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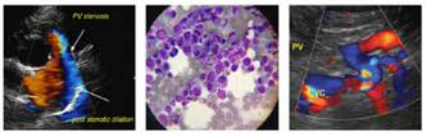

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Brownie Thomas

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

16 Years

WEIGHT

6.4 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

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PRESENTING CLINICAL SIGNS

vomiting blood
Abnormal PE/Chem/CBC/UA Results: BW pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. No mineral is observed. The left kidney is small at 3.09 cm. The right kidney is normal in size, measuring 4.05 cm. There is mild pyelectasia bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.33 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.26 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The 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

The 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. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen is empty with no evidence of obstruction or foreign material.

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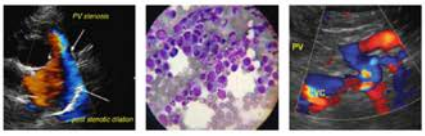

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

Slightly rounded hypoechoic prominent mesenteric lymph nodes are present.

PRIMARY FINDINGS

- **Mild 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.
- **Pancreatic nodular hyperplasia –** Infiltrative neoplasia cannot be ruled out but is considered less likely.
- **Mesenteric lymphadenopathy** – Both reactive lymphadenopathy as well as infiltrative neoplasia are differentials and cannot be differentiated without tissue sampling.
- **Chronic Kidney Disease –** This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.

SECONDARY FINDINGS

- **Gallbladder debris** - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

In addition to a metabolic health screen in the form of a CBC/Chem panel, electrolytes, and urinalysis, a fecal exam, T4 and free T4 are recommended.

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.

A fine needle aspirate of the enlarged mesenteric lymph nodes is recommended if patient's coagulation status is appropriate.

In the meantime, supportive/symptomatic medical management of gastritis is recommended with antiemetics and gastroprotectants, given the reported hematemesis. Empirical deworming with a 5-day course of Panacur and transition to a hydrolyzed protein diet (if tolerated) or a bland, easy to digest diet on a trial and error basis is recommended.

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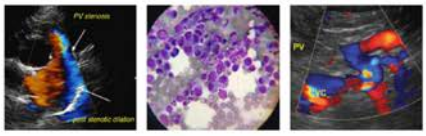

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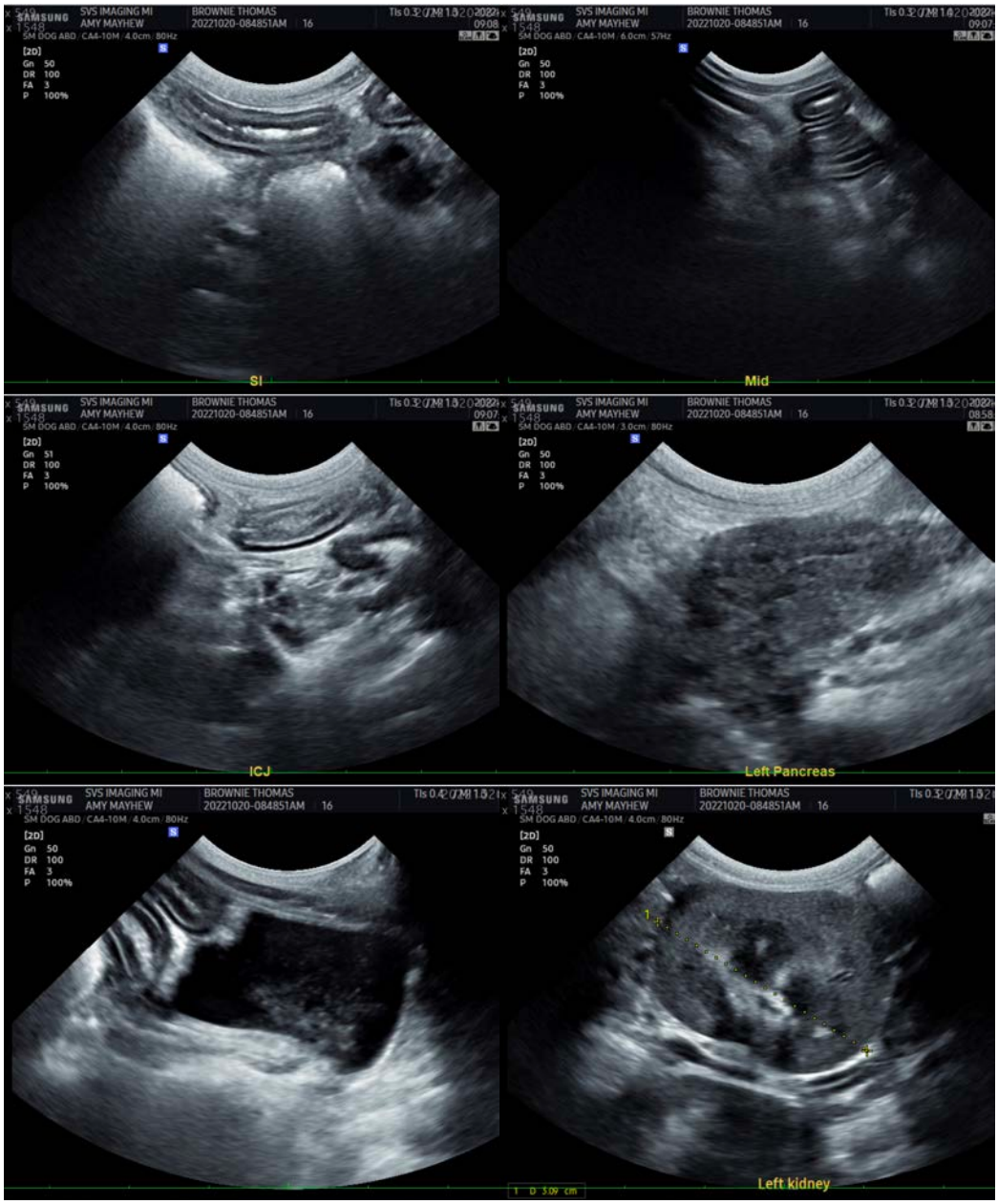
Ultimately, if the vomiting persists, especially hematemesis, upper GI gastroscopy/endoscopy for evaluation and biopsies may be necessary.



