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Clinical Sonography & Telecytology
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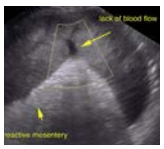
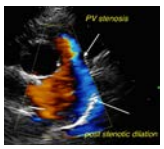
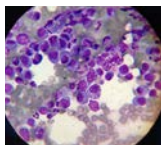
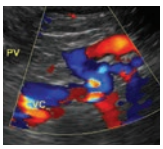





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Pete Twardowski

SPECIES
Feline

BREED
DLH

SEX
Neutered Male

AGE
12 Years

WEIGHT
10.3 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Brian Klug

HOSPITAL NAME
Sondel Family VC

REFERRING VET
Dr. Kara Wallisch

INVOICE
45426

DATE
2/22/23

PRESENTING CLINICAL SIGNS

Eating less, losing weight. Lethargic. No other symptoms.
Abnormal PE/Chem/CBC/UA Results: BW nsf CXR and abd rads nsf

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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.

The right kidney is normal in size (3.7 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.

The left kidney is normal in size (4.1 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

The right adrenal gland is normal in size (0.43 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.43 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

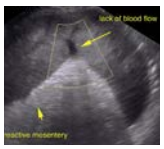
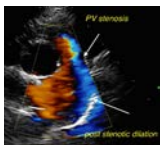
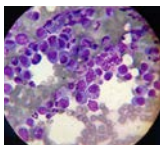
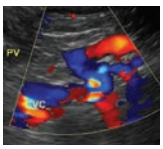
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The 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 stomach is mildly distended and contains an echogenic interface with distal progressively shadowing material consistent with hairball density (or similar fluid absorbing material) noted. **Given the shadowing, full thorough evaluation of the entire gastric wall is limited.

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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The visible colon is normal in wall thickness (< 0.2 cm) and layering. It is subjectively mildly overdistended with subjectively firm stool.

Pancreas

The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

Free Abdomen

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

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC 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.
- **Hyperechoic pancreas –** This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.
- Subjectively firm stool in a mildly overdistended colon
- **Gastric Hairball –** similar density soft foreign material cannot be ruled out. Normal ingesta/gas can't be ruled out, and this finding should be interpreted in combination with clinical signs as well as progression versus resolution with additional fasting.

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.

Additional history regarding this patient's bowel movement is recommended to help identify any possible constipation that could be contributing to decreased appetite. If present, medical management is recommended. However, the appearance of the colon ultrasonographically is very subjective and this very well could be a normal patient variant, so the finding should be interpreted only in combination with whether clinical signs of constipation are present.

Regarding the gastric changes, options include either further evaluation immediately in the form of upper GI gastroscopy/endoscopy, which may not be the best option for removal of a suspected hairball, but could also be used to obtain biopsies of the GI tract, versus an exploratory laparotomy for possible gastric hairball or foreign material removal and full thickness biopsies, or, if a more conservative approach is elected given the lack of vomiting, etc., recheck imaging following additional 12-24 hours of fasting could be considered prior to getting more aggressive.

In the meantime, supportive/symptomatic medical management of potential subclinical nausea, etc. as a cause of the inappetence is recommended with antiemetics, gastroprotectants, empirical deworming with a 5-day course of Panacur, as well as appetite stimulants while trying to obtain a diagnosis.

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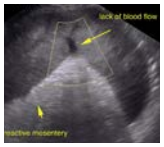
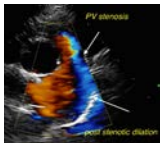
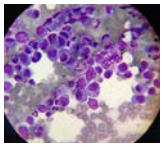
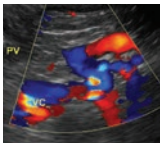

