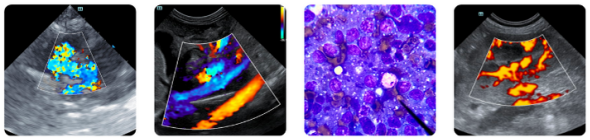

PATIENT

Sam Everett

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

13 years

WEIGHT

8.5 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Vincent Tavella

HOSPITAL NAME

Williamsburg Veterinary Clinic

REFERRING VET

Dr. Vincent Tavella

INVOICE

11564

DATE

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PRESENTING CLINICAL SIGNS

- History of heart murmur - not on any meds.
- History of asthma (on Prednisolone 2.5 mg EOD and Famotidine 5 mg q 12 hrs) for last 2 and 1/2 years.
- Has had some off and vomiting and more vocal and needy than normal for last several weeks. Took to day vet on 3/16.
- Ate yesterday morning but not all and would not last ight. Vomiting started at 1-2 pm yesterday and has continued (usually will stop in past). Has vomited about 30 times since. No diarrhea noted.
- Presented to ER and had labwork and treatment with Cerenia, marbofloxacin, famotidine, and an enema.
- Patient is vomiting on Cerenia.

Abnormal PE/Chem/CBC/UA Results: PE: Depressed/Dehydrated Chem: Glucose 172 (71 - 159 mg/dL), Creatinine 2.5 (0.8 - 2.4 mg/dL), BUN 43 1(6 - 36 mg/dL), Calcium 11.4 (7.8 - 11.3 mg/dL) CBC: Neutrophils 17.15 (2.30 - 10.29 K/µL), Reticulocytes 69.0 (3.0 - 50.0 K/µL) UA: Specific Gravity 1.020, White Blood 11 /HPF Cells, Red Blood >50 /HPF Cells Radiographs: No evidence of foreign body or constipation. (Images submitted with consult.)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended. Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

Kidneys are bilaterally small/normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no mineral observed. Left kidney measures 3.3 cm and contains trace pyelectasia. The right kidney measures3.3 cm.

Adrenal Glands

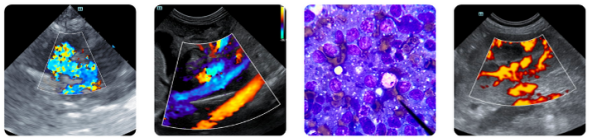
The areas of the adrenal glands are examined without evident adrenal gland pathology.

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

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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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 lumen is moderately over distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. 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 of the small intestine is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme.

The visible colon is normal in wall thickness (< 0.2 cm) and layering but the lumen is diffusely mildly fluid distended.

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 visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

Throughout the abdomen, especially adjacent to the ileocecal colic junction is enhanced, ill-defined, hyperechoic mesenteric fat and omentum.

ULTRASONOGRAPHIC FINDINGS

- Mild/emerging 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 loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- The appearance of the entire gastrointestinal tract is consistent with possible mild ileus secondary to underlying gastrointestinal disease with no definitively visible evidence of an obstructive pattern or shadowing associated with foreign material, plication, etc.
- The diffusely subtly enhanced mesenteric fat and omentum is suggestive of possible inflammation, especially at the ileocecal colic junction which can be seen with infiltrative or inflammatory bowel disease.
- Mild to moderate bilateral chronic kidney disease changes with trace pyelectasia in the left kidney.

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- The liver changes are non-specific but could represent a microscopic hepatopathy including benign hepatopathies such as bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, potentially other benign infectious or inflammatory reactive hepatopathies. Although, infiltrative neoplasia such as round cell neoplasia i.e. lymphoma can't be ruled out without tissue sampling.
- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A routine fecal/giardia exam is recommended if not recently evaluated.

