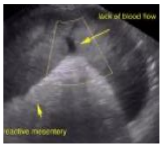
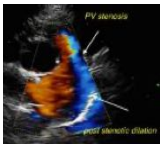
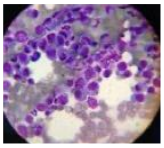
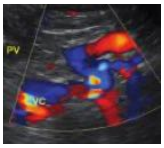
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Prada Ortiz

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
16 years

WEIGHT
10.4 lbs

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

IMAGING PERFORMED BY
Dr. G. Ferrer, DVM

HOSPITAL NAME
Paseos VC

REFERRING VET
Dr. Maria Martes DVM

INVOICE
11421

DATE
8.17.22

PRESENTING CLINICAL SIGNS

History: Patient presented on 8/3/22 for evaluation of diarrhea. PT has diarrhea that resolves and the develop again. Also, patient seems lethargic and depressed at times. Was found Quiet, but responsive, with dental dz, SQ mass (due to previous sternum fracture), heart murmur grade 3/6 systolic and tropical keratopathy. Pt was treated with metronidazole, Panacur and Ponazural. No vomiting has been appreciated.

Abnormal PE/Chem/CBC/UA Results: LABWORK 8/3/22 CBC RBC: 5.79 M/uL (6.54-12.20) HCT: 25.7% (30.3-52.3) HGB: 7.8 g/dL (9.8-16.2) CHEM SDMA: 19 ug/dL (0-14) GLOB 5.7 g/dL (2.8-5.1) LABWORK 8/11/22 CBC RBC:4.63 M/uL (6.54 - 12.20) HTC; 19.9% (30.3-52.3) HGB: 6.0 g/dL (9.8-16.2) RETIC: 1.4 K/uL (3.0-50.0) NEU: 10.55 K/uL (2.30-10.29) BAND: suspected CHEM GLOB: 5.6 g/dL (2.8-5.1) ALKP: 11 U/L (14-111) Na: 144 mmol/L (150-165) K: 2.8 mmol/L (3.5 5.8).

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 and the visible portion of the proximal urethra are normal.

The **left kidney** is normal size (3.87 cm in length); normal shape and with smooth peripheral contours. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. Trace pyelectasia is present (0.22 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter.

The **right kidney** is normal size (3.94 cm in length); normal shape and with smooth peripheral contours. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with moderate loss of 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 size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (0.76 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 slightly rounded peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits minor changes consistent with age-related remodeling. No focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion

The **gall bladder** lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 not dilated. The small intestinal wall is diffusely thickened (up to 0.32 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 and colonic wall are normal. The lumen of the ascending colon is fluid filled. Within the lumen of the descending colon, shadowing fecal material is seen. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and right limb of the **pancreas** are visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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 evidence of free fluid. A few prominent mesenteric **lymph nodes** are visualized, the largest measuring 1.75 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 lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

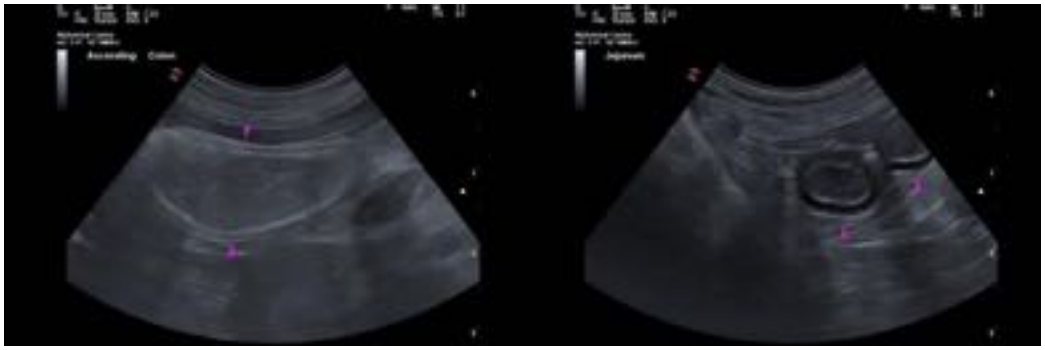
Secondary Findings

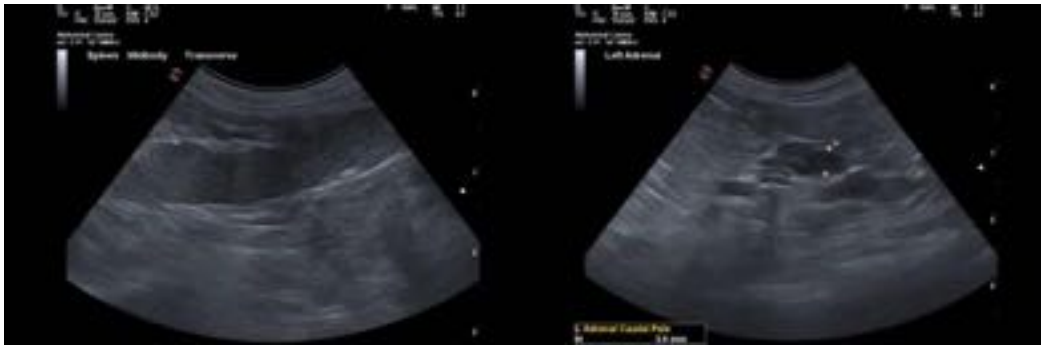
- Age-related pancreatic remodeling +/- fibrosis. Concurrent mild chronic pancreatitis is also possible, particularly if the patient's clinical history is supportive of this diagnosis.
- Bilateral degenerative renal changes with mild pyelectasia.
- Age-related hepatic remodeling

