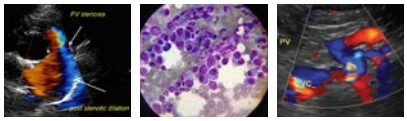
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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DATE

8/16/23

PATIENT

Zoey Miller

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

3/31/06

WEIGHT

3/31/06

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Nexus Vet Specialists

REFERRING VET

Dr. Steele

INVOICE

44732

PRESENTING CLINICAL SIGNS

Suspect primary GI disease. Intermittent GI issues for years but they have been much worse over the past couple of months. Head/neck: ~3mm thyroid nodule. Oro-nasal: mm pink/pigmented CRT <2sec, moderate-marked tartar, halitosis. Cardiovascular: Grade 3/6 L apical systolic murmur, slightly tachycardic, femoral pulses ss. Respiratory: Normal BV sounds bilaterally, eupneic. Abdomen: Soft nonpainful, prominent kidneys bilaterally, impression of mild mesenteric lymphadenopathy, impression of full feeling in cranial abdomen in area of stomach. Rectal: ~4mm pigmented nodule to L of anus. Musculoskeletal: MCS 2/3, moderate diffuse muscle atrophy. Integument: Slightly unthrifty haircoat.

Current Medications: Methimazole 2.5mg BID (not giving right now), Fluoxetine (not giving right now), Cerenia PRN, Miratax PRN, Prednisolone 2.5mg once daily.
Lab Results: 8/2 rDVM Chem unremarkable, CBC--neuts 11K, T4 9.2
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

The right kidney is normal in size (3.93 cm) but 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 left kidney is normal in size (4.11 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 (0.51 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The area of the left adrenal gland is examined without evident adrenal gland pathology.

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is subtly hypoechoic in echogenicity with a mildly coarse/heterogenous echotexture. Punctate, multifocal, discrete, homogeneous, hyperechoic, non-capsule disrupting nodules are noted. 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 very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine 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.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Pancreatic duct dilation is noted.

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

- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

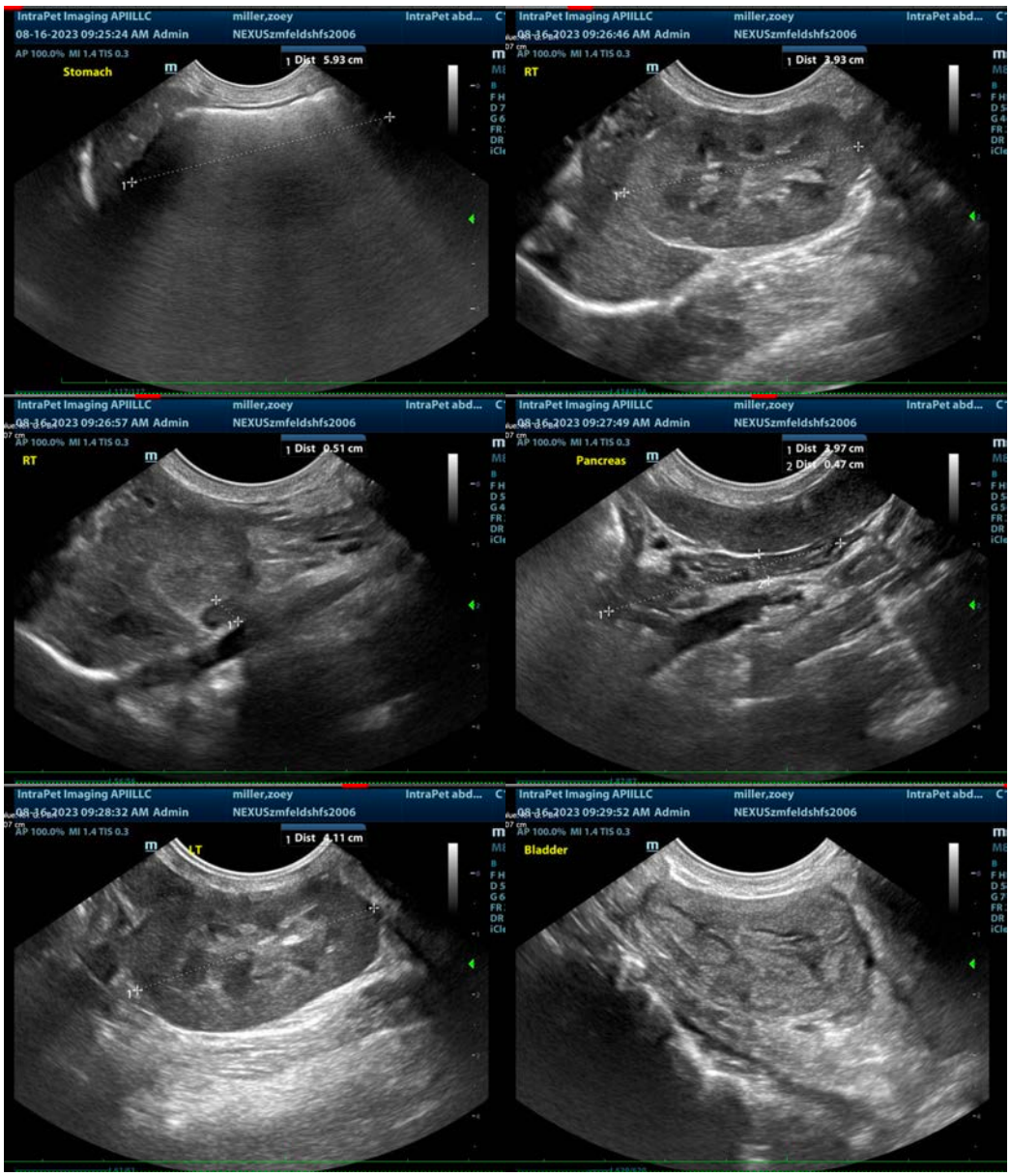
- Subtle Chronic Kidney Disease (affecting primarily the right kidney) – This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.