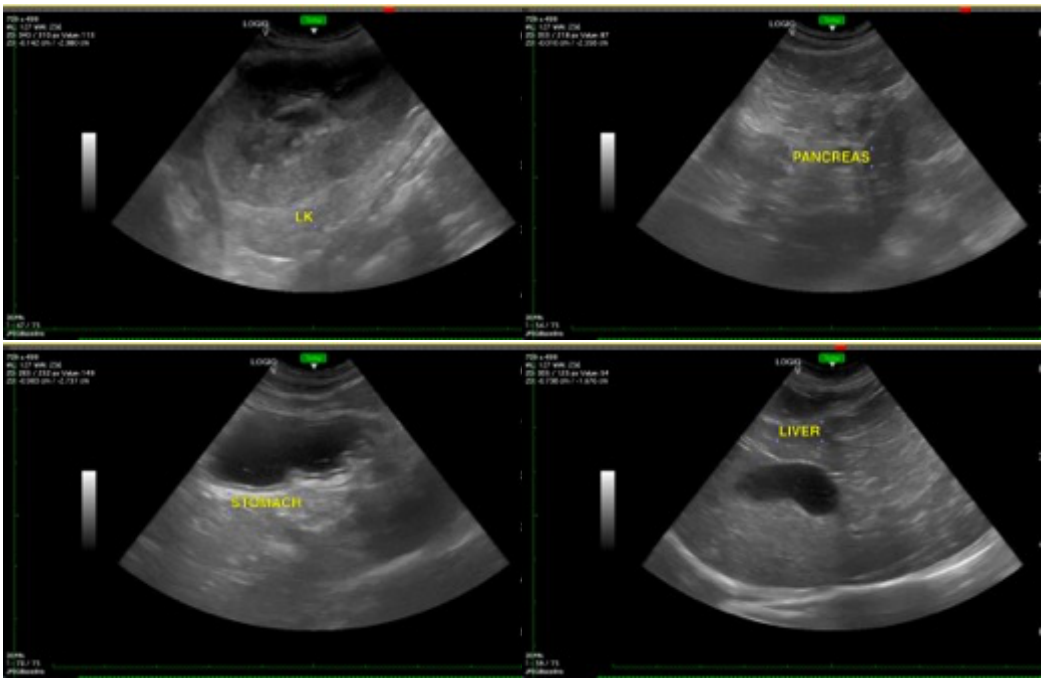
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Pending results of above, fine needle aspirates of the liver could be considered if patient's coagulation status is appropriate.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.

In some areas the bowel is difficult to interpret due to very small images of bowel wall in the very near field. Increasing depth and/or using a linear probe to increase detail of bowel wall layering is recommended if clinical signs persist and a diagnosis is not obtained.



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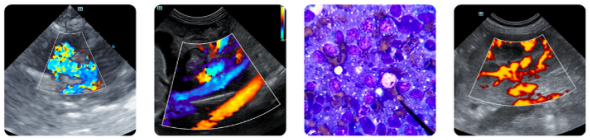

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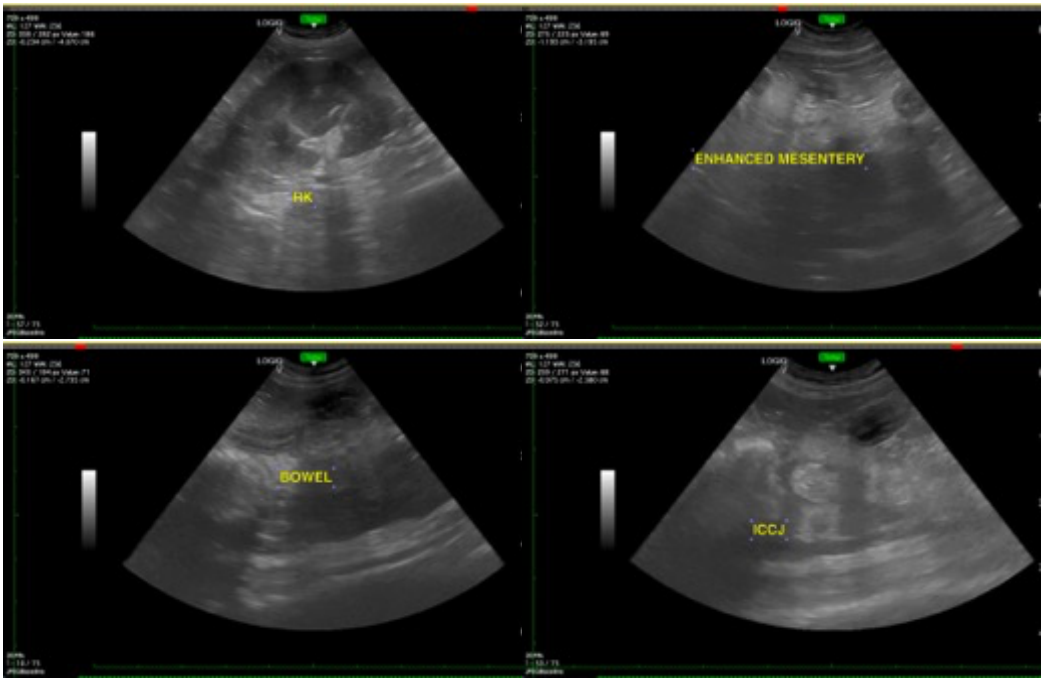

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com