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Clinical Sonography & Telecytology
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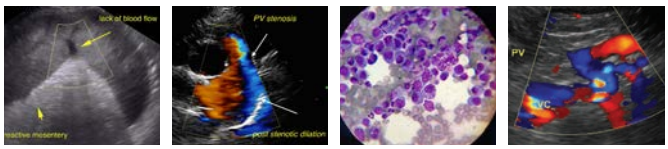

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1-800-838-4268 info@sonopath.com

PATIENT
Kalapana Wallace

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
14 Years

WEIGHT
4.35 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Evan Bell

HOSPITAL NAME
Cedarview AH

REFERRING VET
Dr. Evan Bell

INVOICE
40309

DATE
8/10/22

PRESENTING CLINICAL SIGNS

History of inappetence, inconsistent, for several weeks. NSF on exam.
Abnormal PE/Chem/CBC/UA Results: K slightly low (3.4 (3.5-5.8)) CBC and Chem WNL B12 WNL (~500) USG 1.021

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.

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 mineral or infarcts observed. The left kidney measures 4.0 cm. The right kidney measures 3.6 cm. Mild pyelectasia is noted bilaterally.

Adrenal Glands

The area of both adrenal glands is examined without evident pathology.

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 visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. 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. This finding is most appreciated at the level of the ileum. 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. It is subjectively mildly overdistended with what appears to be firm, well formed stool.

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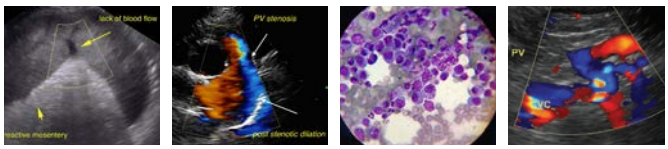

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Pancreas

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.

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.

- **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.

SECONDARY FINDINGS

- Urinary bladder debris

- Age related kidney changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the subjective appearance of the large bowel, questioning regarding any straining to defecate, decreased bowel movement, etc. is indicated, and if constipation is suspected, confirmatory abdominal radiographs could be obtained, followed by therapy for constipation, if present. However, this ultrasonographic appearance is subjective and normal patient variant cannot be ruled out. Therefore, further intervention should be directed by clinical signs.

There does appear to be evidence of infiltrative bowel disease. Therefore, 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. If biopsies cannot be obtained, empirical therapy could include a diet change, empirical deworming with a 5-day course of Panacur, cobalamin supplementation (which may be helpful despite a level of 500, as that is approaching the lower end of normal), and Prednisolone (if not contraindicated based on patient contraindications, comorbidities, etc.

In the meantime, maintaining normal appetite is important to prevent hepatic lipidosis. Therefore, appetite stimulants and antiemetics, gastroprotectants, etc. may also the supportive care necessary to increase appetite. If not, feeding tube placement may be necessary.

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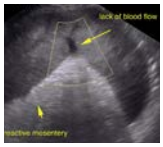
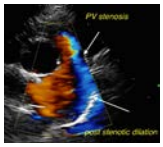
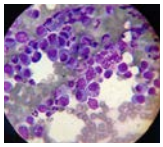
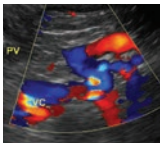

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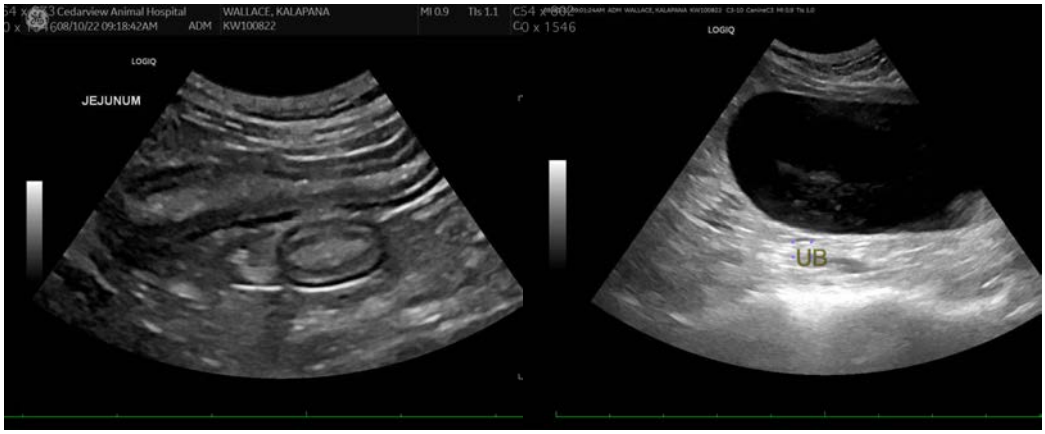

