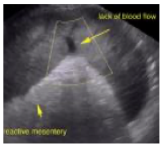
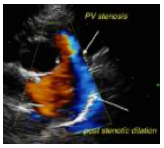
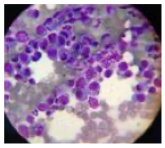
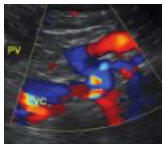
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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**PATIENT**
Ernie Sanducci

**SPECIES**
Feline

**BREED**
DSH

**SEX**
Neutered Male

**AGE**
10 years

**WEIGHT**
6.6 lbs

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

**IMAGING PERFORMED BY**
Kelly Vazquez

**HOSPITAL NAME**
Westwood Regional VH

**REFERRING VET**
Dr. Hartwick

**INVOICE**
11548

**DATE**
8.31.22

## PRESENTING CLINICAL SIGNS

History: Severe constipation, suspect megacolon. R/O other causes. History of trauma in house fire/rescued, history of back issue. Hospitalized for series of enemas etc. Current meds: SQ fluids, starting Lactulose, cisapride, probiotic, antibiotics.

Abnormal PE/Chem/CBC/UA Results: Chem: BUN 15, creat. 0.4. CBC: HCT 27.2%, HGB 9.5, retics. 63.7.

## 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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1-2 cm, are normal.

The **left kidney** is normal size (3.76 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. Moderate pyelectasia is present (0.43 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (3.80 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The **left adrenal gland** is normal size (0.27 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The region of the **right adrenal gland** is evaluated. No obvious pathology is observed.

### *Spleen*

The **spleen** is normal in size (0.71 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 slight rounding of the peripheral margins on the left side. The parenchyma is isoechoic relative to the spleen and homogenous in appearance. No distinct focal lesions are observed. 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 visible/tortuous, but not overtly dilated. The duodenal papilla is prominent (0.50 cm in width).

### *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. In the distal ileum, a small amount of soft, shadowing material is observed within the lumen. The ileocecal colic junction is normal. The wall of the descending colon is thickened (up to 0.69 cm) and irregular, with questionable retention of the normal

layering pattern. The mesentery effacing the serosal surface in this region is hyperechoic. There is no evidence of obstructive disease.

***Pancreas***
The **pancreas** is diffusely visible and is normal in size with minimal deviation from the normal peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.13 cm in diameter).

***Free Abdomen***
Trace free fluid is observed. A cluster of enlarged, rounded, hypoechoic to slightly heterogenous **lymph nodes** are observed in the caudal aspect, the largest measuring 1.75 cm in length. In addition, a few colic lymph nodes are seen, the largest measuring 0.57 cm in length. The mesentery surrounding all nodes is hyperechoic.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

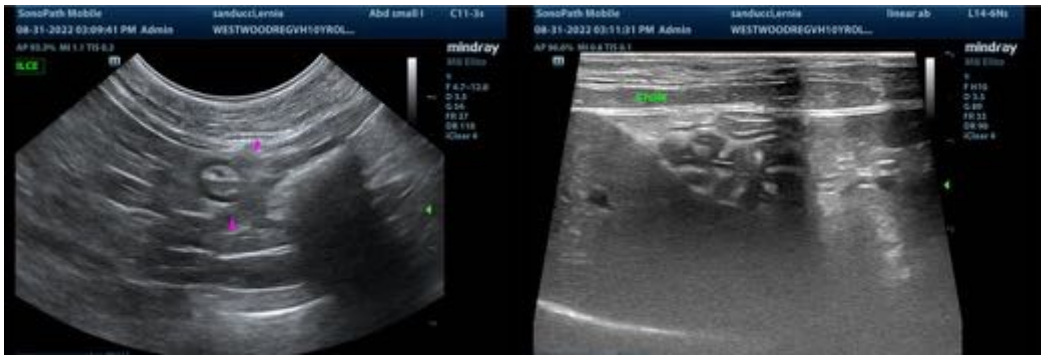
- The colonic wall changes could be consistent with Inflammation, emerging neoplasia, hypertrophy, other. Regional peritonitis is present. The soft, shadowing material in the distal ileum may represent foreign material (i.e., hair, grass) and/or chyme.
- The abdominal lymphadenopathy may be secondary to reactive lymphadenopathy, lymphoid hyperplasia, or infiltrative neoplasia.
- Trace ascites

