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Clinical Sonography & Telecytology
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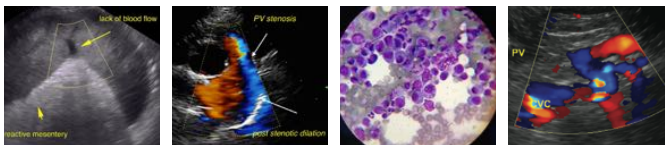

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Faith Larue Sliker

SPECIES
Feline

BREED
Domestc Shorthair

SEX
Spayed female

AGE
12 years

WEIGHT
6.5 lbs

INTERPRETED BY
Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY
Dr. Christensen

HOSPITAL NAME
Tranquility VC

REFERRING VET
Dr. Christensen

INVOICE
42245

DATE
12/20/22

PRESENTING CLINICAL SIGNS

History: Anorexia and vomiting for the past 48 hours. Lethargic past 2 weeks and occasional urinary accidents.
Elevated BUN/Creat./Amylase/PrecisionPSL/WBC count. See attached report

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with complete loss of corticomedullary definition. No evidence of pelvic dilation was present. Renal pelvises were bilaterally moderately dilated measuring 3.1 mm on the left and 3.4mm on the right. Ureter is non-dilated. The left kidney measured 3.6 cm and right kidney 3.18 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 1.0 cm in length x 0.19 cm at the caudal pole and 0.24 cm at the cranial pole. The right adrenal gland measured 0.95 cm in length x 0.23 cm at the caudal pole and 0.34 cm at the cranial pole.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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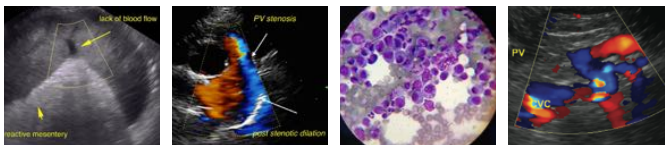

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering with a prominent muscularis layer. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

Pancreas is diffusely prominent and hyperechoic with no fluid accumulations and no surrounding free fluid.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Pancreatitis
2. Prominent muscularis layer in small intestine
3. Bilateral decreased corticomedullary distinction with pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Bilateral pyelectasia with concurrent azotemia is concerning for pyelonephritis and urinalysis and culture are recommended, along with initiation of broad spectrum antibiotics while awaiting urine culture results along with IV fluid therapy. Pancreatic changes are consistent with acute pancreatitis. Treatment for pancreatitis is supportive and involves fluid support, GI support (anti-nausea, appetite stimulant), analgesia and enteral nutrition. Small intestinal changes may be related to acute inflammation associated with gastroenteritis, but prominence of muscularis layer re most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or less likely GI lymphoma being the top differentials. No overt neoplastic criteria present in the bowel given that curvilinear layering is still intact which would suggest inflammatory bowel as opposed to round cell neoplasia (LSA, MCT and similar). Intraoperative US-guided bx would be optimal in this patient to obtain the most representative samples in the GI tract. I cannot rule out a preneoplastic (LSA) state however and follow-up sonograms recommended especially If the patient is not responding to empirical efforts. Endoscopic biopsy is less invasive but may miss lesions due to inability to sample more than top 1-2 layers of GI tract and inability to obtain samples from all sections of the GI tract. Surgical biopsies are more likely to be diagnostic but are more invasive. A GI panel (PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation.

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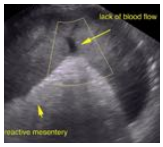
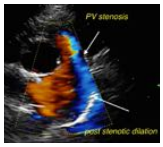
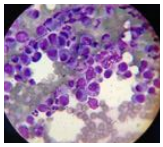
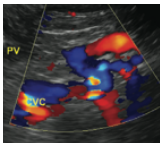

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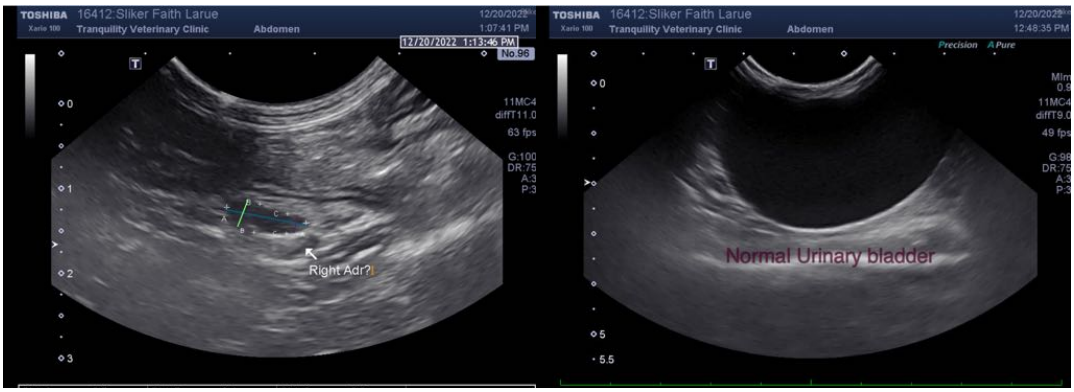

