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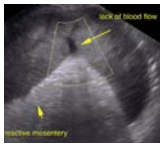
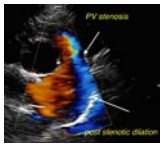
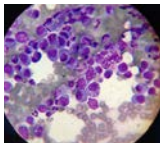
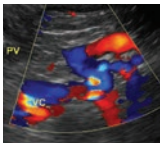

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1-800-838-4268 info@sonopath.com

PATIENT
Lola Bechtel

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
10 Years 10 Months

WEIGHT
9.5

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Jessica Green

HOSPITAL NAME
Stanglein Vet Clinic

REFERRING VET
Dr. Laura Green

INVOICE
43307

DATE
6/20/23

PRESENTING CLINICAL SIGNS

Presented 5/12/23 for difficulty eating. Prev full mouth extraction- mouth looked fine and rest of PE was good except had lost 0.7lbs. Bloodwork wnl. P put on gabapentin and given cerenia and SQF. P seen again on 6/7/23 for same issue. sits at bowl and cries but will not eat. Lost another 1.0lbs, Rads performed at that time wnl. Sent with appetites stimulant and nutrical. Came in today (6/20/23) for Lyme's test (o request since patient indoor/outdoor cat)- negative. P has lost another 0.5lb. P is lethargic and still has decreased appetite and occasional vomiting.

Abnormal PE/Chem/CBC/UA Results: wnl

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.

The right 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.

The left kidney is normal in size (3.32 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 (0.32 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.37 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

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. 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.

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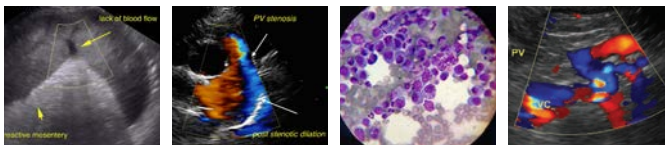

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Gastrointestinal

The gastric wall in some views appears more normal in thickness and layering, but in occasional views the antrum approaching the pylorus appears mildly thick, measuring 0.64 cm with some possible emerging loss of layering. The stomach is non-distended and primarily empty except for a focal curvilinear gas pattern near the pylorus. A non-obstructive foreign body isn't consider probable but can't be definitively ruled out.

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 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

A trace amount of free fluid is present.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Mild gastric wall thickening is suspected in some images, and given the gas pattern described above, a non-obstructive gastric foreign matter isn't consider probable but can't be definitively ruled out.
- 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.
- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- Trace amount of free fluid
- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient's presenting complaint of wanting to eat and appearing hungry, approaching the bowl, etc. but then crying and not eating is an atypical presentation for primary gastrointestinal disease, and more consistent with pain and/or other mechanical problem eating. Therefore, in addition to the dental evaluation that has already been done, further evaluation for possible jaw pain, cervical pain, etc. that may be contributing is recommended.

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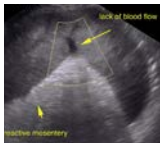
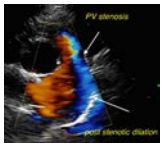
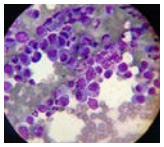
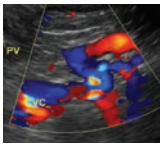

