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Clinical Sonography & Telecytology
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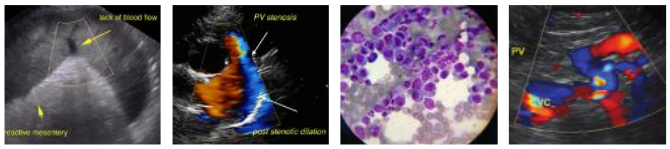


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Blake Gordon

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
13 Years

WEIGHT
9.6 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Sheldon

HOSPITAL NAME
Advanced Pet Care of Oakland

REFERRING VET
Dr. Sheldon

INVOICE
20865

DATE
1/30/23

PRESENTING CLINICAL SIGNS

History: Pet has weight loss, increased appetite, chronic diarrhea. On mirtazapine.

Abnormal PE/Chem/CBC/UA Results: CBC: mild monocytosis (0.788), PLT 88 clumping w/ fibrin strands, slide review shows moderate decreased platelets 50-100k. Chem: SDMA 18, CK 540, all else is normal. Urine: SpGr. 1.041, pH 5.5, protein 2+, quiet sediment. Thoracic Abd rads - L kidney appears slightly rounder, no other obvious abnormalities GI panel pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately 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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measures 3.28 cm. The right kidney measures 3.54 cm.

Adrenal Glands

Left adrenal gland is normal in size (0.43 cm at cranial pole and 0.29 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.35 cm at cranial pole and 0.24 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. 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

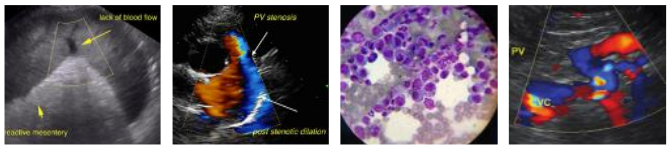
Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. A 0.5 cm discrete hyperechoic nodule is noted in the caudoventral liver. Visible 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.

Gastrointestinal

The visible stomach wall is normal in thickness 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 intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular,



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thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness and layering. Soft stool is noted in the distal colon.

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Pancreatic duct dilation is noted.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Chronic active pancreatitis
- Liver nodule – Differentials for a discrete liver nodule include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.

Secondary Findings

- Age-related kidney changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, prior to more invasive intervention, T4 and free T4 is recommended.

As is reportedly already pending, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Ideally, biopsies of the GI tract, being sure to include ileum, if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.

If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5-day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Other supportive therapeutic considerations could include fiber supplementation, especially with large bowel diarrhea and/or a probiotic.

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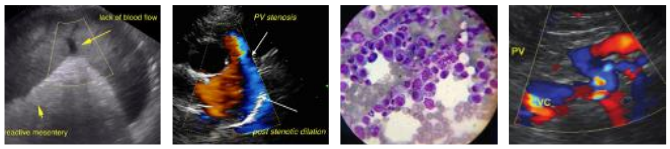

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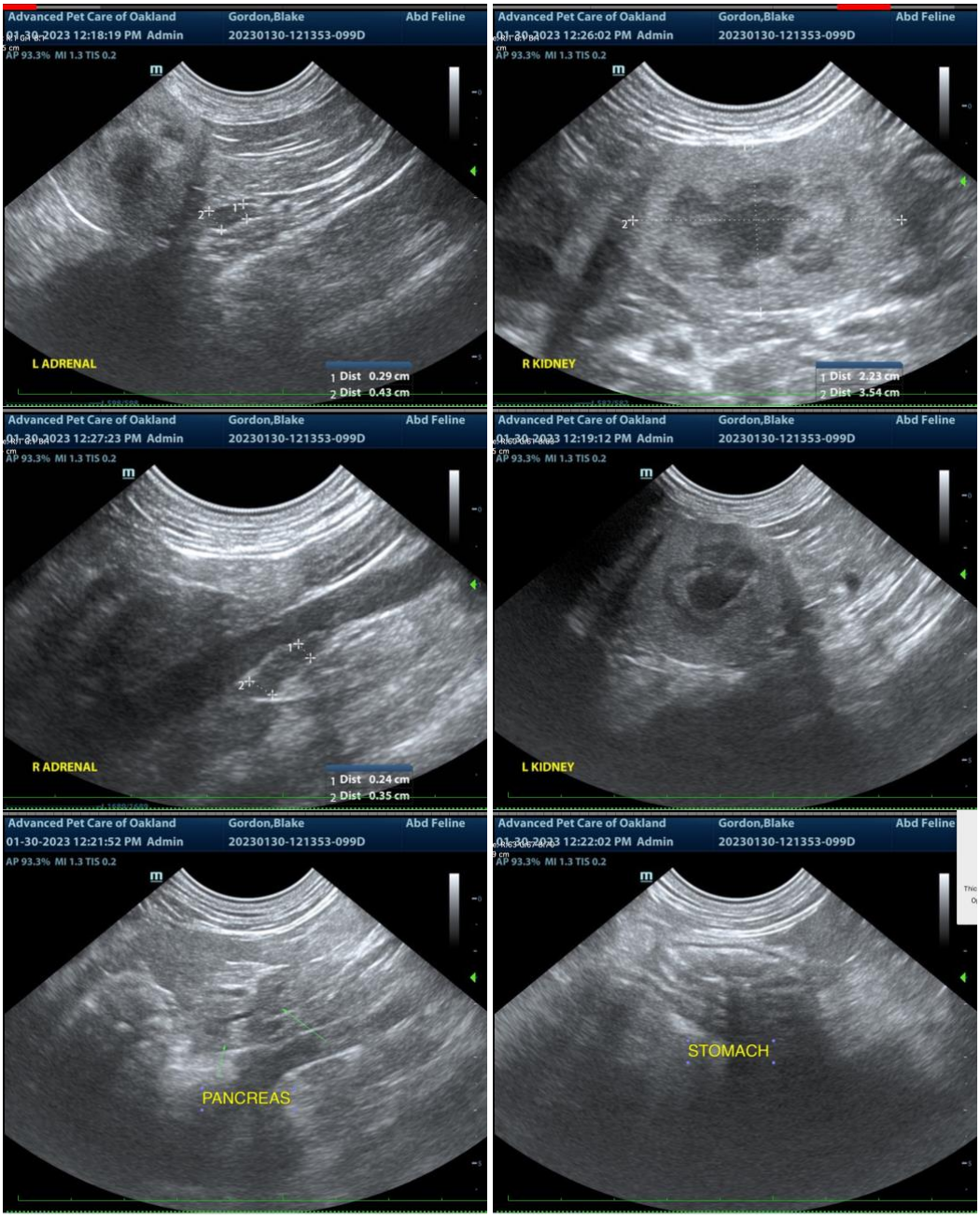

