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Clinical Sonography & Telecytology
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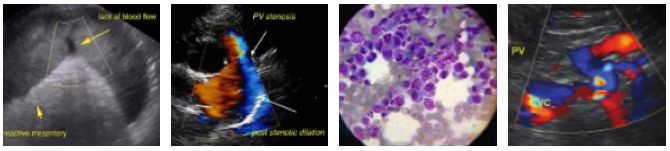


PATIENT
Abigail Kowalchuk

SPECIES
Feline

BREED
Domestic shorthair

SEX
Female, spayed

AGE
15 Yrs. 3 months

WEIGHT
5.6 kg.

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

IMAGING PERFORMED BY
Dr. Brian Barnes

HOSPITAL NAME
Westview VH

REFERRING VET
Dr. Brian Barnes

INVOICE
13809

DATE
8/10/22

PRESENTING CLINICAL SIGNS

History: Losing weight, Not eating or drinking 1 week. Did start drinking yesterday. Stopped BMs few days ago. Vomiting on and off for 2 weeks. Hairballs then bile.
Abnormal PE/Chem/CBC/UA Results: CBC - HCT low (27%), RBC WNL, No Retic response -Stress Lymphopenia suspected Chem - SDMA 32, Creat, BUN WNL - Rest BW WNL Snap FPL - ABNORMAL Pancreatitis UA - USG 1.016 LOW, Quiet sediment

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. The region of the trigone was normal.

The left kidney is normal size (3.34 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.41 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.25 cm cranial; 0.29 cm caudal; 1.09 cm length). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.33 cm cranial; 0.34 cm caudal; 1.58 cm length). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

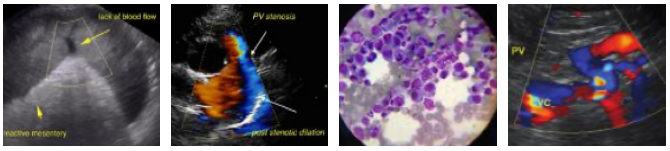
The spleen is normal in size (0.69 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal 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 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.

Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is diffusely thickened (up to 0.32 cm) with retention of the normal layering pattern. There is disruption of the normal 1:3 muscularis: mucosal ratio with a >1:1 ratio in most segments. The ileum is diffusely thickened



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(up to 0.47 cm) with prominent muscularis layer. The ileocecocolic 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

No free fluid is observed. Several enlarged, rounded hypoechoic mesenteric lymph nodes are visualized, the largest measuring 3.03 cm in length. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging neoplasia.
- The abdominal lymphadenopathy may be secondary to reactive lymphadenitis, lymphoid hyperplasia, or infiltrative neoplasia (i.e., lymphoma).

Secondary Findings:

- Bilateral, age-related degenerative renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a fine needle aspirate of one of the enlarged mesenteric lymph nodes, if clotting status is appropriate. A 25-gauge needle should be used. If the nodes are not accessible or if cytology results are inconclusive, surgical biopsies of the GI tract and abdominal lymph nodes should be considered to get a definitive diagnosis. Three-view thoracic radiographs are recommended prior to anesthesia. If biopsies are not pursued, empirical treatment for inflammatory bowel disease (i.e., corticosteroids, novel protein diet) can be considered as long as the client understands the risk of treatment without a definitive diagnosis.
- A malabsorption panel including serum cobalamin, folate, TLI and PLI is also recommended due to the presence of diffuse small intestinal disease.
- A fecal evaluation for ova and Giardia is also recommended, if not already performed.

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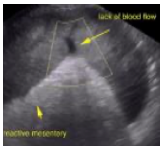
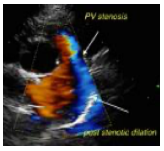
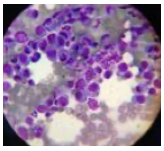
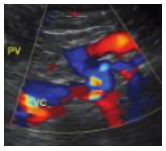

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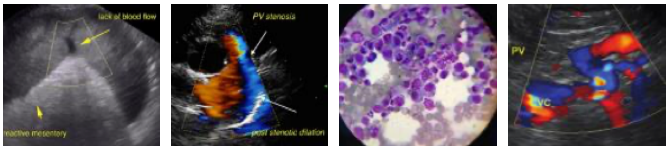

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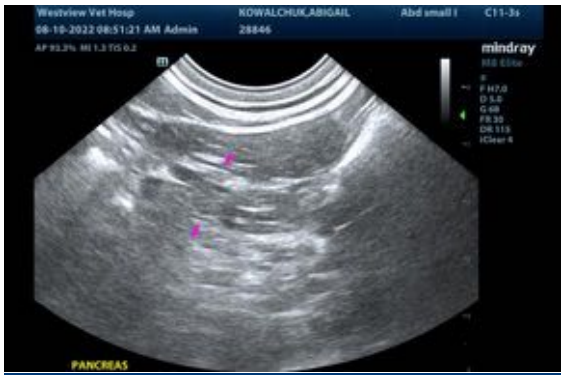

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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