### Secondary Findings

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- Bilateral minor degenerative renal changes. The left pyelectasia may be secondary to pyelonephritis, age-related remodeling, or some combination thereof.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If accessible, fine-needle aspirates of the enlarged caudal abdominal lymph nodes can be considered (if clotting status is appropriate). Twenty-five gauge-needles should be used. If the lesions are not accessible or if cytology results are inconclusive, consider a colonoscopy with biopsies. Three-view thoracic radiographs should be performed prior to anesthesia.
- If the patient's constipation persists and an underlying etiology is not definitively identified, a subtotal colectomy may be warranted.
- Regarding the left pyelectasia, consider a urinalysis with culture and sensitivity to assess for pyelonephritis.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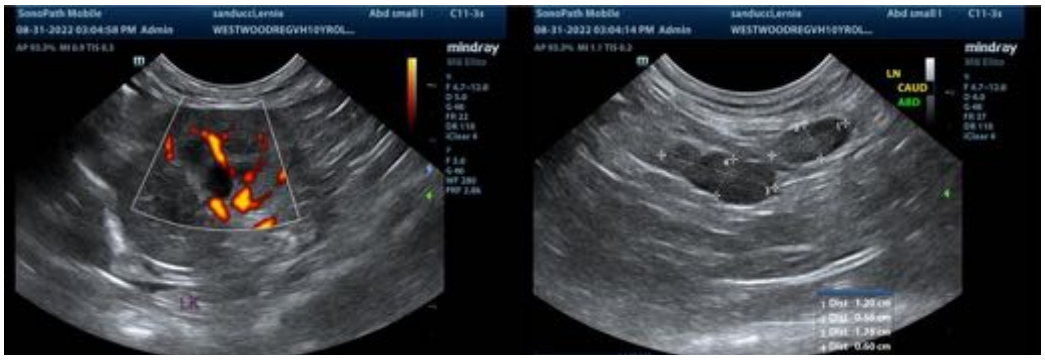
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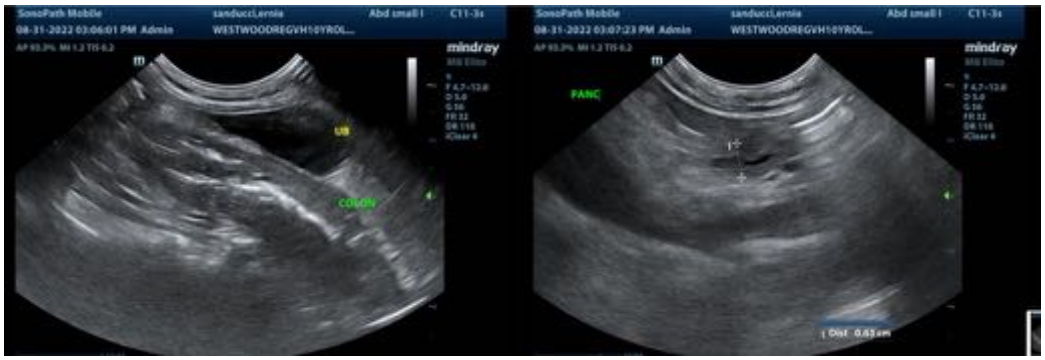
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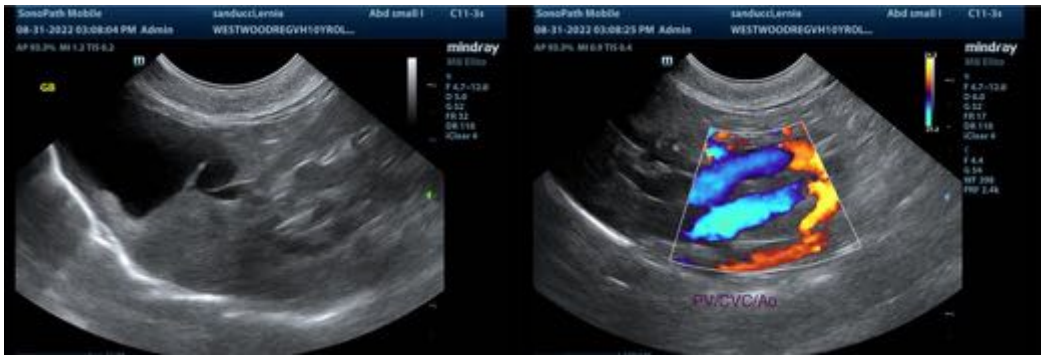



**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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)
info@SonoPath.com