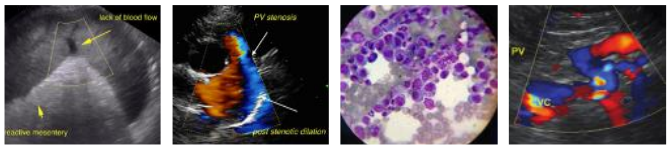
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™




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

**PATIENT**

Spencer Letchford

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

3 Years

**WEIGHT**

7 Pounds

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Dr. Carlos Abdul-Chani

**HOSPITAL NAME**

Byram AH

**REFERRING VET**

Dr. Carlos Abdul-Chani

**INVOICE**

16619

**DATE**

7/15/22

## PRESENTING CLINICAL SIGNS

History: Wt. loss with thick ropey intestines, no vomiting or diarrhea reported. Dewormed multiple times. no current meds.

Abnormal PE/Chem/CBC/UA Results: FeLv/ FIV/ Corona. Toxo- negative. chem- Normal CBC: WBC: 30.3 Neuthrophil: 18,483 Eosin: 3030 Fecal; negative

## 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.

Left kidneys are normal in size (4.26 cm) with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. Infiltrative disease (infectious, neoplastic, etc.) or nephritis cannot be ruled out but is considered less likely.

Right kidneys are normal in size (4.04 cm) with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. Infiltrative disease (infectious, neoplastic, etc.) or nephritis cannot be ruled out but is considered less likely.

### *Adrenal Glands*

Left adrenal gland is normal in size (0.39 cm at cranial pole and 0.42 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.34 cm thick), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *Spleen*

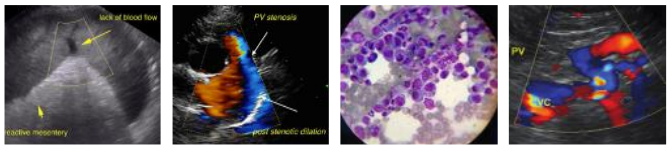
The spleen (if the structure believed to be the spleen is the spleen) appears without evident pathology.

### *Liver*

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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

### *Gastrointestinal*

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The visible stomach wall is normal in thickness 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 severely 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 and layering. Contents are consistent with normal formed feces and gas.

### *Pancreas*

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

### *Free Abdomen*

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail. No appreciable free fluid is noted in these images.

## ULTRASONOGRAPHIC FINDINGS

### Primary 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.

- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely

### Secondary Findings

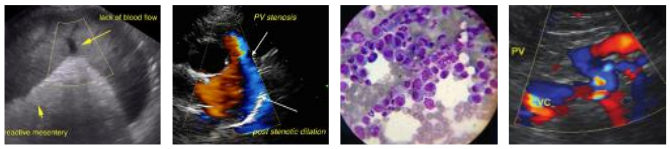
- Urinary bladder debris

- Gallbladder debris (feline) – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

## 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.

- Given this patients young age and eosinophilia, a fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.