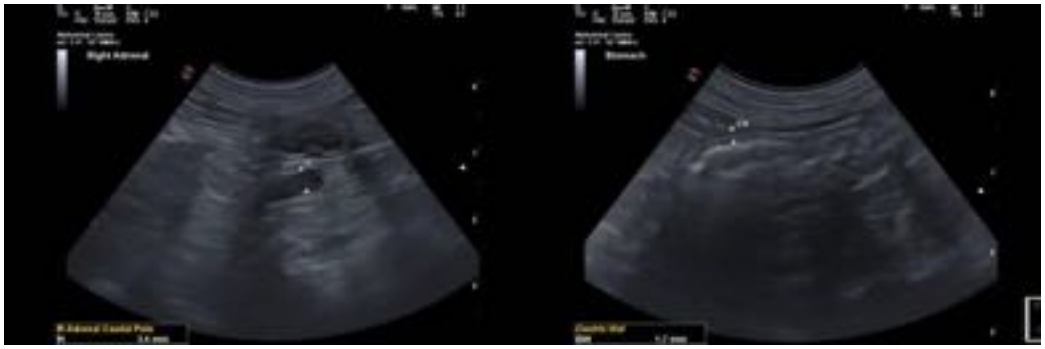
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

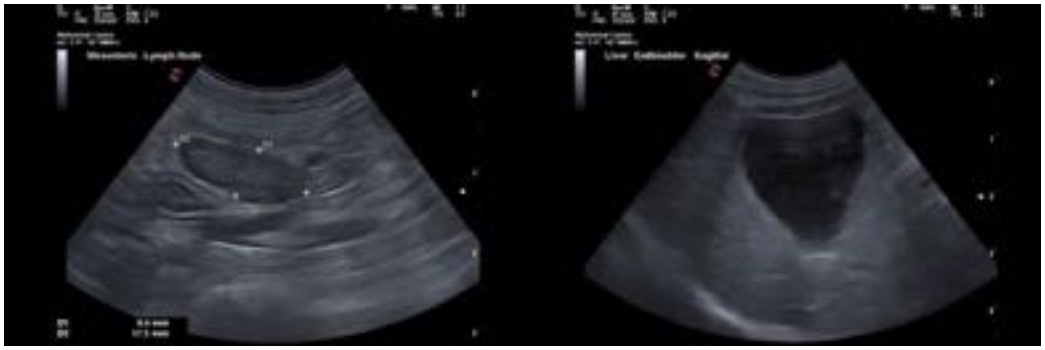
- A malabsorption panel including serum cobalamin and folate, TLI and PLI is recommended.
- A fecal evaluation for ova and Giardia is also recommended.
- Consider empirical treatment for small intestinal bacterial overgrowth with a 4-week course of Tylosin
- A 6-week limited antigen diet trial is recommended.
- Ultimately, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis. If biopsies are pursued, three-view thoracic radiographs are recommended prior to anesthesia. If biopsies are not pursued, consider empirical treatment for inflammatory bowel disease (i.e., corticosteroids, novel protein diet), as long as the client understands the risks of treatment without

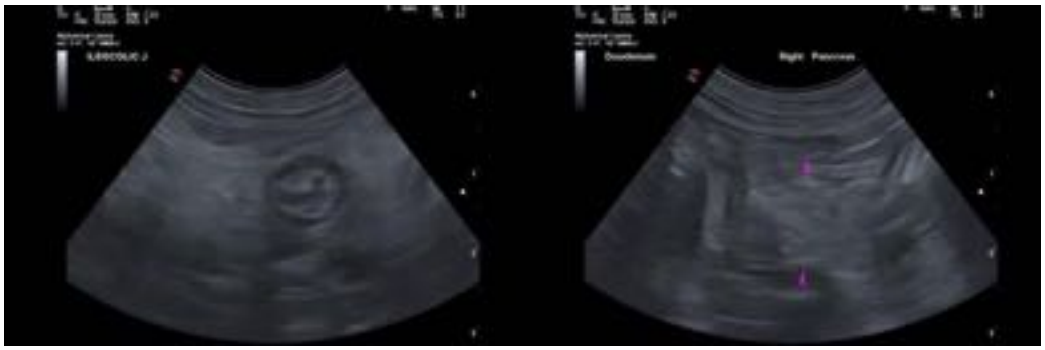
a definitive diagnosis.











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