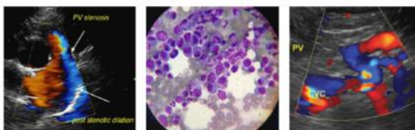
IMAGING PERFORMED BY
SVS Mobile Imaging CT 262 - 366 - 5970
fredgromalak@gmail.com



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

**PATIENT**

Soy Hoppmal 54478A

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Spayed Female

**AGE**

13 Years

**WEIGHT**

6.88 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Tom McNeill

**HOSPITAL NAME**

SVS Imaging CT

**REFERRING VET**

Madison VS- Dr. Daggett

**INVOICE**

17914

**DATE**

11/8/22

## PRESENTING CLINICAL SIGNS

History: Soy presented to the MVS Emergency Service on Nov 08, 2022, at 7:15am, for evaluation of vomiting and inappetence. Soy was seen at MVS on 11/6 for same reason. After bringing Soy home from 11/6 visit owner has seen no improvement. Owner was unable to give the Omeprazole they were sent home with. Soy also has not eaten for the past two days either and vomited 2 times this morning. Owner also mentioned that he has seen footprints in the litterbox but no production.

Abnormal PE/Chem/CBC/UA Results: Bloodwork from 11/6 was within normal limits.

## 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.

Left kidney is normal is size (3.58 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.

Right kidney is normal is size (3.67 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.

### *Adrenal Glands*

Left adrenal gland is normal in size (0.41 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.38 cm), 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.

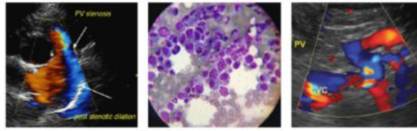
### *Liver*

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. 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.

### *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.



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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 of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

### *Pancreas*

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

### *Free Abdomen*

There is no evidence of peritoneal effusion.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

## ULTRASONOGRAPHIC FINDINGS

- Mild inflammatory bowel disease (IBD) pattern – Mildly 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.

- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely

- Age-related pancreatic remodeling

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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 to a hydrolyzed protein diet, 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.).

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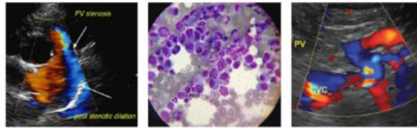

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LEFT KIDNEY SAG
D1 3.58 cm

LEFT ADRENAL GLAND
D1 0.41 cm

RIGHT KIDNEY SAG
D1 3.67 cm

RIGHT ADRENAL GLAND
D1 0.38 cm

DUODENUM
PANCREAS RT
D1 0.70 cm

PANCREAS LT
D1 0.62 cm

MES LN
D1 0.51 cm
D2 3.13 cm
D1/2 16.41 %
Avg(D1,2) 1.82 cm
Avg(All) 1.82 cm

JEJUNUM
D1 0.20 cm

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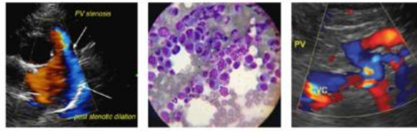

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**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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