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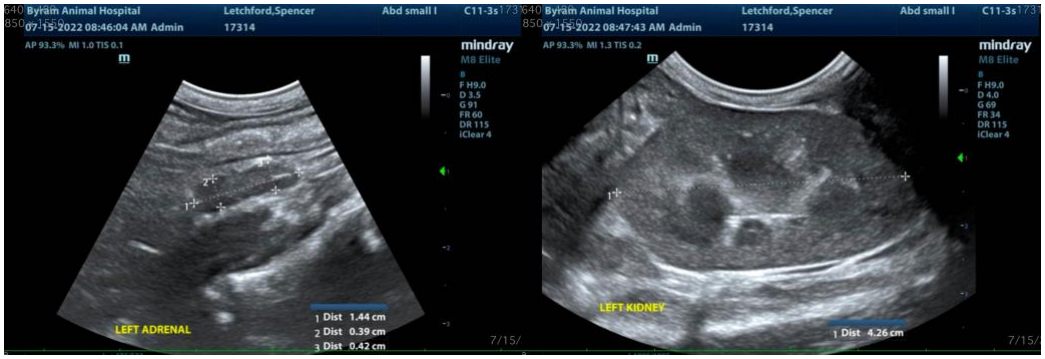
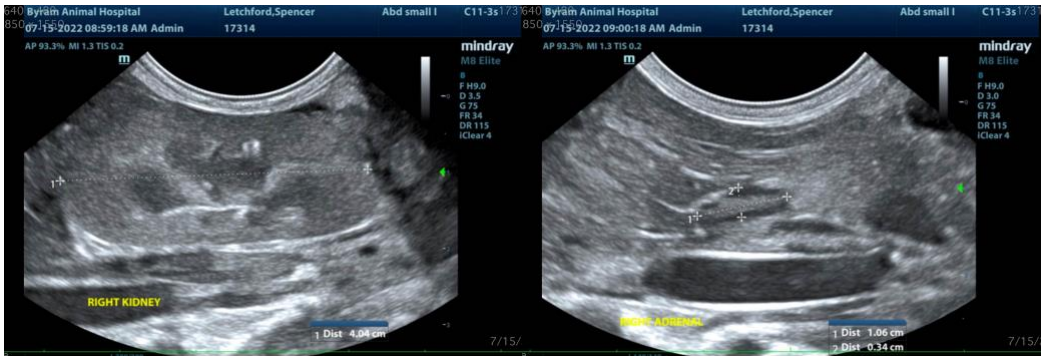
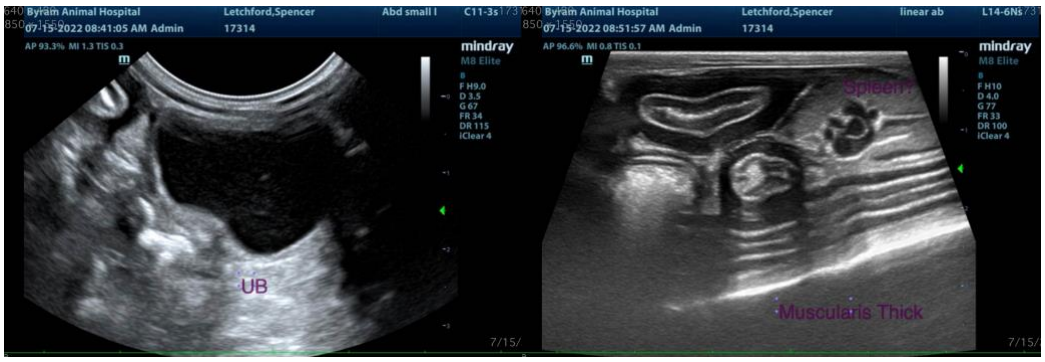
- Ideally, biopsies of the GI tract, being sure to include ileum (if possible) are recommended to definitively diagnose and therefore manage the infiltrative bowel disease. However, given this patients young age and the eosinophilia, a food allergy is at the top of the differential list, therefore, if a less invasive approach is elected, empirical therapeutic management could include a diet change to a novel or hydrolyzed protein diet with monitoring for improvement in clinical signs prior to pursuing biopsies.

- If diet does not alleviate clinical signs (or as a less invasive option to biopsies even before pursuing a diet trial), a FNA of the mesenteric nodes as well as possibly the thick bowel, could also be considered, if possible, to obtain and if patient's coagulation status is appropriate, prior to biopsies.



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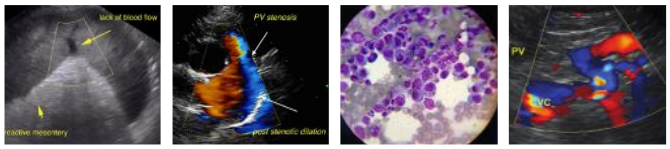

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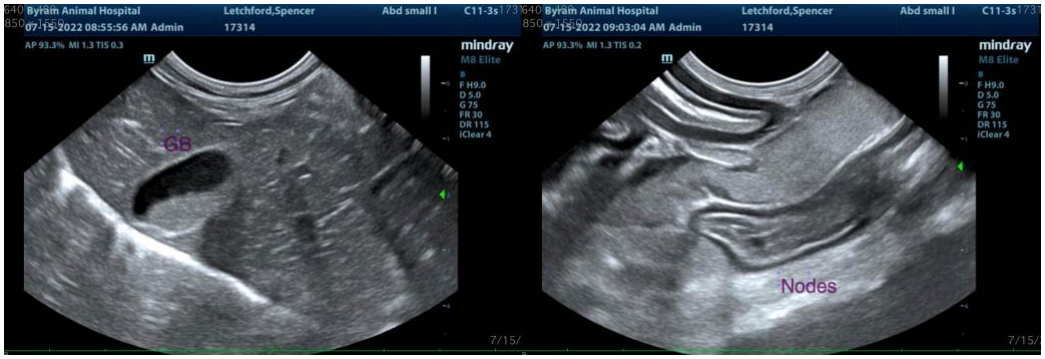


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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