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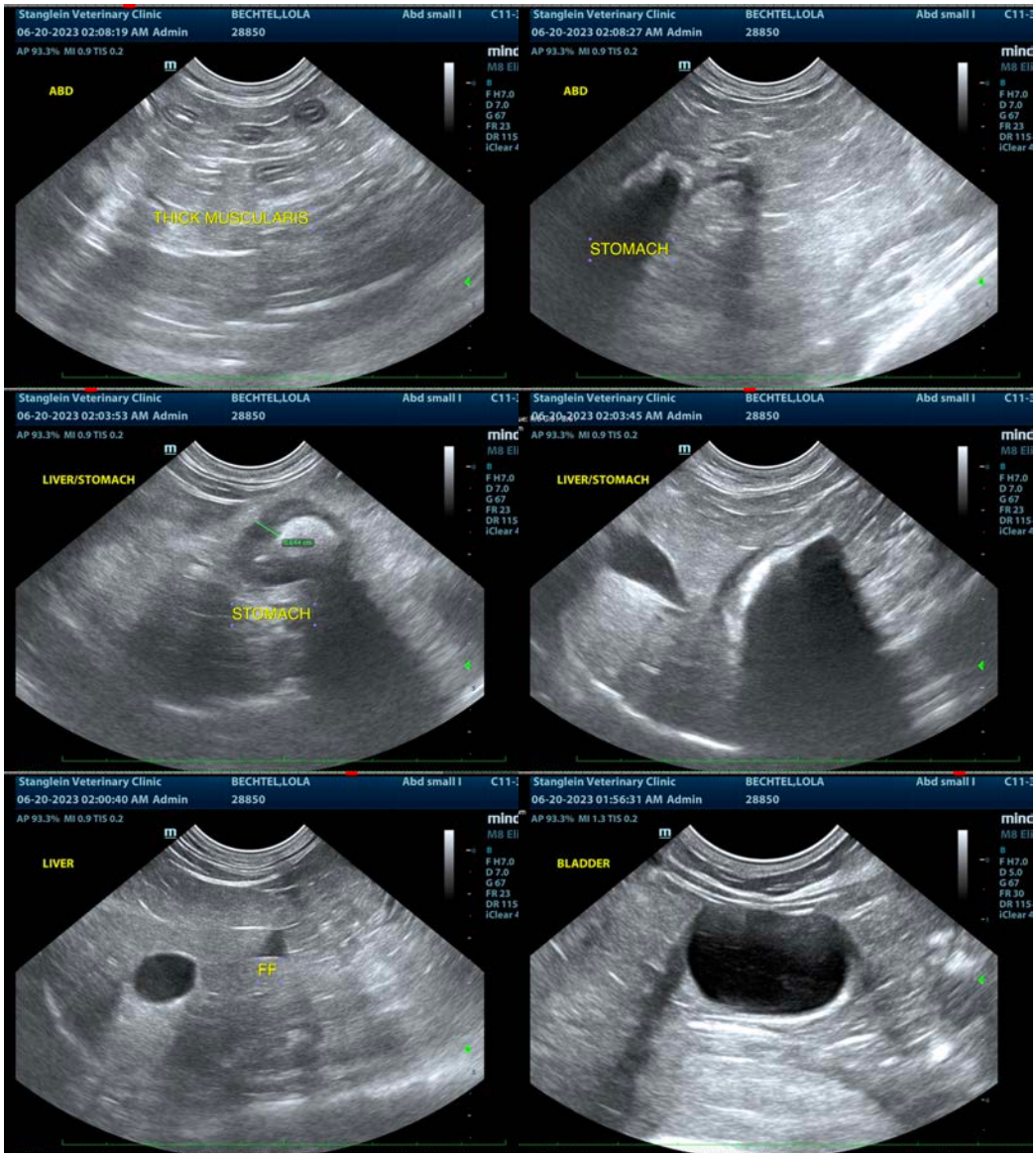
In the meantime, given the liver changes and reported weight loss from anorexia, hepatic lipidosis is likely emerging, and therefore addressing nutrition via a feeding tube while diagnosing the underlying cause of the inappetence may be necessary. Having said that, and given the subtle bowel changes, additional evaluation of gastrointestinal health is recommended, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory and potentially proceeding to upper GI endoscopy for further evaluation of the gastric lumen as well as biopsies of the stomach and small bowel.



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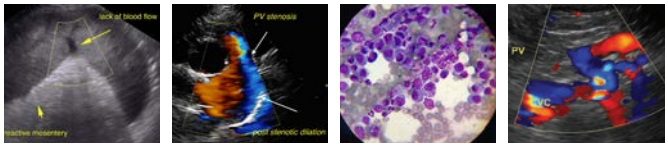

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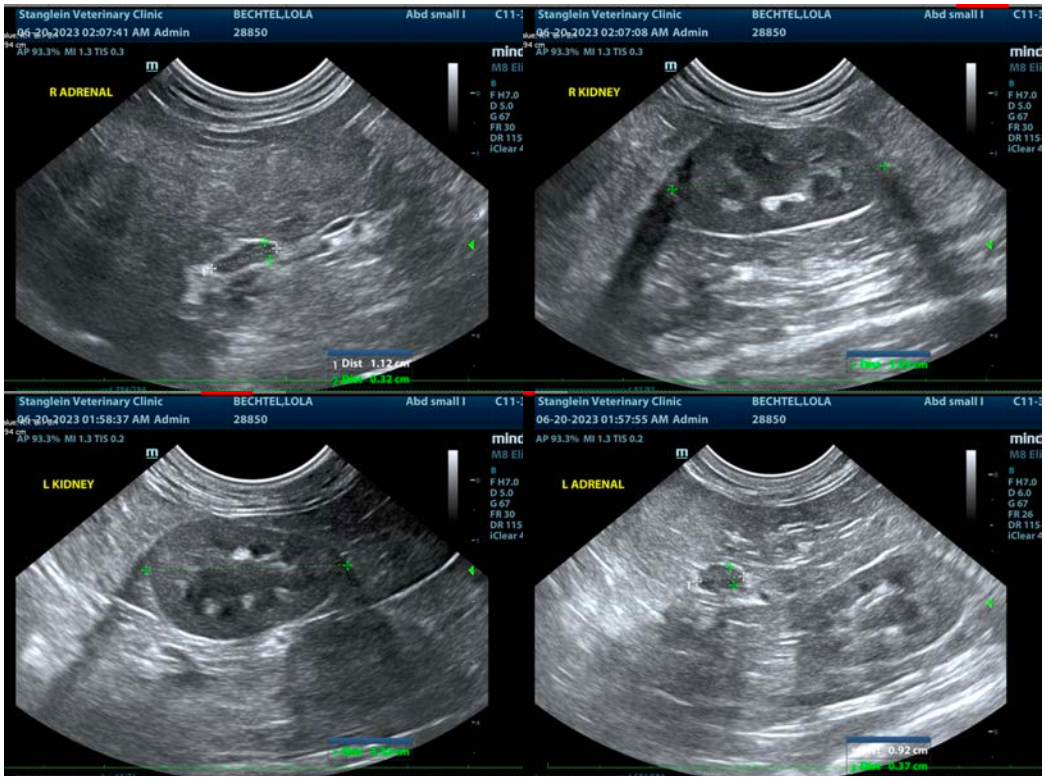

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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