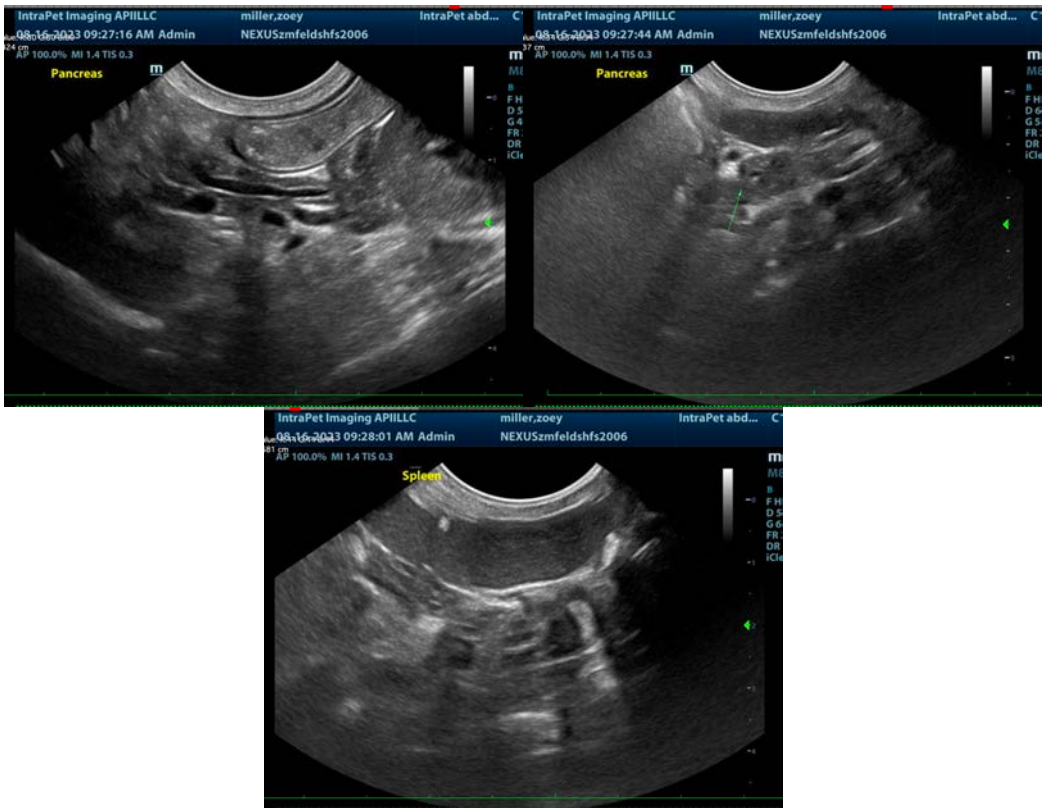
- Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

- Urinary bladder pathology is suspected based on the overall subjective thick irregular appearance of the wall (combined with reported clinical findings) but can't be fully interpreted without urinary bladder filling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations regarding this exam will be implemented by attending internist Dr. Cara Steele.





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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