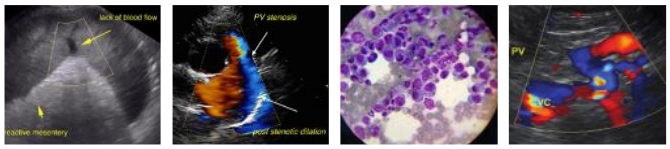
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Buster Winger

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

5.3 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Anna Wepprich

HOSPITAL NAME

Wilvet Salem

REFERRING VET

Dr. Anna Wepprich

INVOICE

21622

DATE

3/14/23

PRESENTING CLINICAL SIGNS

Brief History: Missing for 2 days while owner was out of town (petsitter noted that food and water was disappearing but did not see pet). O found pile of vomit with ribbon in it and feels he may have been chewing on leather On PE temp 105F, vocal, dehydrated, hematochezia diarrhea adhered to rectum

Abnormal PE/Chem/CBC/UA Results: Lab/trends: cbc - Hct 52.2, Neut 13.6k, bands, mono 0.89k, eo 0.01k chem - BG 258, TP 10, Alb 3.8, glob 6.2, ALT 161, ALP <10, Tbili 1.3 EPOC - Na140 K 3, Cl 104, lac 2.7 FAST - hyperechoic mesentery, 2 areas of small intestine have shadowing material that is non-obstructive (tapers on both sides, no dilation), stomach empty, possible inflammation and prominent LNs around pancreas Radiographs - impending diarrhea and colitis, no overt FB UA fPL -high t4-0.8ug/dL Temp still elevated after IVFT all day.

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.

Left kidney is normal in size (4.4 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 in size (4.5 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 (0.47 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The area of the right adrenal gland is examined without evident adrenal gland pathology.

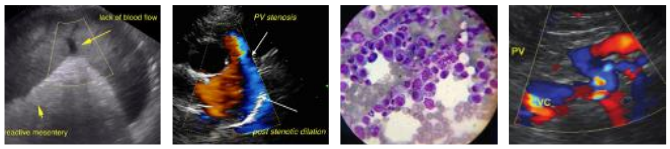
Spleen

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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with fluid, as well as some echogenic nonshadowing luminal contents and gas consistent with normal ingesta/chyme with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are diffusely normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease. Focally, in the cranial abdomen, the duodenum has a thick muscularis layer relative to the mucosa, as well as some echogenic shadowing luminal contents that are most consistent with chyme and gas. There is no plication or dilation to suggest foreign body or an obstruction, however, luminal foreign material cannot be definitively ruled out. Additionally, surrounding that area of bowel, there is enhanced hyperechoic mesenteric fat.

The visible colon is diffusely thick, measuring between 0.3 cm and 0.5 cm thick with intact layering but a subjectively prominent submucosal layer.

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

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

Primary Findings

- The appearance of the bowel in these images is most consistent with an infiltrative disease, infectious, parasitic, inflammatory, or less likely infiltrative neoplasia, however, infiltrative neoplasia cannot be definitively ruled out, affecting primarily the colon, as well as partially the proximal small bowel, i.e., duodenum. Intraluminal foreign material cannot be definitively ruled out, but there is no distinct obstructive pattern, strong acoustic shadowing, plication, etc., to definitively diagnose that. Having said that, there is evidence of cranial abdominal inflammation/focal peritonitis surrounding the abnormal appearing duodenum.

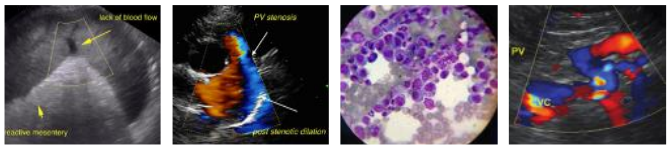
- Reactive mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.

