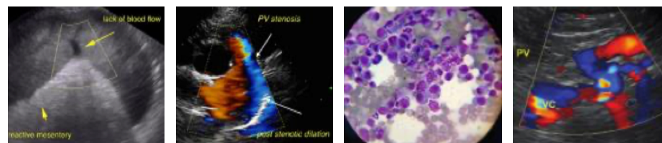
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Leo Krause

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

7 Yrs. 5 months

WEIGHT

11.94 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Budden

HOSPITAL NAME

Frontier VH

REFERRING VET

Dr. Budden

INVOICE

13767

DATE

7/25/22

PRESENTING CLINICAL SIGNS

History: Seen 7/22/22 for decreased appetite starting 7/19/2022. Seems excited to eat and then does not. Chronic vomiting. Seems to drink and urinate frequently. Started on Elura. Since then owner has seen minimal improvement. Has seen a few episodes of vomiting since then and appetite is still low. Owner noticed diarrhea starting today. Ultrasound to assess for cause of decreased appetite and chronic vomiting.
Abnormal PE/Chem/CBC/UA Results: CBC/Chem/UA 7/22/2022 creatinine elevated 2.5, BUN normal at 30: r/o CKD vs. other renal rest of cbc/chem wnl T4 2.1 - wnl USG 1.021, rest of sediment nsf. dilute urine. cobalamin/folate pending exam 7/25/2022: very intermittent arrhythmia on auscultation, no murmur, mild dental tartar, adequate hydration, stable weight from previous exam 7/22/22, no pain on abdominal palpation, lost about 3# since 9/18/2021 (purposeful per owner)

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 mostly anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal size (4.25 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is poor corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. Trace pyelectasia is present (0.14 cm in the transverse pane). There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (4.09 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is poor corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

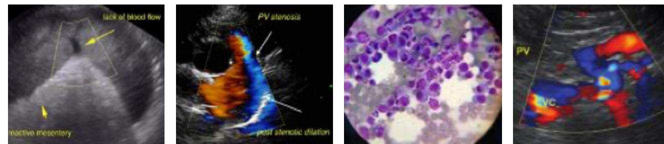
The right adrenal gland is normal in size (xxx cm length; xxx cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent to enlarged with slightly swollen peripheral contours. The parenchyma is homogenous. No focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

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. A few small, intrahepatic biliary stones are visualized. Hepatic vasculature is of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is mildly thickened (up to 0.15 cm) and hyperechoic. A small to moderate amount of gravity-dependent mineralized sand is observed within the lumen +/- distinct cholelith. 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 thickness is normal with a normal layering pattern and appropriate mural detail. 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 prominent in size with slightly irregular peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

There is no evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

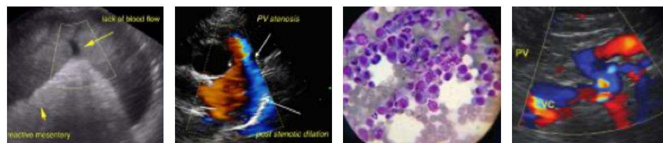
- The pancreatic changes are consistent with chronic +/- active pancreatitis.
- The small intestinal wall pattern is suggestive of inflammatory bowel disease.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The bilateral renal changes are most consistent with chronic interstitial nephrosis/nephritis.

Secondary Findings:

- The gallbladder wall changes could be consistent with cholecystitis and/or benign age-related hyperplasia. Mineralized gallbladder sand +/- distinct choleliths (incidental).
- Intrahepatic biliary stones, incidental.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the gastrointestinal signs, consider the following:
    1. Malabsorption panel including serum cobalamin, folate, TLI and PLI.
    2. A fecal evaluation for ova/Giardia.
    3. Consider a 6 week limited antigen diet trial when the patient's appetite has normalized.
    4. Ultimately, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. If pursued, thoracic radiographs (three-view) should be performed prior to anesthesia.



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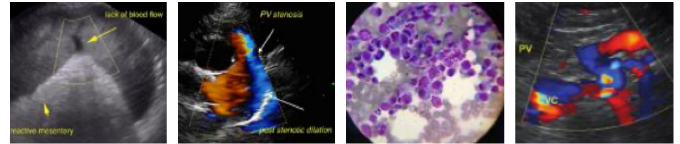
- Given the history of an arrhythmia, also consider an echocardiogram, ECG, and baseline blood pressure measurement, particularly if the patient is to undergo anesthesia.
- Regarding the renal changes, serial monitoring (i.e., every 3-4 months) of the patient's renal values is recommended. If proteinuria is present, a UPC should be considered. Also consider a urine culture and sensitivity.



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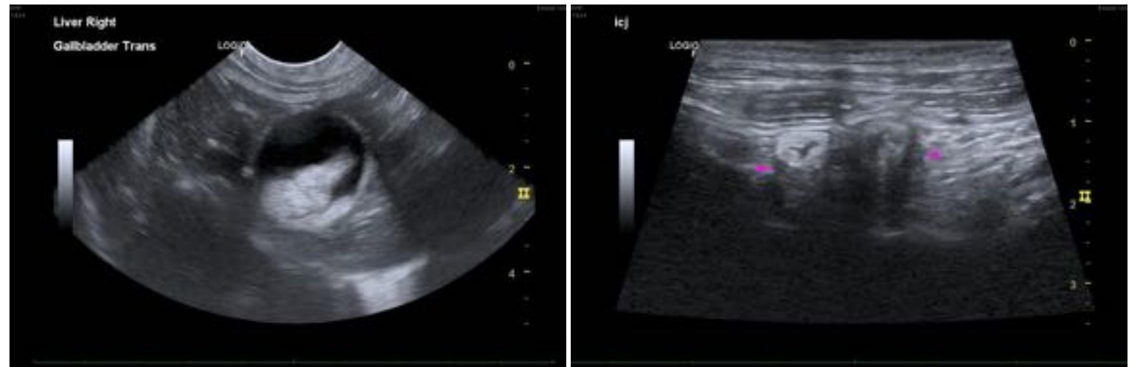

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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