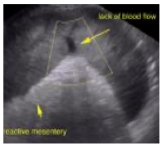
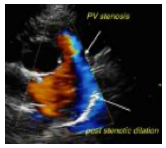
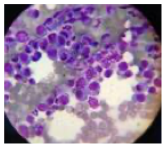
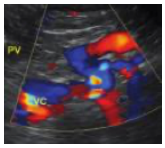
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Tilly Colvin

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
15 years

WEIGHT
6.3 lbs

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

IMAGING PERFORMED BY
Jessica Bailes

HOSPITAL NAME
All Creatures Great&Small VC, Corvallis OR

REFERRING VET
Justin Vaughn

INVOICE
11487

DATE
8.25.22

PRESENTING CLINICAL SIGNS

History: chronic hx of vomiting, anorexia, and diarrhea for >2 year; AUS performed >1.5 years ago - consistent w/ suspected IBD. biopsies declined. Has been OK w/ LID and prednisolone until the last few weeks. Most recent bloodwork has showed a non - regenerative anemia and neutrophilia.

Abnormal PE/Chem/CBC/UA Results: Greasy unkept haircoat, generalized sarcopenia, otherwise NSF on PE Bloodwork: Chem 10: ALT 260. All other wnl. CBC: WBC 18.5, Neut 16835, lymph 925, Hct 22, RBC 5.0, All other UR. Retic count: 37800 Thoracic rads taken today: NSF Maldigestion profile pending

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 moderate amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. The region of the trigone is normal.

The **left kidney** is normal size (3.34 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. A cortical infarct is suspected at the cranial pole. Trace pyelectasia is present. There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

The **right kidney** is borderline small in size (3.01 cm in length); normal shape and smooth peripheral contours. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.22 cm cranial; 0.24 cm caudal; 0.84 cm length). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (0.20 cm cranial; 0.21 cm caudal; 0.77 cm length). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (0.62 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 prominent in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen. A 1.14 cm ill-defined hyperechoic nodule/area is observed in the region of the right medial lobe. The remaining parenchyma is homogenous. 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. A small amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

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 most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas
The **pancreas** is visible with minimal deviation from the normal peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.20 cm in diameter).

Free Abdomen
There is no evidence of free fluid. One to two colic **lymph nodes** are visible, the largest measuring 0.73 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Bowel pattern consistent with inflammatory bowel disease. There is some potential for emerging lymphoma. However, neoplasia is considered less likely at this time.

