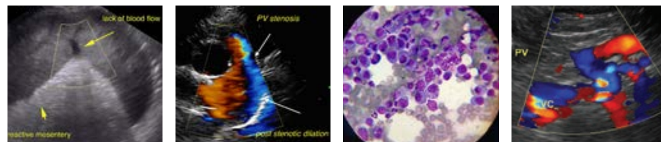
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Mack Daddy Smith

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

10.6 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Harold Mike Beard

HOSPITAL NAME

Animal Care VC

REFERRING VET

Dr. Hartman

INVOICE

43121

DATE

6/14/23

PRESENTING CLINICAL SIGNS

Constipation and weight loss. RDVM did enema under sedation, no polyp or mass palpated in colon yesterday.

Abnormal PE/Chem/CBC/UA Results: We are unkempt. Palpably enlarged colon. Plain view xrays reveal feces still in colon in spite of enema yesterday by RDVM. Chemistry WNL, CBC WNL, T4 okay.

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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measures 3.5 cm. The right kidney measures 4.02 cm.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

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.

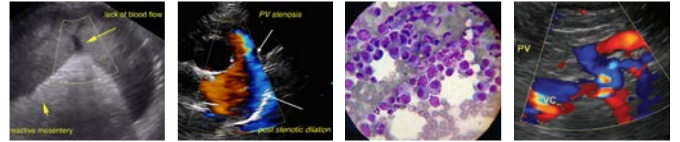
The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The 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.

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 visible colon is normal in wall thickness (< 0.2 cm) and layering. It is diffusely distended with subjectively firm dry stool, consistent with this patient's reported history of constipation to the level just dorsal to the proximal urethra, where a subtle possible stricture could be present, beyond which the colon is empty. This appearance however could be artifact related to the recent enema and recent emptying of just the distal colon.



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Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. 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

- Constipation with a possible subtle stricture in the distal colon unable to be definitively diagnosed or ruled out.
- Subtle/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.
- Age related kidney changes

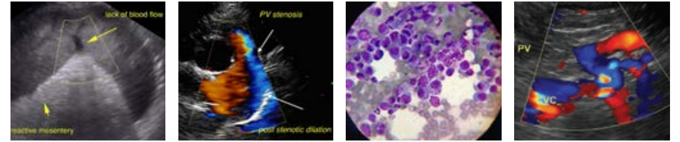
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further evaluation of this patient's renal status, hydration, etc. is recommended if not recently evaluated. Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

Given the subtle small bowel changes and weight loss, additional evaluation of digestion and absorption is also recommended beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function. This evaluation is even more important if the patient's weight loss cannot be attributed to the decreased appetite.

If, however, the patient's appetite is decreased and weight loss can be attributed to that, then the primary reason is most likely the constipation, regardless of possible mild concurrent infiltrative small bowel disease. Regardless, further treatment of the constipation is recommended in the form of fluid therapy to ensure adequate hydration, potentially even a sedated or anesthetized deobstipation procedure, at which time potentially a deeper rectal exam could evaluate whether or not there is an emerging distal colonic stricture, followed by stool softeners, potentially a higher fiber or colitis diet, etc.

Ultimately, pending results of the above, response to more aggressive therapy, etc., a colonoscopy may be warranted for further evaluation of the distal colon, and, if elected, upper GI endoscopy should be considered at the same time for further evaluation and biopsies of the stomach and small bowel.



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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