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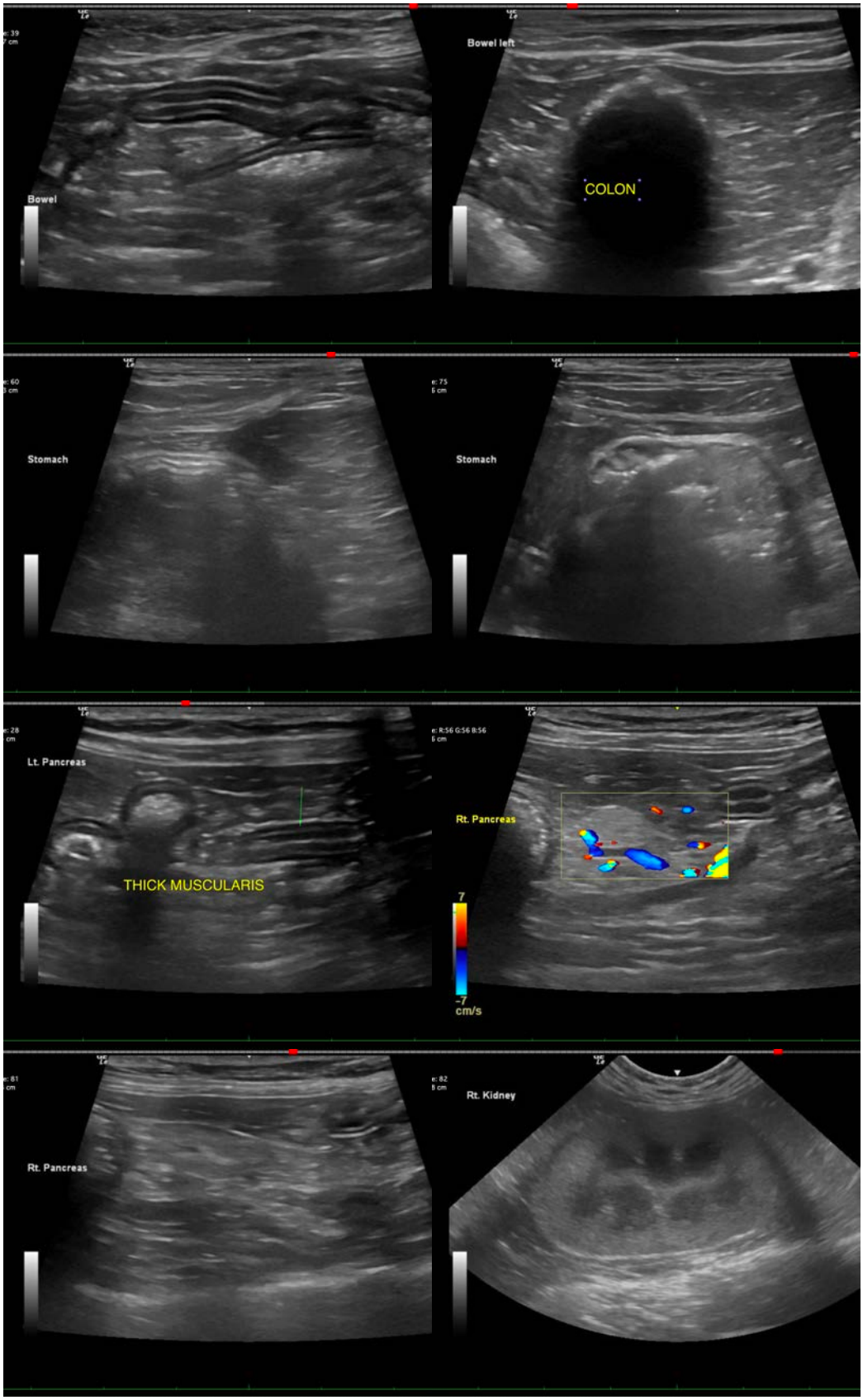

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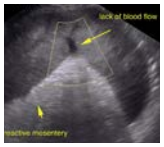
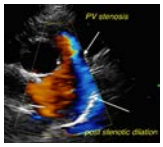
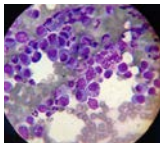
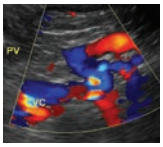

