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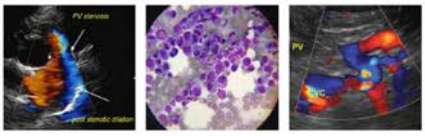

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Remington Pruett

SPECIES

Feline

BREED

Russian Blue

SEX

Neutered Male

AGE

10 Years

WEIGHT

14 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Briarwood VH

INVOICE

40693

DATE

8/24/22

PRESENTING CLINICAL SIGNS

Recent visit to ER for painful abdomen and not eating.
Abnormal PE/Chem/CBC/UA Results: Azotemia and low USG

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 large in size (5.51 cm), with increased cortical thickness and echogenicity. A normal smooth peripheral margination and shape are maintained. There is some early loss of normal corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is large in size (4.83 cm), with increased cortical thickness and echogenicity. A normal smooth peripheral margination and shape are maintained. There is some early loss of normal corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.48 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.46 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mildly 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 visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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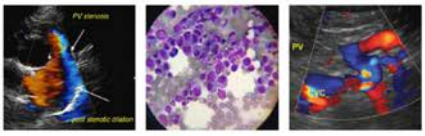

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Pancreas

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 a scant amount of anechoic free fluid appreciated. No evidence of pericardial or pleural effusion appreciated in these images.

There is no apparent lymphadenopathy noted in these images.

The entire cranial abdomen from both kidneys extending cranially around the area of the pancreas is hyperechoic in appearance with enhanced fat and mesentery.

ULTRASONOGRAPHIC FINDINGS

- **Feline renomegaly –** These renal changes can be seen with glomerular or interstitial nephritis, FIP, amyloidosis, acute tubular necrosis or infiltrative neoplasia such as lymphoma. Normal variant due to fat deposition cannot be ruled out but is less common in an enlarged kidney.
- **Chronic active pancreatitis -** Acute on chronic smoldering pancreatitis cannot be definitively ruled out.
- The cranial abdominal changes are consistent with inflammation likely brought on by the process affecting the kidneys. However, acute pancreatitis compounding nephritis is possible.
- **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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient's abdominal pain is likely brought on by an acute inflammatory process involving both kidneys. A fine needle aspirate of the kidneys could be considered if patient's coagulation status is appropriate, to look for evidence of and/or rule out lymphoma.

Given the mildly thick muscularis layer and pancreatic changes, 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, medical supportive/symptomatic therapy of acute kidney disease +/- mild pancreatitis with IV fluids, antiemetics, gastroprotectants, appetite stimulants, and/or nutritional support as needed, pain management and broad-spectrum antibiotics is recommended.

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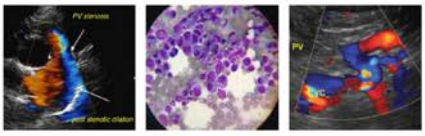

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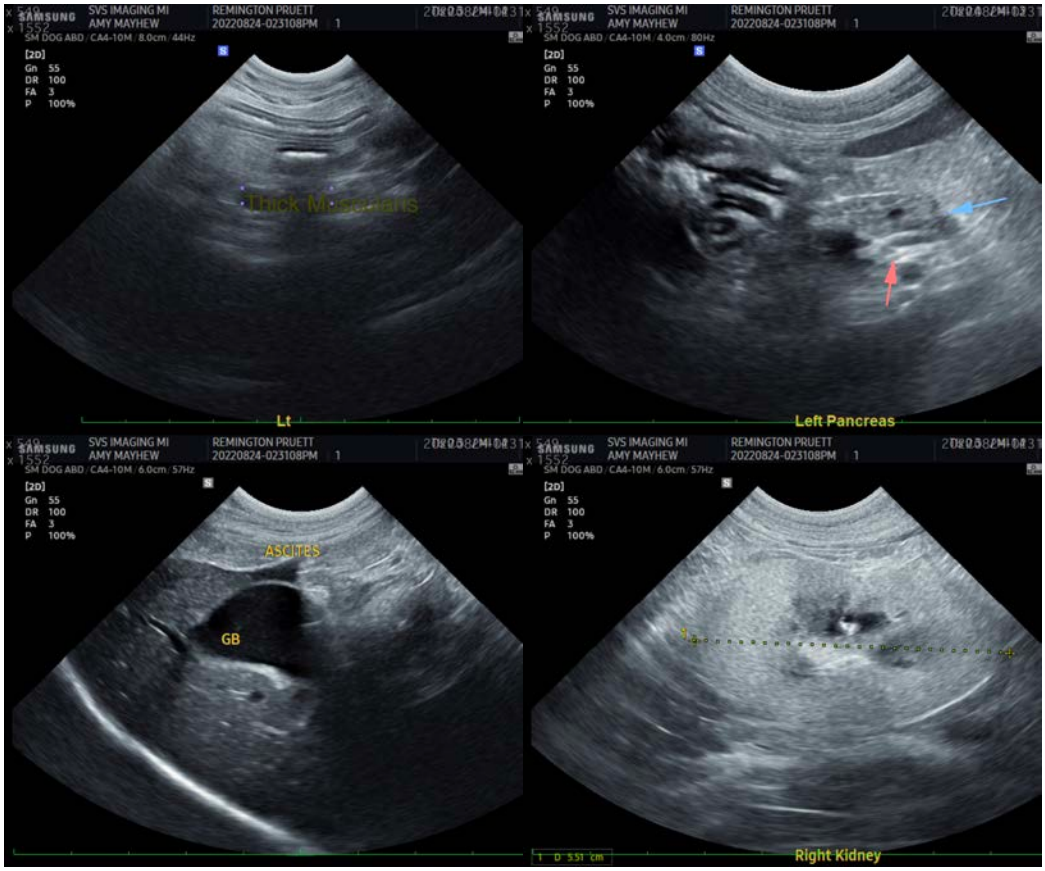

