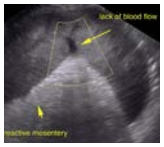
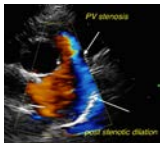
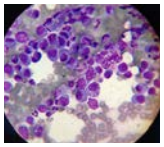
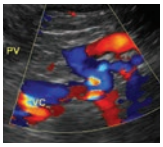
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Suki Michelson

SPECIES

Feline

BREED

Siamese

SEX

Spayed Female

AGE

3 Years

WEIGHT

5.0 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Michelle Roche

HOSPITAL NAME

Fredon AH

REFERRING VET

Dr. Michelle Roche

INVOICE

40032

DATE

8/2/22

PRESENTING CLINICAL SIGNS

2 lbs weight loss, not eating, wobbly, distant, lethargic, o feels fading rapidly
Abnormal PE/Chem/CBC/UA Results: BCS 3.5/9, ataxic, head sway, circling, profound dullness, intention tremors? BUN 71, phos 9.8, TP 5.6, ALT 374, AST 245, ALP 97, tbili 0.5, CK 5708

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.

The right kidney is normal in size (4.02 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 or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

The left kidney is normal in size (3.74 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 (0.57 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The area of the left adrenal gland 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

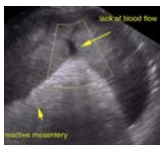
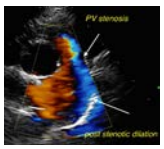
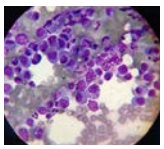
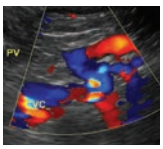
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal 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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is markedly distended with echogenic fluid. 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. The bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication, and/or visible foreign material. Hyperperistalsis is suspected.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. It is mildly distended with echogenic fluid.

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

There is a scant amount of anechoic free fluid noted.

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.

- **Gastroenteritis –** Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Concurrent gastric distention and suspect diarrhea in the large bowel.

SECONDARY FINDINGS

- Non-obstructive nephrolith in the right kidney

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's young age and neurologic signs, bile acids are recommended if not recently evaluated. Beyond that, given the concurrent AST and CK increases, underlying neuromuscular disease is suspected, and recommendations include a comprehensive infectious disease workup including but not limited to viral diseases, toxoplasmosis, fecal enteropathogens, etc.

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.

In the meantime, in addition to aggressive symptomatic/supportive medical management of clinical signs, gastrointestinal signs, hydration, etc., empirical therapy with Clindamycin as well as empirical therapy for possible hepatic encephalopathy could be considered while awaiting results.

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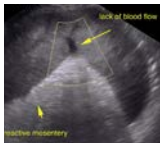
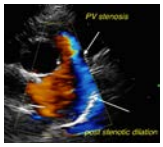
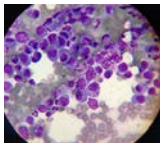
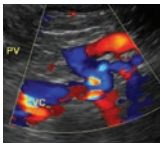

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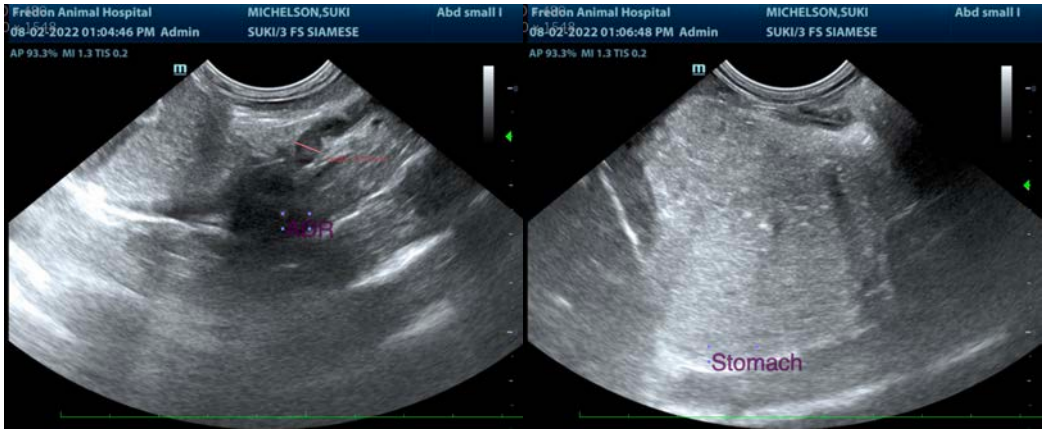

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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