changes, "triaditis" is a consideration.

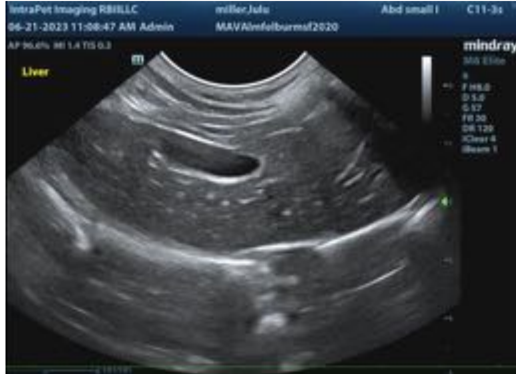
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the patient’s clinical history and sonographic changes, consider the following:

  1. A T4/free T4 by equilibrium dialysis is recommended (if not already performed)
  2. Texas GI panel including serum cobalamin and folate, TLI and PLI is recommended.
  3. A 4-week hydrolyzed protein or limited antigen diet trial should also be considered to assess for food allergies.

4. Thoracic radiographs are recommended to evaluate for occult esophageal disease.
5. Consider heartworm testing (i.e., antibodies, antigen), as heartworm disease can be a cause of chronic vomiting in cats.
6. Ultimately, endoscopic, or surgical GI biopsies, +/- liver biopsies may be necessary to get a definitive diagnosis.





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