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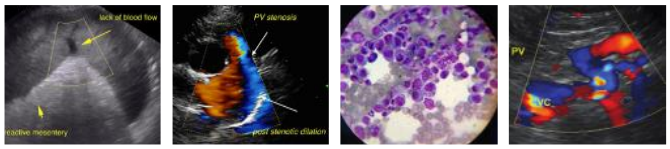

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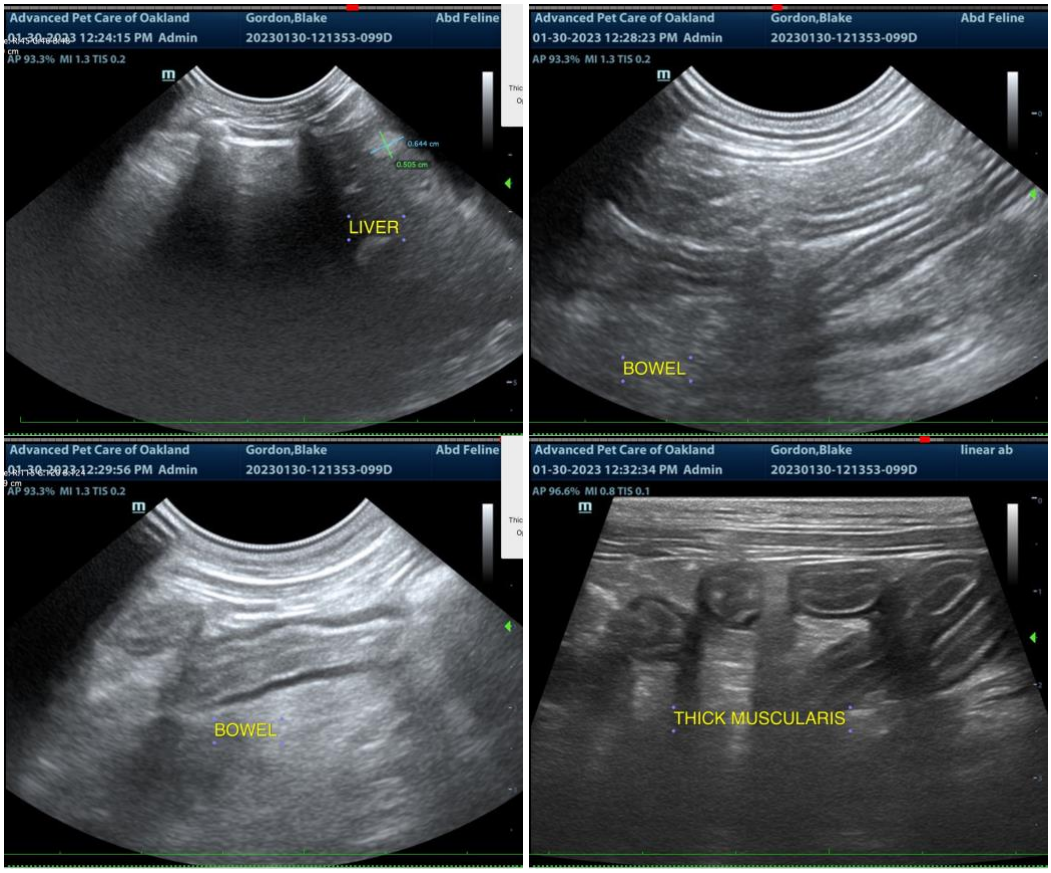

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

Beth.Johnson@SonoPath.com