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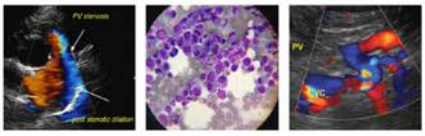

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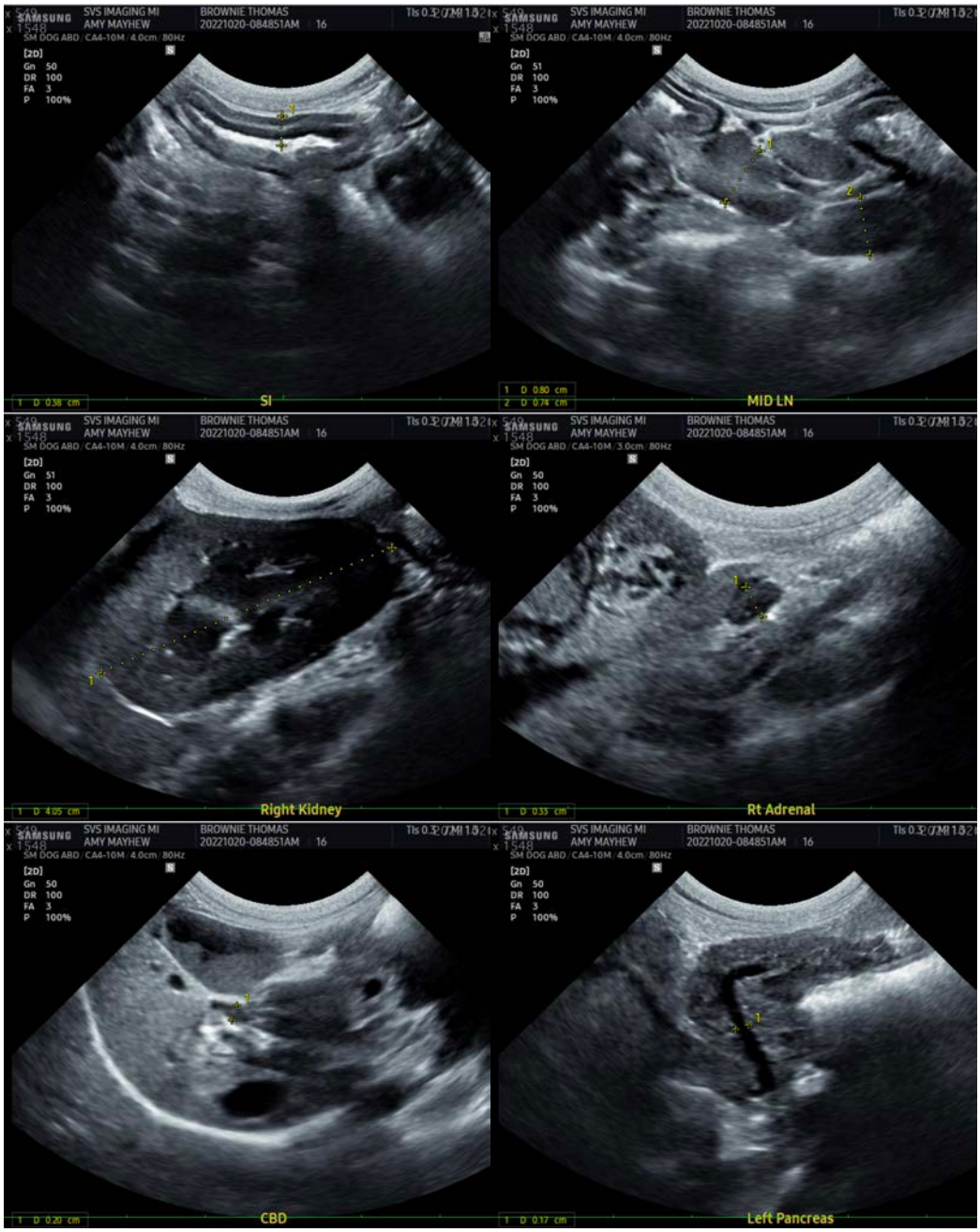

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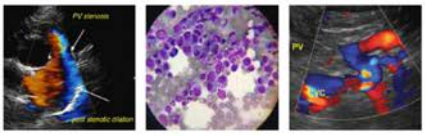

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com