

**DATE PRESENTING CLINICAL SIGNS**

6/20/23 Chronic soft stools with intermittent hematochezia since Dec 2022. Also on radiographs noted small right kidney and hypertrophies left kidney that also has a urolith.

PATIENT

Sano Davis
Current Medications: None. Started hydrolyzed diet this week
Lab Results: mild non-regenerative microcytic anemia, mild increase of BUN.
Radiographs: See attached radiology report.

SPECIES

Feline
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Dexdomitor/Torbugesic.
Stat Report: Not requested.
Imaging Performed By: Stephanie Warga RDCS, RVT.

BREED

DSH

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.

SEX

Neutered Male

AGE

8/6/11

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The right kidney is small measuring 2.22 cm. The left kidney is large (compensatory) measuring 4.78 cm.

WEIGHT

15.5 Pounds

Adrenal Glands

The right adrenal gland is normal in size (0.28 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

INTERPRETED BY

Beth Johnson, DVM
DACVIM

The left adrenal gland is normal in size (0.39 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.3 cm thick) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

HOSPITAL NAME

Perry Hall AH

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.

REFERRING VET

Dr. Hatzigiannakis

INVOICE

43318

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 intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min).

The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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

- **Chronic Kidney Disease** – This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.
- **Hypersplenism** – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should 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

Given this patient's gastrointestinal signs, further evaluation of the GI tract is recommended despite the relatively unremarkable appearance of it ultrasonographically. Recommendations include:

A fecal exam if not recently evaluated.

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

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.

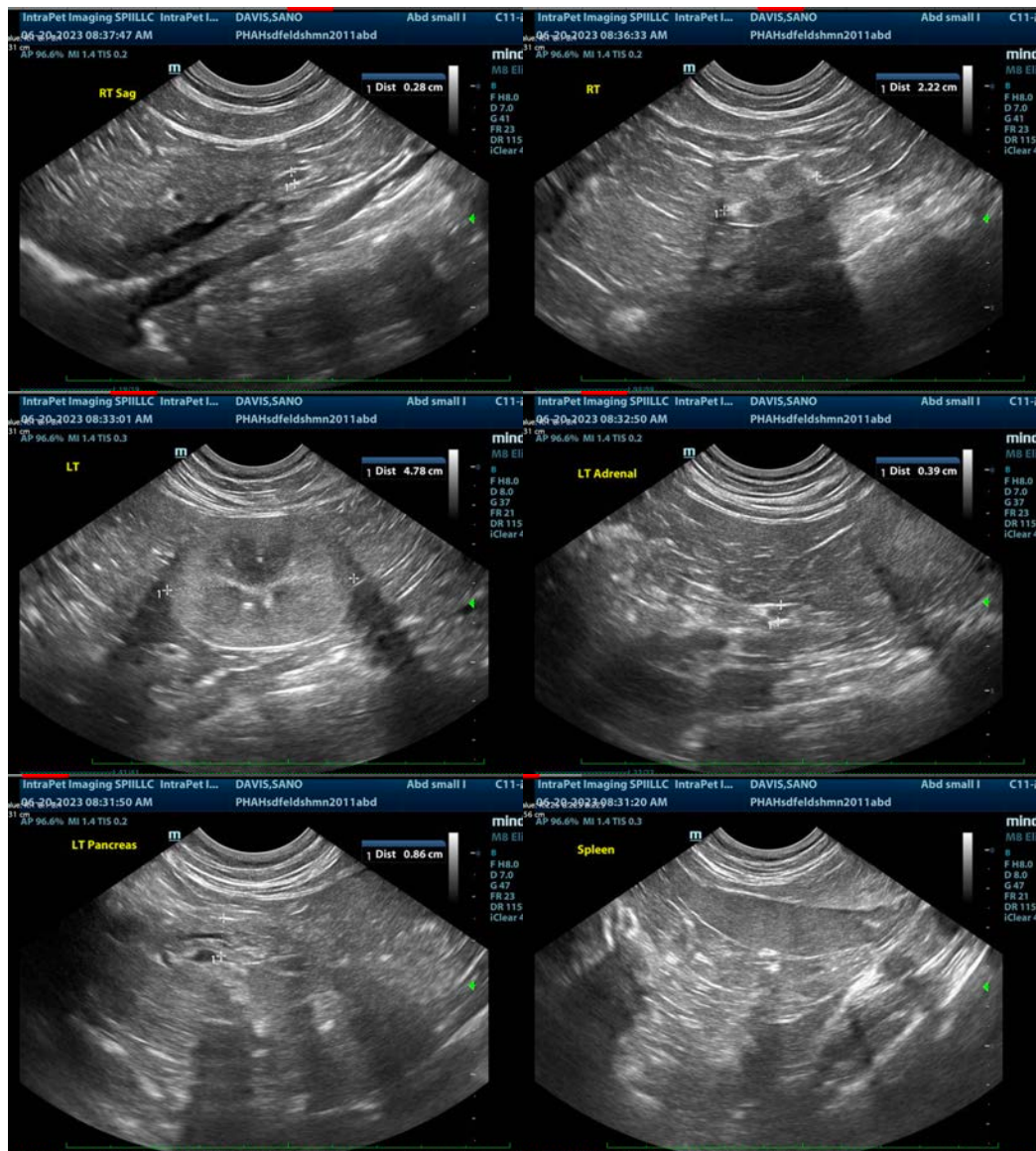
Additionally, a fine needle aspirate of the spleen could be considered if patient's coagulation status is appropriate.

Given this patient's kidney changes and if not recently evaluated, a 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 ration is recommended.

A blood pressure is also recommended.

In the meantime, supportive/symptomatic medical management of clinical signs including a probiotic such as Visbiome or Provable, empirical deworming with a 5-day course of Panacur, and if tolerated, as is reportedly already in place, transition in diet, beginning with a hydrolyzed protein diet, are all recommended.

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



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