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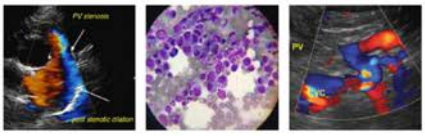

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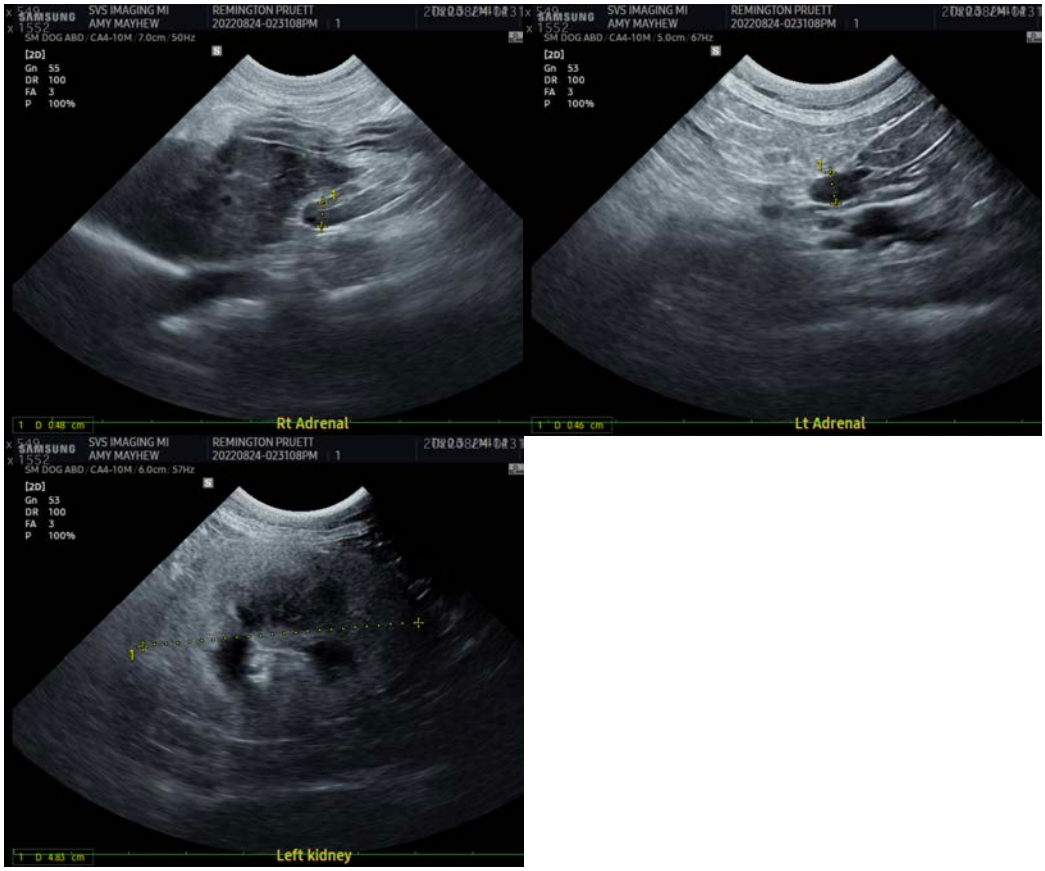

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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