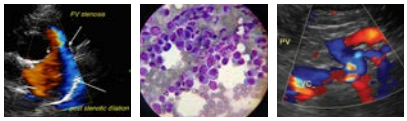
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

3/30/23

PATIENT

Jambi Fecko

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

4/10/18

WEIGHT

9.35 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Bay Country VH

REFERRING VET

Dr. McLean

INVOICE

46314

PRESENTING CLINICAL SIGNS

Intermittent bloody vomiting. Occurs approx. every 2-4 months, vomits very bright bloody mucusy vomit 2-3 times, then resolves spontaneously. Treated with Flovent inhaler for asthma (well controlled).

Current Medications: Flovent inhaler 44mcg/actuation BID.
Lab Results: CBC/Chem and pro BNP WNL in October 2022.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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 (3.65 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 (3.53 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 (0.34 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The area of the left adrenal gland is 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). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses 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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

Some of the bowel loops, primarily appreciated in the ileum, exhibit a 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.

The visible colon is normal in wall thickness (< 0.2 cm) 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 free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- **Mild inflammatory bowel disease (IBD) pattern (primarily affecting the ileum) –** 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.

- **Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

- **Pancreatic age-related remodeling –** 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

Recommendations include a recheck overall general metabolic evaluation (CBC, chemistry panel with electrolytes, coagulation panel, urinalysis and fecal exam.

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.

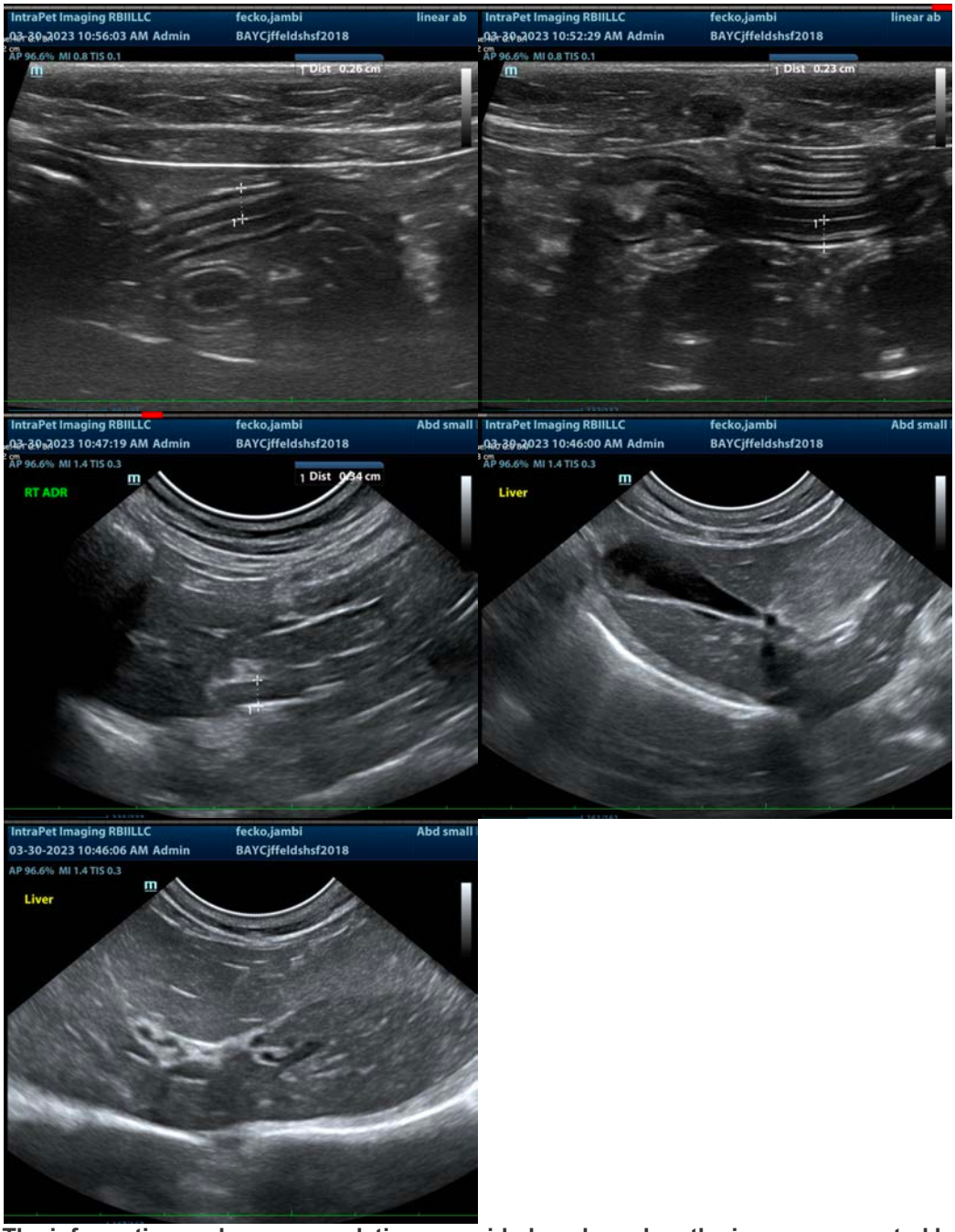
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

If geographically appropriate, testing for Histoplasma via urine Ag to MiraVista, is also recommended.

In the meantime, supportive/symptomatic medical management of clinical signs including anti-emetics, gastroprotectants (including sucralfate), a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur, +/- metronidazole or tylosin and if tolerated a short term course of a bland, easy to digest or possibly fiber responsive diet.

Ultimately, if clinical signs persist, and a diagnosis is not reached, further evaluation of the GI tract via upper and lower endoscopy for visualization and biopsies may be warranted.

The liver changes described above may be normal patient variant or resolved cholangiohepatitis, etc., and should be interpreted in combination with chemistry panel results. If indicated, further evaluation is recommended in the form of a fine needle aspirate of the liver if patient's coagulation status is appropriate.



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