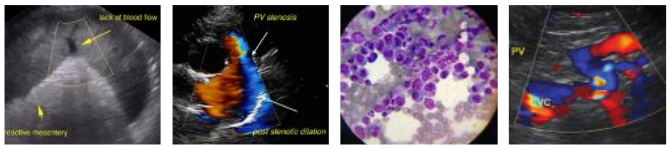
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Alley Rhode

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10 Years

WEIGHT

15.4 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Elaina Petrone

HOSPITAL NAME

Long Branch AH

REFERRING VET

Elaina Petrone

INVOICE

19003

DATE

12/5/22

PRESENTING CLINICAL SIGNS

History: 10yo mn dsh intermittent vomiting, peri renal fluid, renal cysts, and thickened jejunum seen on ultrasound Nov 20th. Peri renal fluid 1.25cm. Patient clinically improving.

Abnormal PE/Chem/CBC/UA Results: Creatinine 1.9 BUN: 47

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.

The left kidney is normal in size with irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney contains multiple cortical cysts, the largest of which measures 1.3 cm in diameter, as well as perinephric fluid encircling the kidney, measuring approximately 2.5 cm deep at the caudal pole. The left kidney measured 4.4 cm.

The right kidney is normal in size with irregular and diffusely echogenic with decreased corticomedullary and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The right kidney measured 4.3 cm. The right kidney contains multiple cortical cysts.

Adrenal Glands

The area of the adrenal glands is examined without evident pathology.

Spleen

Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

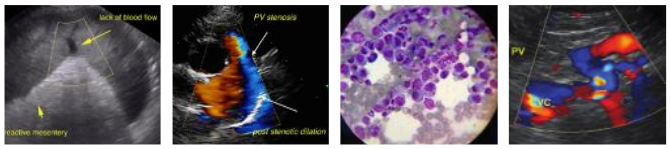
Liver

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 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 or foreign material.

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. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. 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

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.

- Hypersplenism – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis (leave amyloidosis out if canine) as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

- Chronic Kidney Disease – This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc. Multiple cortical cysts are noted bilaterally, as well as perinephric fluid around the left kidney, consistent with a perinephric pseudocyst, however, cystic neoplasia cannot be ruled out.

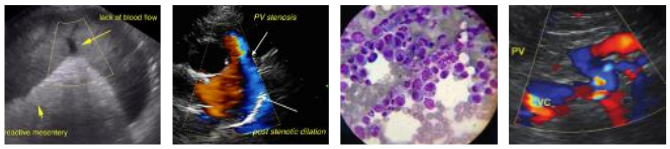
Secondary Findings

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, both urinalysis and fluid analysis with culture and sensitivity of the perinephric fluid are recommended. The chronic kidney disease and perinephric fluid, however, could be incidental findings when it comes to the vomiting, which may be caused by the suspected infiltrative bowel disease. Therefore, additionally, 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.