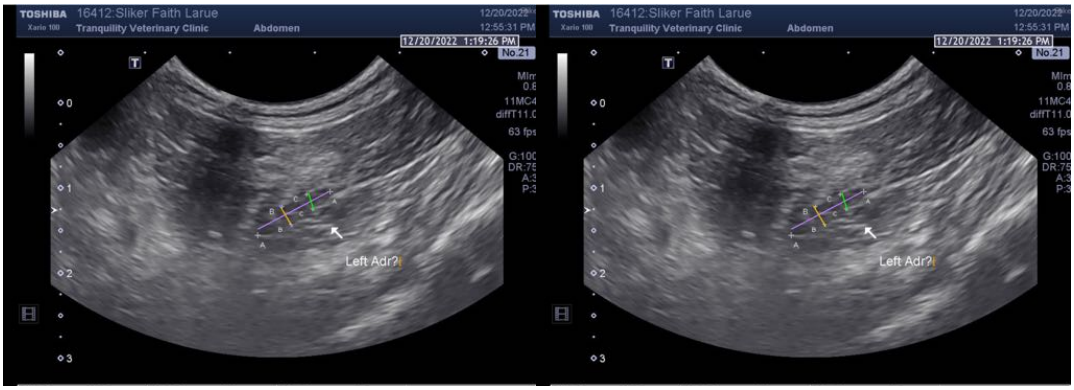

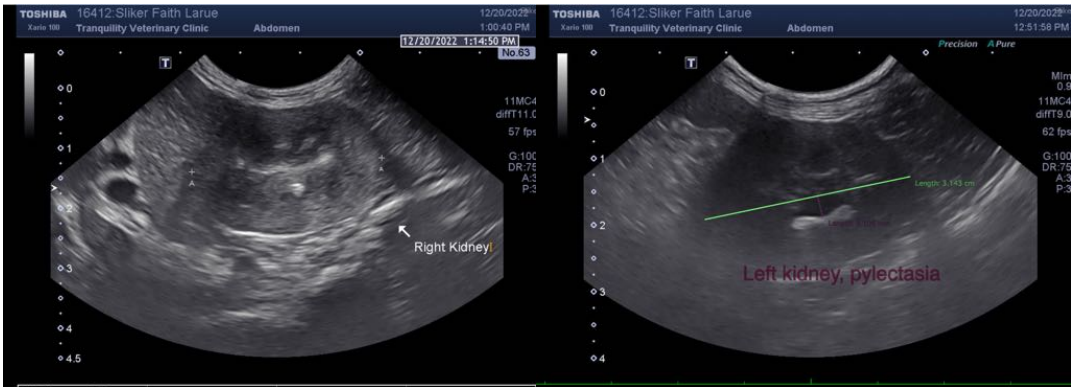

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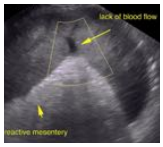
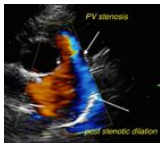
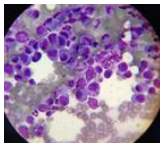
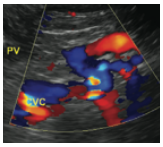

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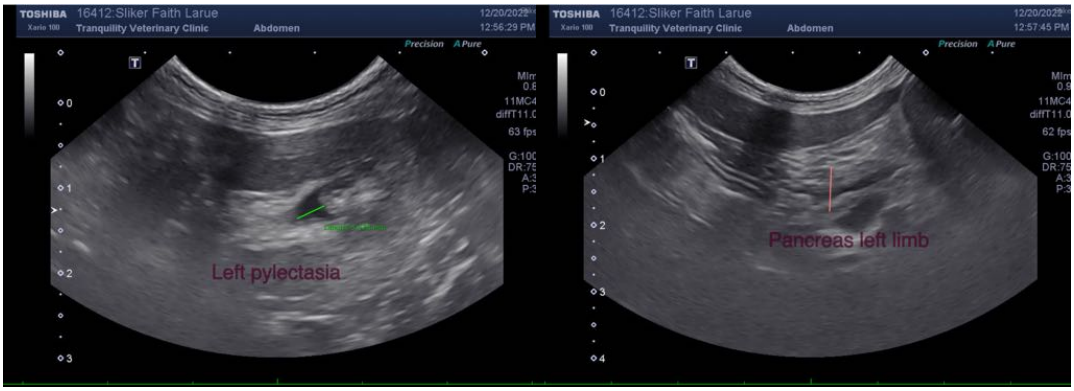