Secondary Findings

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further evaluation for underlying causes of infiltrative diffuse small and large bowel disease is recommended, beginning with a fecal exam (if not recently evaluated), as well as a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, for further



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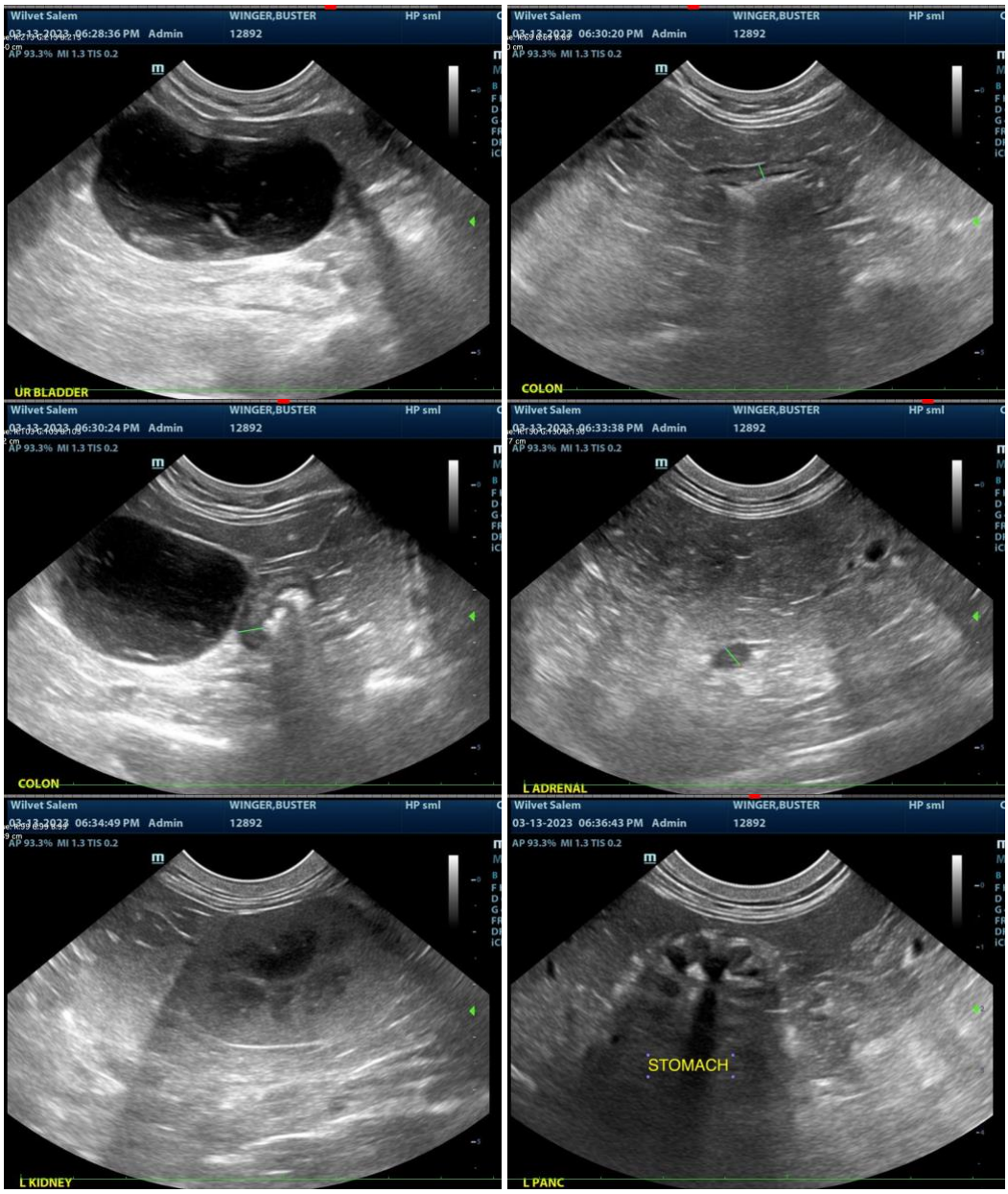
evaluation of GI and pancreatic function, and a fecal enteropathogen PCR panel to Texas A&M GI Laboratory, for further evaluation of possible infectious disease.

In the meantime, supportive/symptomatic medical management of gastroenteritis/hemorrhagic gastroenteritis is recommended in the form of broad spectrum antibiotics, antiemetics, gastroprotectants, including Sucralfate, a probiotic, such as Visbiome or Proviable, empirical deworming with a 5-day course of Panacur, and if tolerated, a short-term transition to a bland or easy-to-digest, or possible fiber responsive diet and fluid therapy.

If clinical signs persist, recheck imaging is recommended for further evaluation of the intraluminal possible foreign material (unable to be ruled out). Ultimately, however, if clinical signs persist, and exploratory laparotomy for full thickness GI biopsies with colonoscopy for colonic biopsies at the same time, may be necessary for a definitive diagnosis, and therefore management.



