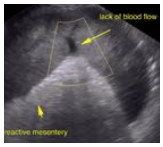
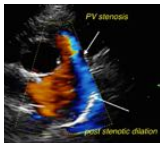
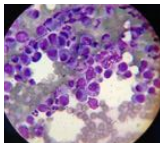
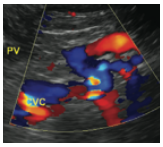
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™





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

PATIENT
Oliver Yau

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
5 years

WEIGHT
7.9 lbs

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

IMAGING PERFORMED BY
M Kermendy CVT

HOSPITAL NAME
Wauwautosa VC

REFERRING VET
Dr. Oakes

INVOICE
43498

DATE
3/27/23

PRESENTING CLINICAL SIGNS

History: Oliver has a history of chronic vomiting. He vomits about once daily. His appetite, energy, and defecation are normal. Owner switched him to I/D a few days ago which has helped. Blood work and urine performed in August 22--results normal. Not currently on any medications.

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 were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The right kidney measured 3.47 cm. The left kidney measured 3.59 cm.

Adrenal Glands

Both adrenal glands were not visualized.

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.

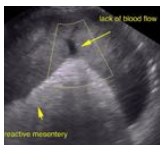
Liver

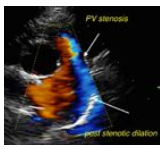
The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. 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

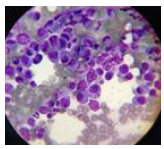
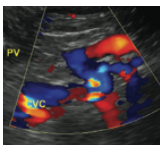
Gastrointestinal

Loops of small intestine were thickened measuring up to 0.26cm (ref <0.22cm) with normal wall layering. Bowel loops follow a curvilinear path with distinct wall layering. There were no focal lesions consistent with obstruction or a mass effect observed.

The stomach contains ingesta. 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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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

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Thickened small intestinal loops with normal wall layering

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Small intestinal thickening is most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or GI lymphoma being the top differentials. Chronic changes from food hypersensitivity is possible given lack of muscularis thickening. No overt neoplastic criteria present in the bowel given that curvilnear 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. Recheck imaging after transition to i/d diet, which has reportedly improved symptoms, in 4-6 weeks could be considered to monitor for improvement in thickening prior to more invasive testing. A GI panel (PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation.

Empiric treatment for IBD 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.

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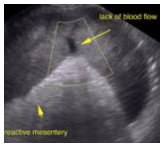
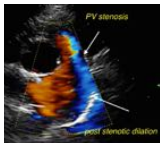
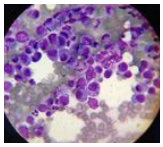
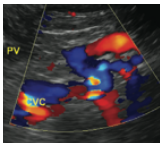

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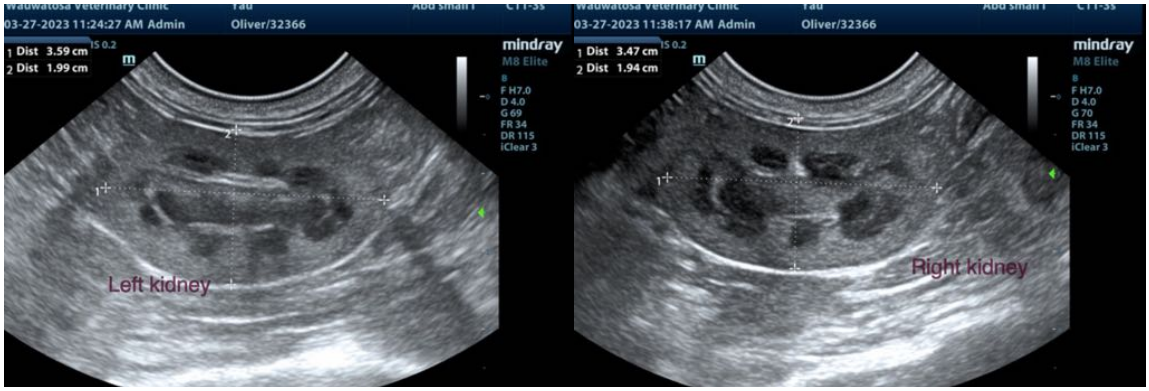

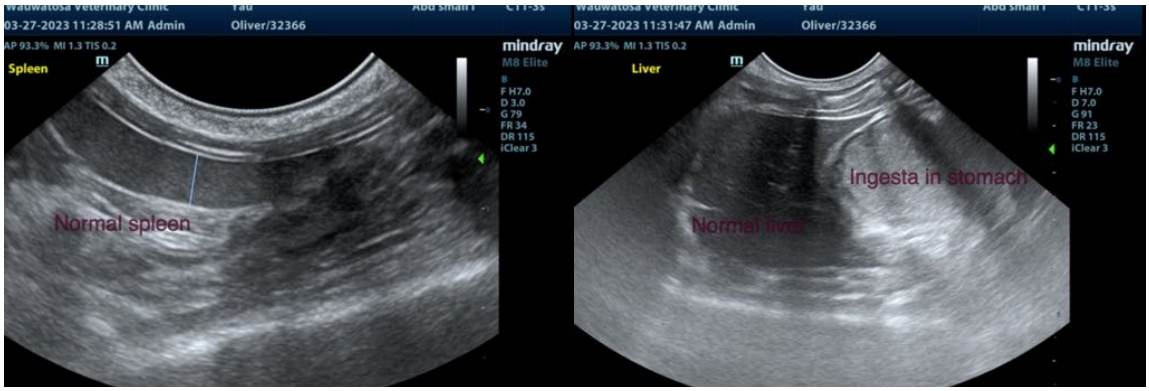

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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