SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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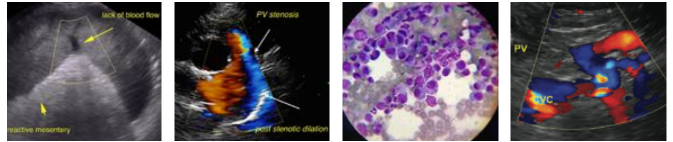


PATIENT

Magic Hurley

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

3y

WEIGHT

5kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Caitlin Goeres

HOSPITAL NAME

Kelowna VH

REFERRING VET

Dr. Chalifour

INVOICE

10261

DATE

6/15/2023

PRESENTING CLINICAL SIGNS

Acute onset of vomiting, hematemesis, anorexia on June 9th. Initially responded to supportive therapy (cerenia and mirtazapine). Vomiting and diarrhea since June 10th, minimal response to supportive therapy, transitioned to hypoallergenic diet, poor appetite. Hematochezia noted last night, profuse diarrhea (clostridial overgrowth noted today). Anorexic since June 12 AM, ate small amount of hypoallergenic diet. Gagging, lethargic, vocalizing when having bowel movement. Hx of asthma 62.5mg Metronidazole PO q12h 1.88mg Mirtazapine PO q24h PRN (last dose June 14 PM) 1mg/kg Cerenia IV (last dose June 14 PM 5pm) Inhaler q12-24h PRN (orange puffer?)"

Abnormal PE/Chem/CBC/UA Results: very nauseated, nothing under tongue. gagging and licking on cranial abdominal palpation and during ultrasound despite sedation and cerenia BW attached – unremarkable.

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 (3.76 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 (3.67 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 area of the right adrenal gland is examined without evident adrenal gland pathology.

The left adrenal gland is normal in size (0.27 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

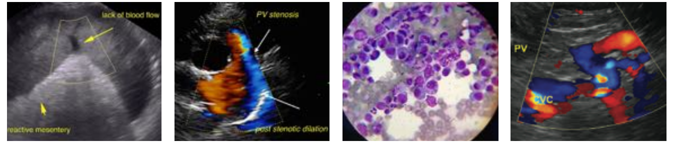
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

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



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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 or foreign material. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of 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 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 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.

Diffuse lymphadenopathy from the cranial abdomen "gastric nodes" throughout the mesenteric nodes to colonic nodes are noted.

ULTRASONOGRAPHIC FINDINGS

- **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.

- Diffuse lymphadenopathy involving gastric mesenteric and colonic nodes. Both reactive lymphadenopathy as well as infiltrative neoplasia i.e., lymphoma are differentials and cannot be differentiated without tissue sampling.

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. A fecal exam is recommended if not recently evaluated as is 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 prior to obtaining stool for submission for the PCR panel. Ideally, biopsies of the GI tract, being sure to include the small bowel, ileum, and colon if possible are recommended to definitively diagnose.

If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5-day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted), and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Other supportive therapeutic considerations could include fiber supplementation, especially with large bowel diarrhea, and/or a probiotic.

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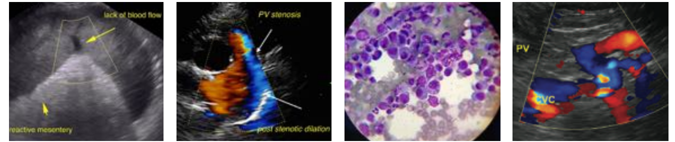

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THICK MUSCULARIS
JEJUNUM

NODE
DUODENUM

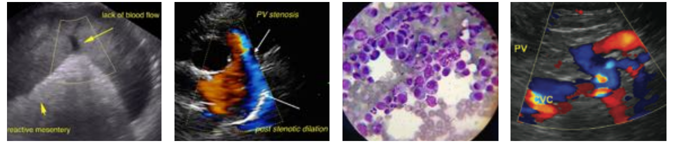
ADR
LT KIDNEY

JEJUNUM

JEJUNUM

RT KIDNEY

LT KIDNEY



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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