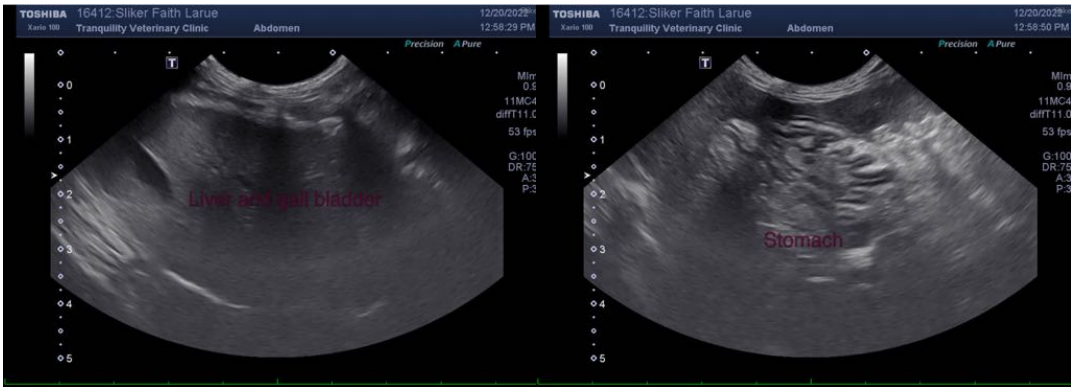

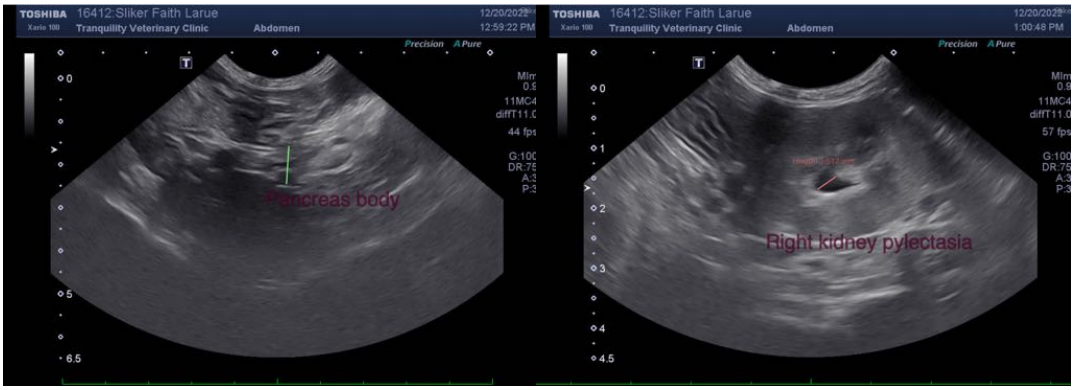

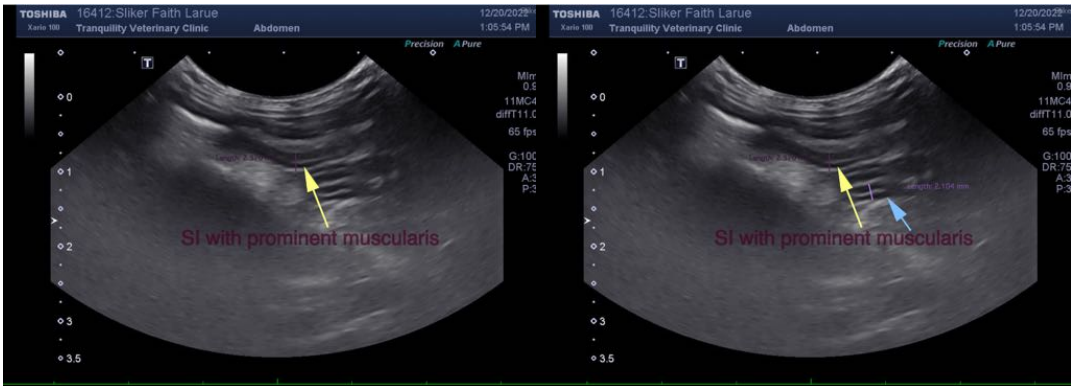

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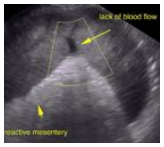
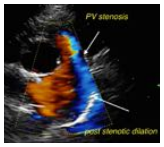
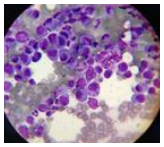
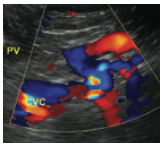

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com