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Clinical Sonography & Telecytology
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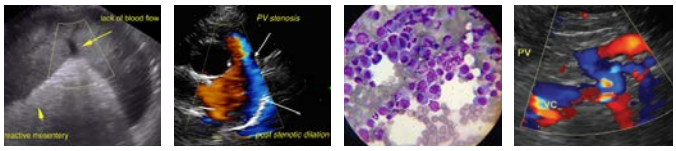

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Handful Darlington

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

2.51 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Westview VH

REFERRING VET

Dr. Brian Barnes

INVOICE NUMBER

34351

DATE

1/19/22

PRESENTING CLINICAL SIGNS

Not eating or drinking dull and depressed. has been vomiting.
Abnormal PE/Chem/CBC/UA Results: 1. Small bowel mechanical obstruction. It cannot be determined if this is secondary to a foreign object or potentially infiltrative disease such as neoplasia. 2. Constipation. 3. It should be confirmed the patient can urinate normally. 4. Previous tail luxation. 5. Previous right sacroiliac luxation. 6. Fractures of the transverse processes on the right at L6 and L7. 7. Hypovolemia. 8. Dynamic tracheal collapse. A surgical exploratory also may be warranted in this patient. Prior to surgery an abdominal ultrasound could be done to determine if the distention can be made between a foreign body obstruction and small bowel neoplasia. CBC OK, CL slight low, Sl increase Urea, Creat and SDMA Normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Right kidney is normal in size (3.97 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Left kidney is normal in size (3.39 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of mineral or infarcts observed. The renal pelvis is dilated (mild pyelectasia), measuring (0.33 cm). No visible obstruction is observed, but cannot be ruled out.

Adrenal Glands

Right adrenal gland is normal in size (1.56 cm long x 0.38 cm at the cranial pole and 0.38 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Left adrenal gland is normal in size (1.16 cm long x 0.39 cm at the cranial pole and 0.26 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged. Margins are smooth but round. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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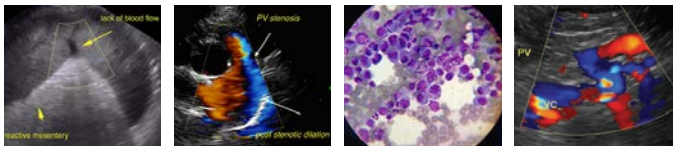

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Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease. A mid abdominal suspicious jejunal to jejunal intussusception is noted. In the area, the bowel is mildly thick with mildly hypoechoic loss of layering. Focal peritonitis characterized by scant free fluid and hyperechoic mesentery/omentum is noted. Oral to the intussusception, small bowel is markedly dilated and filled with sonolucent fluid, consistent with a mechanical obstructive pattern.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic hepatomegaly – consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- Mild left pyelectasia - Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.
- Small intestinal intussusception, suspected to be jejunal to jejunal, likely caused by infiltrative inflammatory bowel disease and resulting in mechanical obstructive pattern. Infiltrative neoplasia such as lymphoma cannot be ruled out, but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations include thoracic radiographs to further assess cardiopulmonary status as well as to look for any evidence of metastatic disease if not already evaluated, followed by laparotomy for correction of the intussusception with resection of any compromised bowel and resection and anastomosis of healthy bowel. Ful thickness biopsies of the small bowel are recommended, including ileum, if possible, to definitively diagnosis the underlying infiltrative process. In the meantime, a gastrointestinal malabsorption panel including TLI, PLI, folate and cobalamin to Texas A&M GI laboratory is also recommended to help guide post-operative therapy of possible inflammatory bowel disease long-term.

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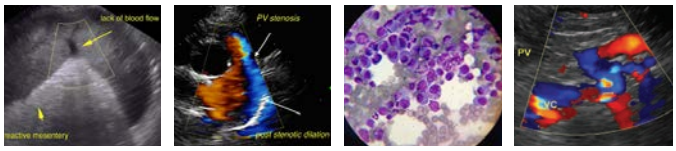