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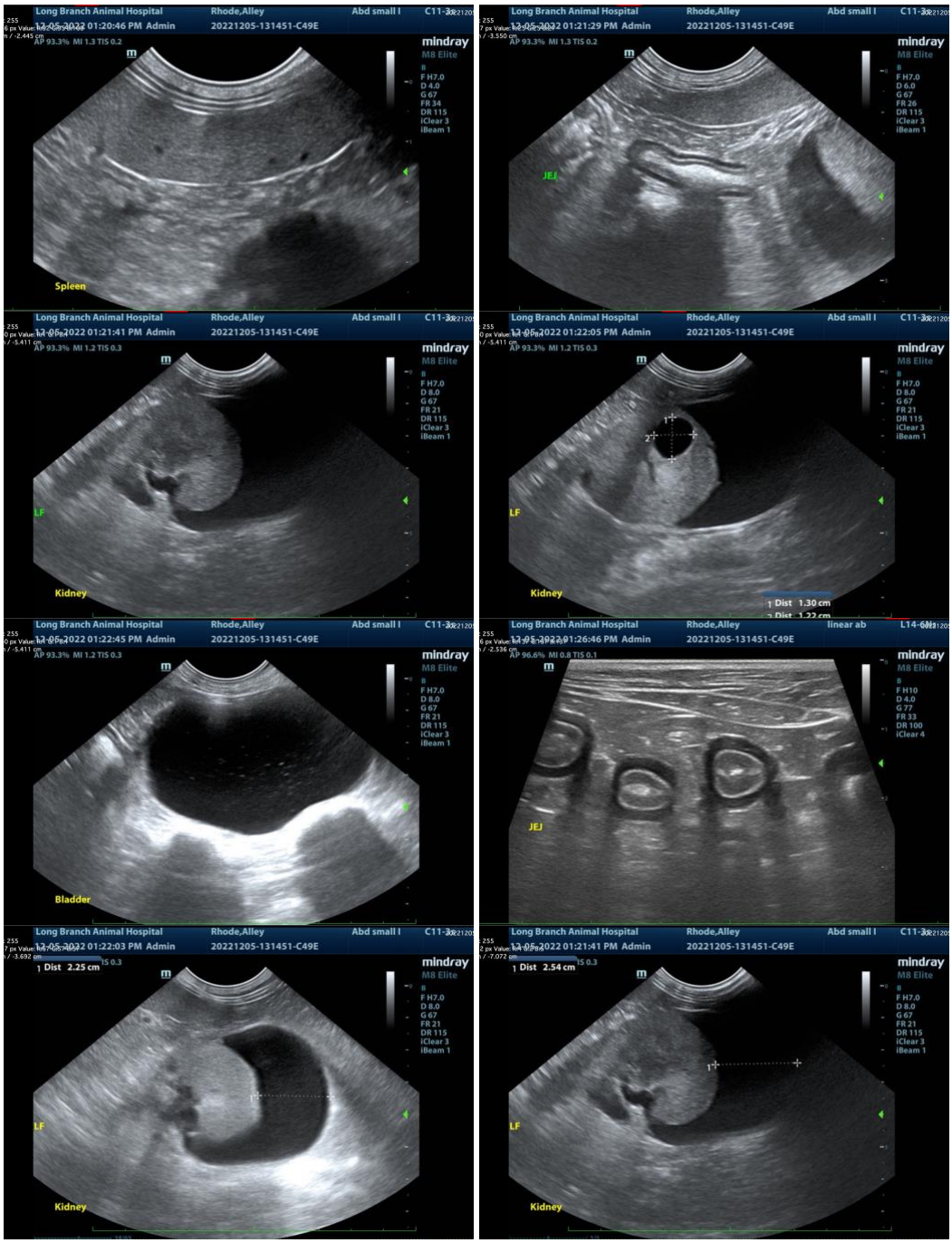
If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



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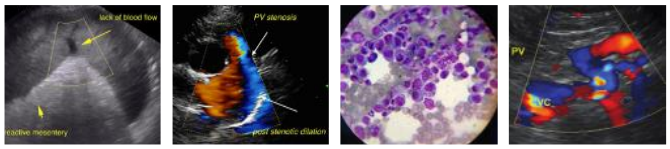

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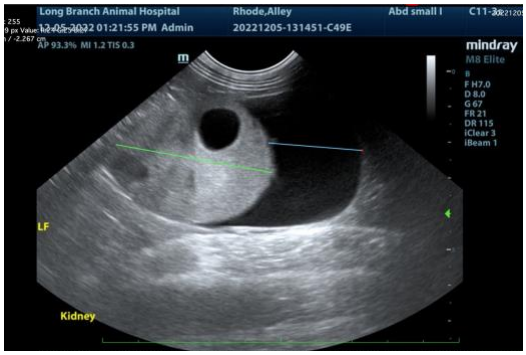

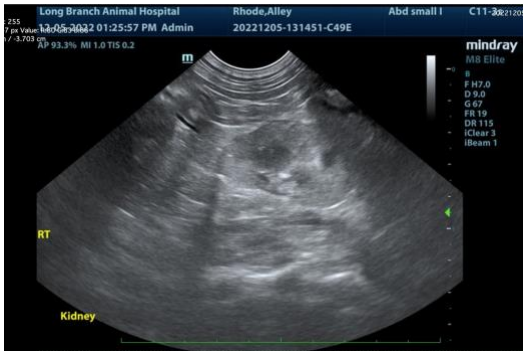

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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