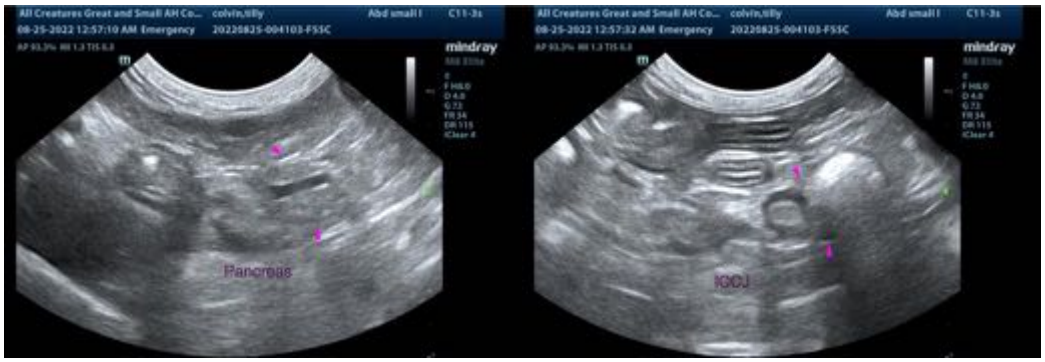
Secondary Findings

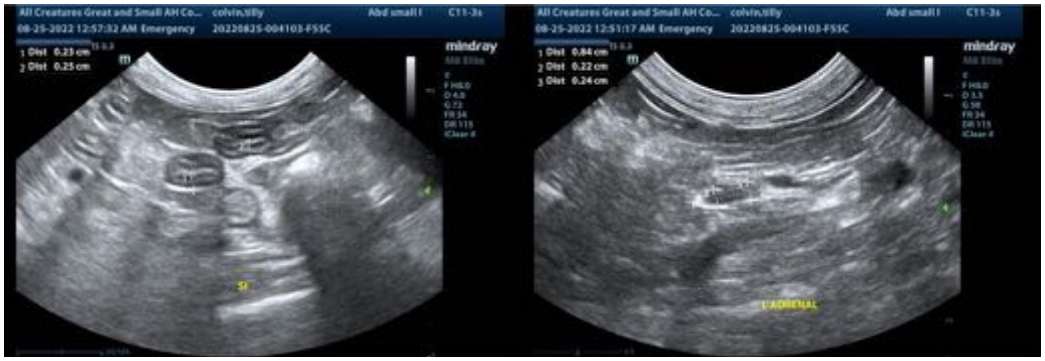
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral degenerative renal changes with a suspected left cortical infarct

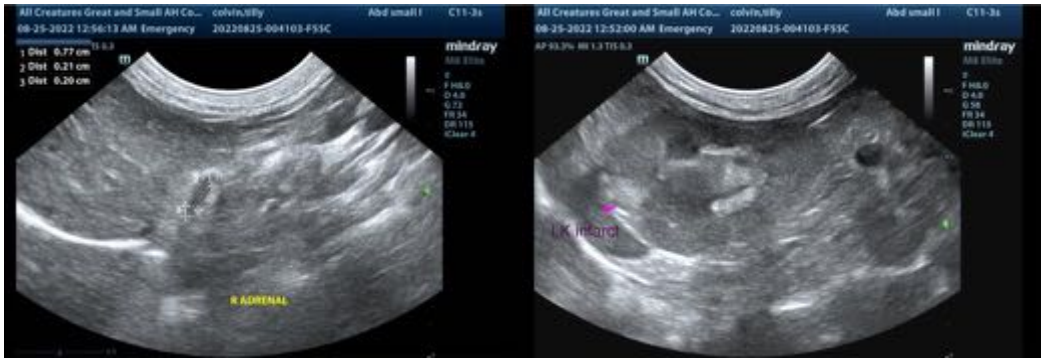
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

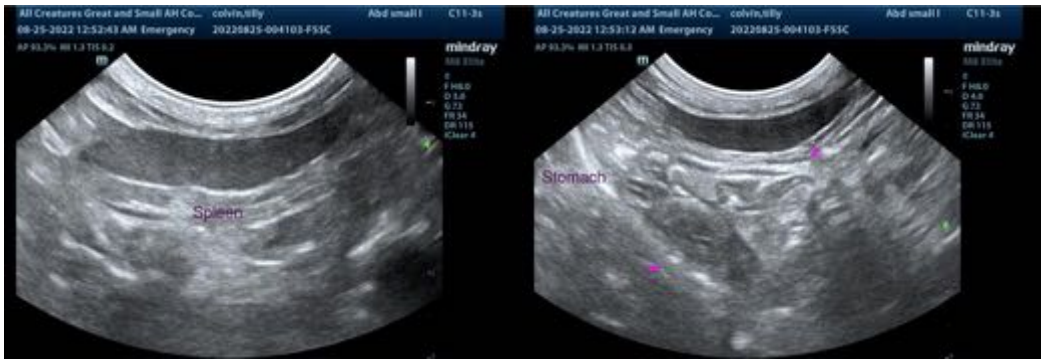
- A T4/free T4 by equilibrium dialysis is recommended, if not already performed.
- Also consider feline leukemia and FIV testing.
- A fecal evaluation for ova and Giardia is recommended.
- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
- A novel protein diet trial is recommended, if not already initiated.
- Consider GI biopsy (i.e., endoscopic, or surgical) to further assess for inflammatory bowel disease. Endoscopic evaluation may be useful in evaluating for gastroduodenal ulcers.
- In the meantime, consider empirical treatment for GI ulceration with a proton pump inhibitor and sucralfate.
- Regarding the elevated ALT and sonographic changes, consider pre-and postprandial serum bile acids +/- hepatic tissue sampling (i.e., fine-needle aspirate or surgical biopsy), if clotting status is appropriate.

- Nutritional support (i.e., via temporary feeding tube) should also be considered, particularly if the patient's caloric intake is inadequate.









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.

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