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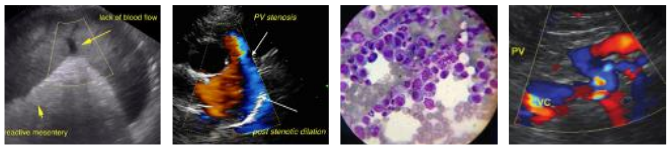

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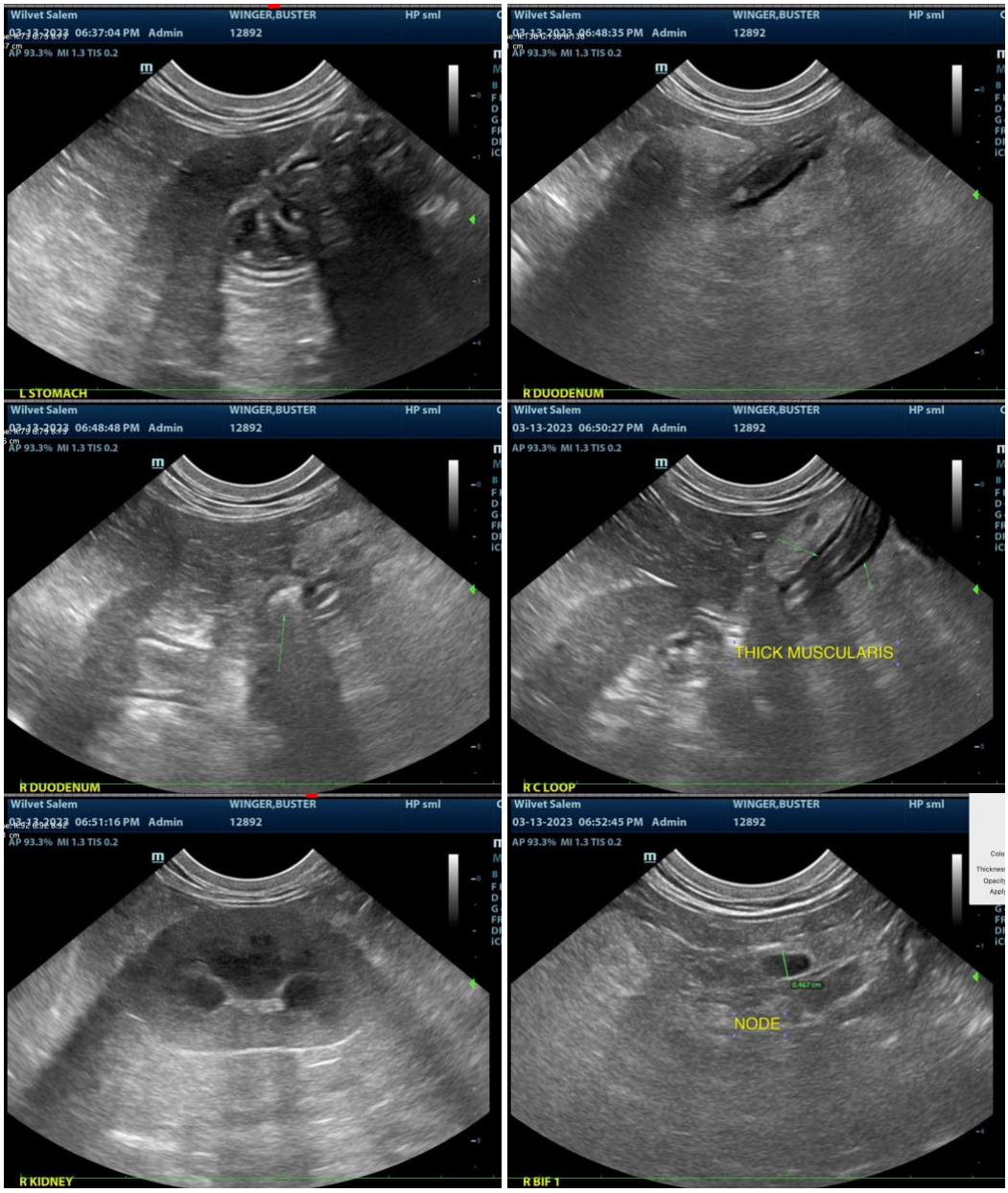

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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