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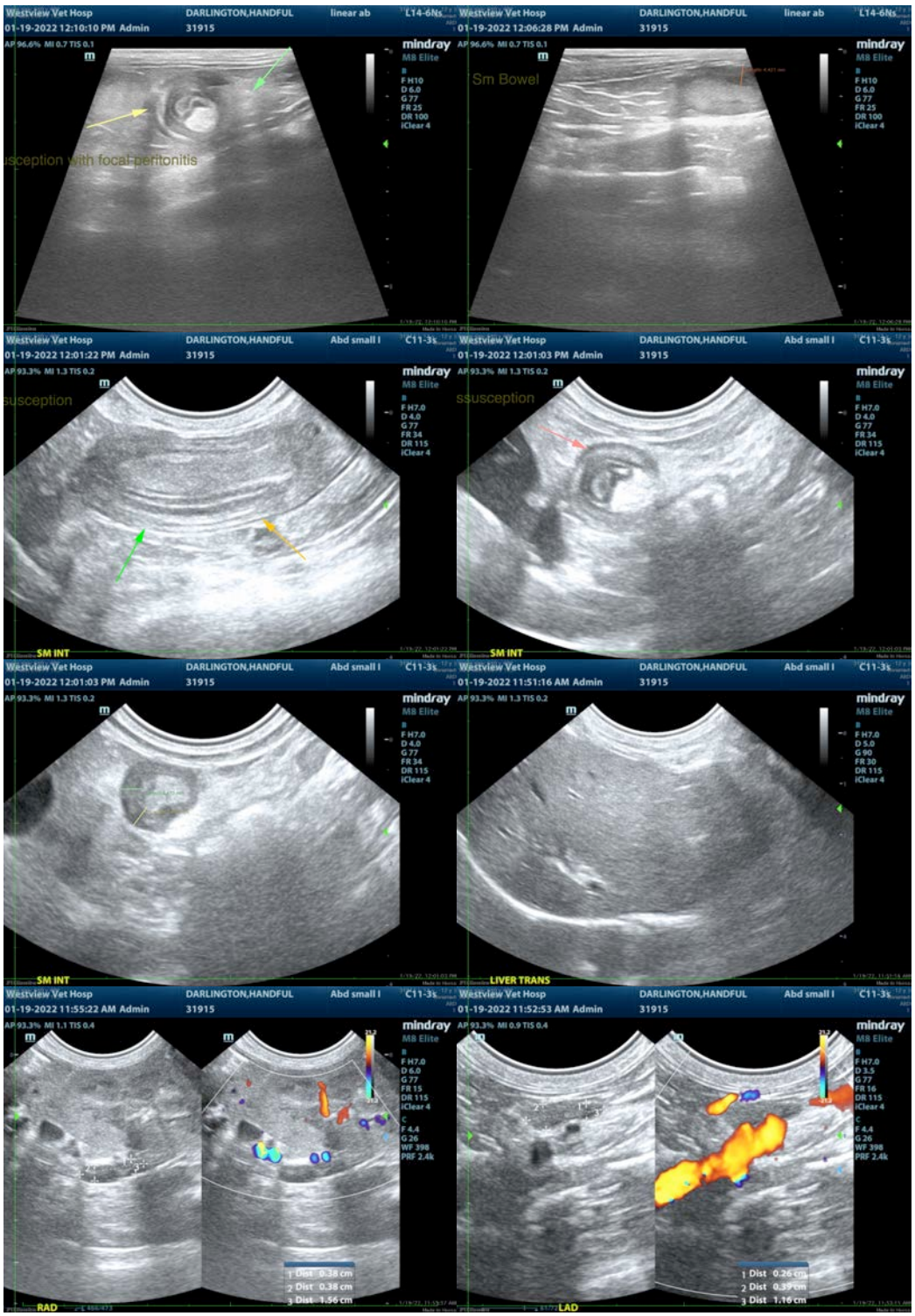

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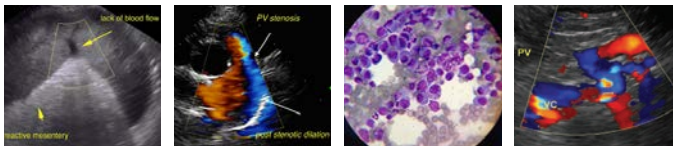

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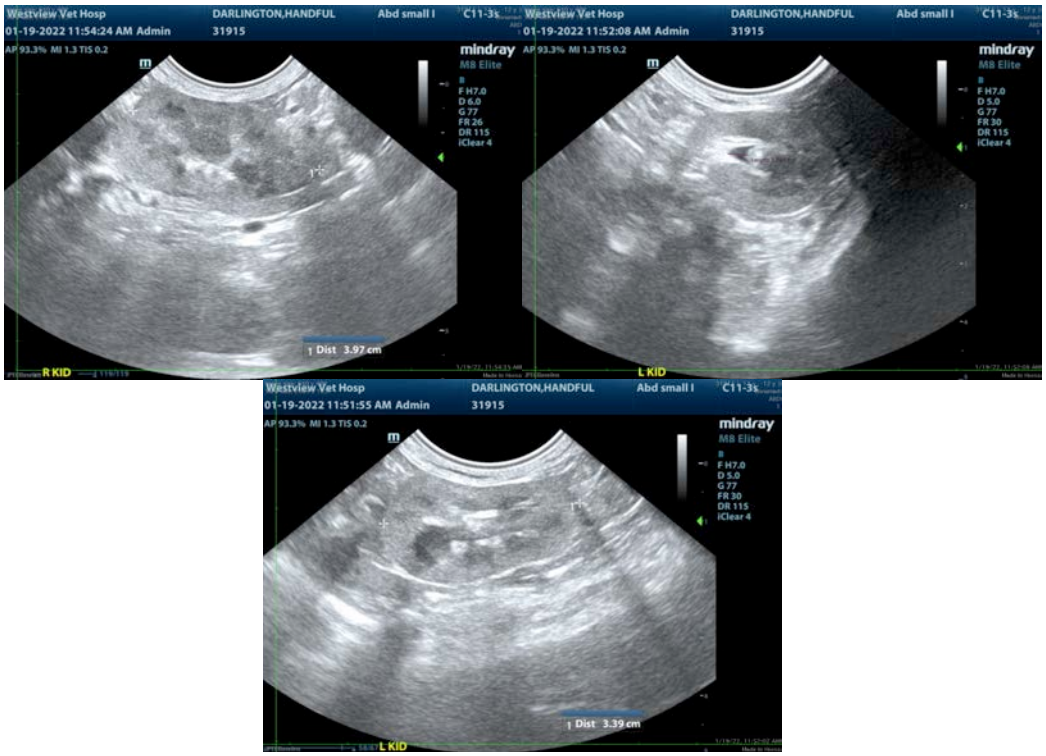

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
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