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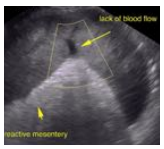
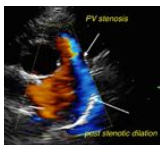
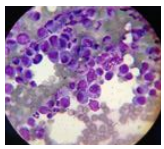
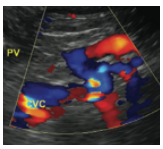
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™





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

PATIENT
Beans Burneyko

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Spayed female

AGE
16 years

WEIGHT
8.4 lbs

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

IMAGING PERFORMED BY
Dr. Roche

HOSPITAL NAME
Fredon AH

REFERRING VET
Dr. Roche

INVOICE
42618

DATE
2/7/23

PRESENTING CLINICAL SIGNS

History: Vomits nightly, losing weight. on pred every other day for asthma. Also recently started sucralfate and B12.
Abnormal PE/Chem/CBC/UA Results: BCS 4/9, T4 3.2, SDMA 17

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 an irregular capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. The left kidney measured 3.56 cm and the right kidney measured 3.67 cm.

Adrenal Glands

The adrenal glands were not visualized; however, the region of the adrenal glands were unremarkable.

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.

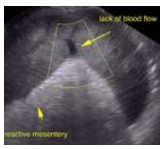
Liver

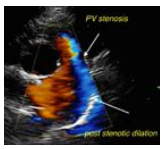
The liver is subjectively normal in size with somewhat irregular contours and normal structure. The parenchyma is heterogenous with a coarse appearance with no specific nodules or masses seen. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing gravity dependent debris present. There is no surrounding free fluid or signs of active inflammation.

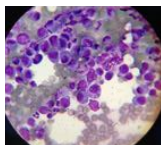
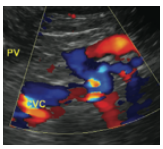
Gastrointestinal

The stomach contains a small volume of liquid hypoechoic luminal contents and gas. Gastric walls are subjectively slightly thickened/prominent. 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.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is increased measuring up to 0.3cm (ref <0.22cm). Bowel loops follow a curvilinear path with distinct wall layering with a thickened muscularis layer. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.





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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness.

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 right limb and body are prominent with surrounding hyperechoic mesentery. No fluid accumulations visualized and no surrounding free fluid. No mass effect consistent with pancreatic neoplasia visualized.

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 gastric walls and thickened small intestinal loops
3. Degenerative renal changes
4. Coarse liver parenchyma

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pancreatic changes are consistent with acute pancreatitis. Measurement of PLI is recommended to further support diagnosis. Small intestinal findings are most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or 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). Together with pancreatic findings this is likely part of the triaditis complex seen in cats, though there is no ultrasonographic evidence of cholangiohepatitis at this time, and this may not be a feature of the syndrome in Beans.

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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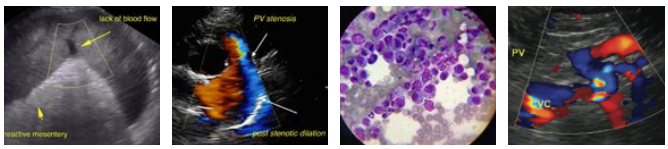

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Empiric treatment for IBD vs lymphoma includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, GI support as needed (anti-nausea, appetite stimulant). Treatment with steroids (budesonide vs prednisolone) is often required – biopsies should be acquired prior to treatment with steroids. Steroids may ultimately be tapered to the lowest effective dose or discontinued in some cases. As Beans is already on steroids, increasing the dose or frequency, along with other supportive measures, may improve clinical signs.

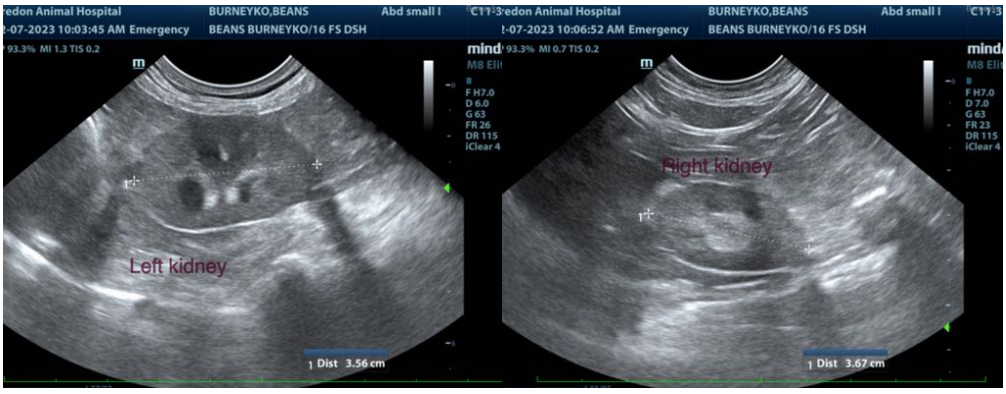
Treatment for pancreatitis is supportive and involves fluid support, GI support (anti-nausea, appetite stimulant), analgesia and enteral nutrition. Antibiotics are generally not warranted for acute pancreatitis as it is generally sterile. Serial imaging is indicated if clinical signs are not resolving to assess for possible progression to pancreatic abscessation or post hepatic bile duct obstruction.