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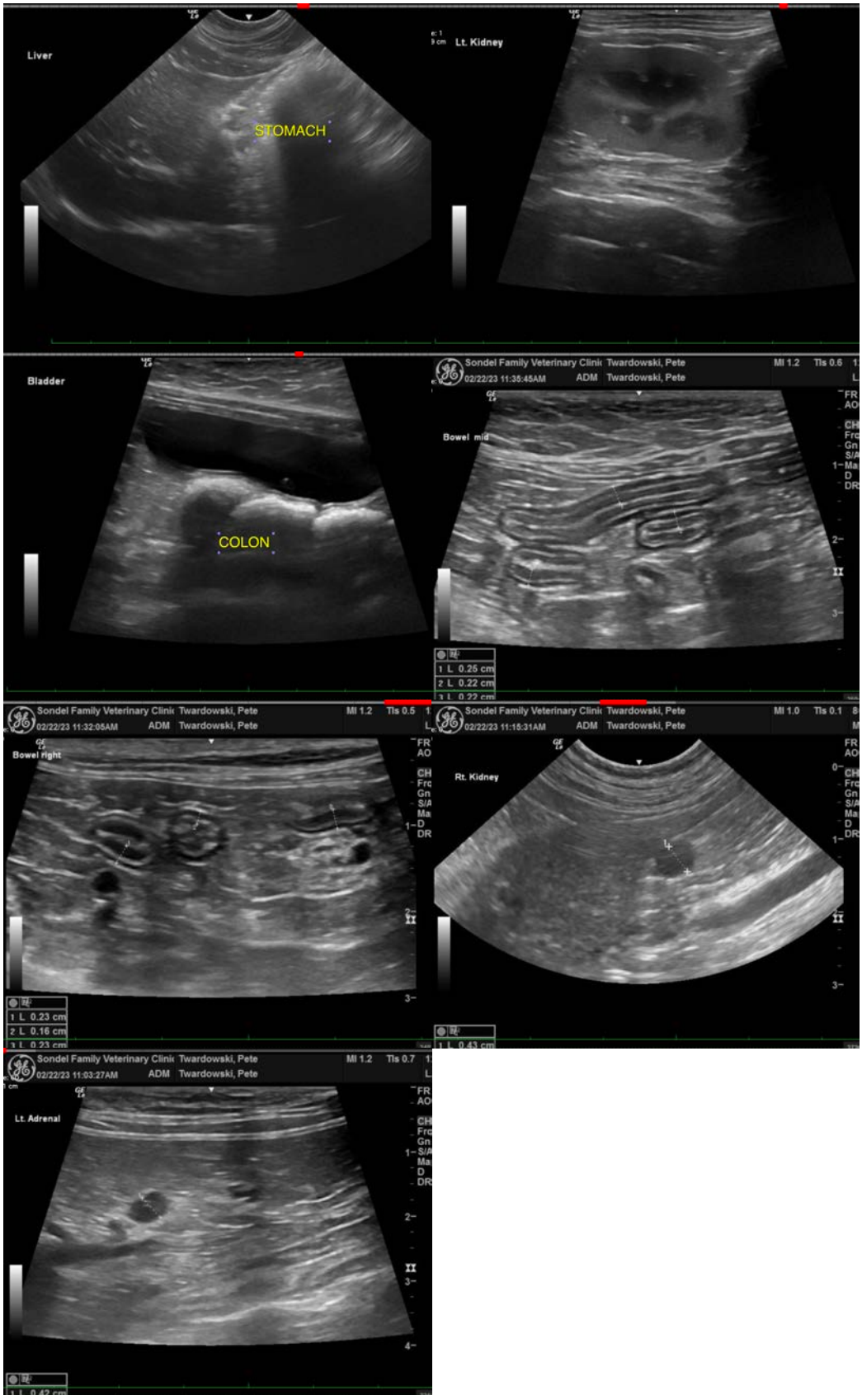

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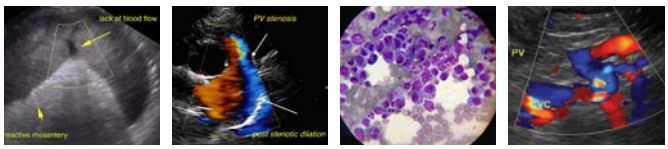

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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