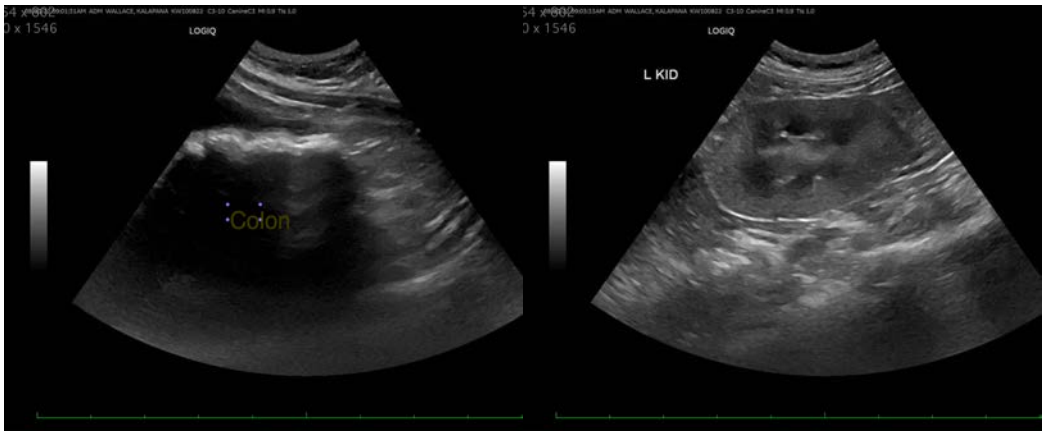

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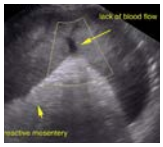
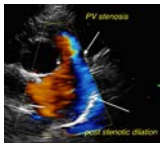
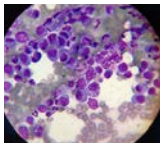
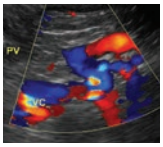

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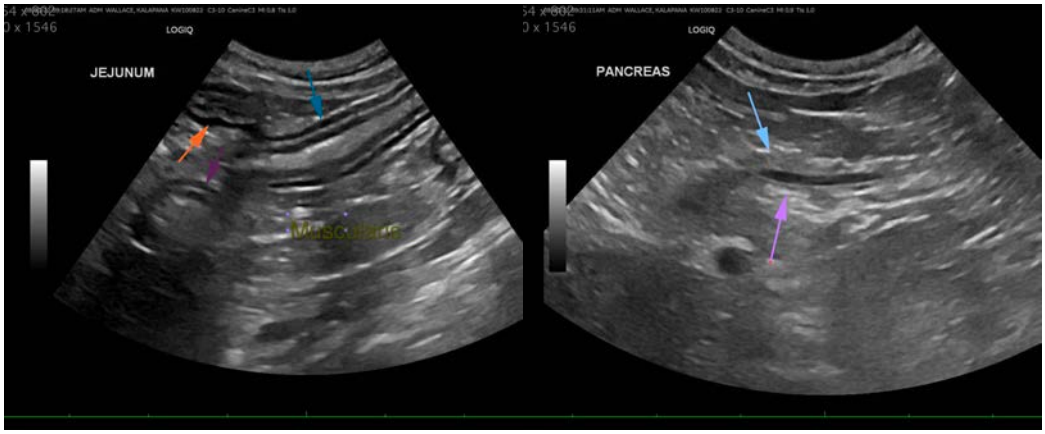

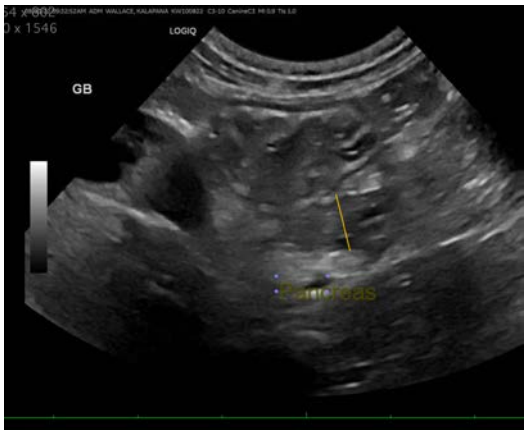

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com