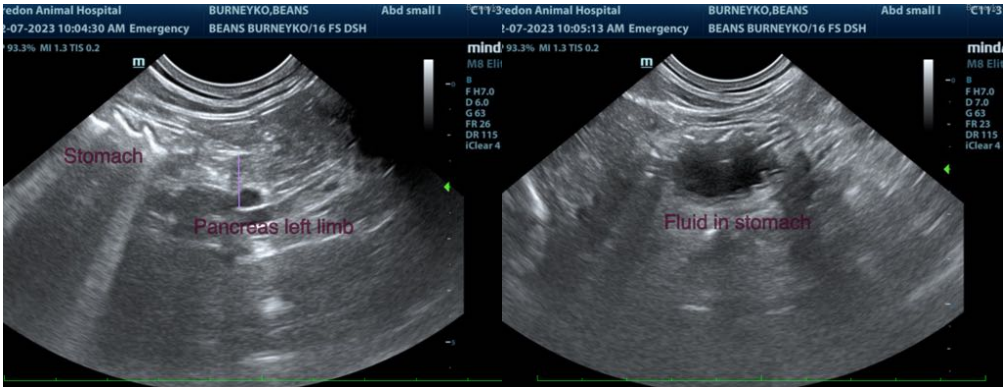
Free T4 measurement is recommended to further investigate the total t4 in the grey zone given the patients weight loss.

Renal changes are likely age related degeneration. Correlate clinical significance with blood work/urinalysis findings and clinical signs.

Liver changes are a common benign age related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. Fine needle aspirate could be considered to further characterize parenchymal changes if clinically indicated, especially given weight loss is noted.

Gall bladder debris is likely an incidental finding and is often subclinical and often does not warrant specific treatment or further investigation. Correlate clinical significance with bloodwork findings and clinical signs. Serial imaging for monitoring could be considered especially if liver enzymes subsequently become elevated.





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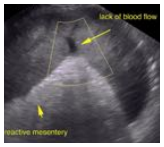
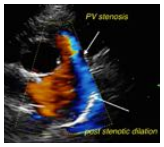
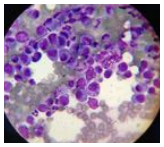
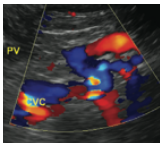

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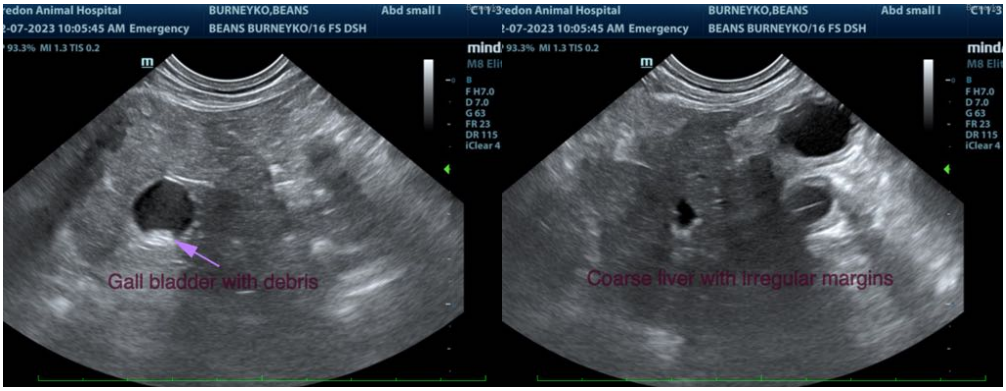

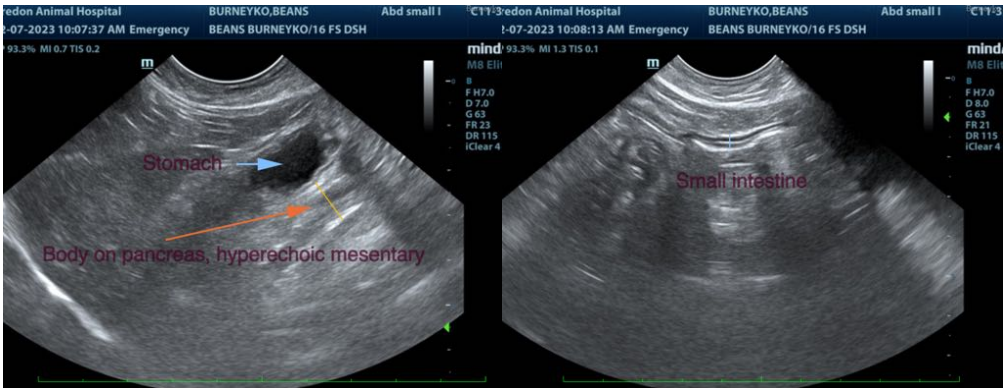

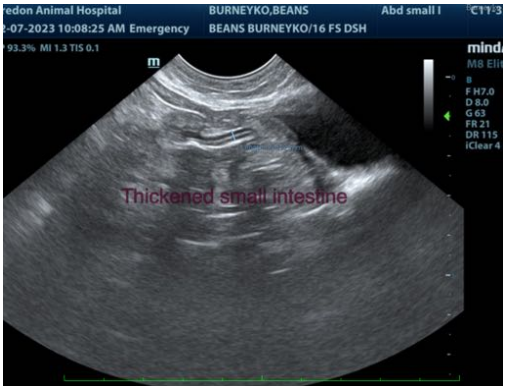

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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