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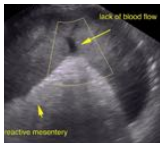
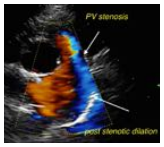
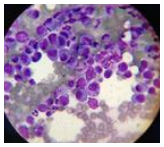
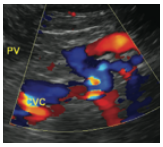

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1-800-838-4268 info@sonopath.com

PATIENT
Beau Godfrey

SPECIES
Feline

BREED
Burmese

SEX
Neutered male

AGE
13 years

WEIGHT
11.7 lbs

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

IMAGING PERFORMED BY
Dr. Carpenter

HOSPITAL NAME
Pennridge AH

REFERRING VET
Dr. Depew

INVOICE
43546

DATE
3/28/23

PRESENTING CLINICAL SIGNS

History: 14 yo MN Burmese 11.7# Sedated with butorphanol Presented for weight loss, intermittent vomiting, polyphagia per O. Dental disease noted. Heart murmur noted - pro BNP checked and was 65 (normal). Bloodwork performed - NSF with b/w, including normal total t4. Has lost 2 pounds in the last 4 months. NSF with chest rads. Here for screening AUS for further workup of weight loss.

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 nearly complete loss of corticomedullary definition. Left renal pelvis is moderately dilated measuring 2mm. Right renal pelvis is moderately dilated measuring 2.3mm. Ureters are non-dilated. The left kidney measured 4.25 cm and the right kidney measured 4.03 cm.

Adrenal Glands

Adrenal glands were not distinctly visualized but the vasculature and area of the adrenal glands was within normal limits.

Spleen

The spleen was mildly enlarged measuring 0.96cm with a slightly irregular capsule and homogeneous normal parenchyma with normal splenic vasculature with no signs of congestion or thrombosis. No specific nodules or masses were visualized.

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 with a prominent muscularis 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 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.

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

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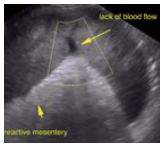

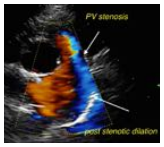

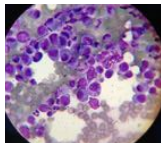
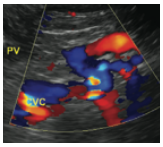

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Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

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.

Pleural Space

Scant pleural effusion visualized across the diaphragm in view of right liver.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Thickened SI loops with prominent muscularis
2. Splenomegaly
3. Scant pleural effusion
4. Degenerative renal changes with bilateral pyelectasia

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. 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.

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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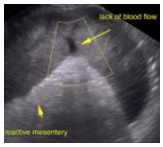
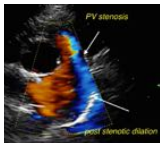
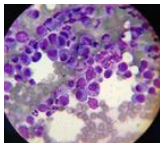
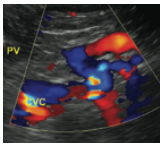

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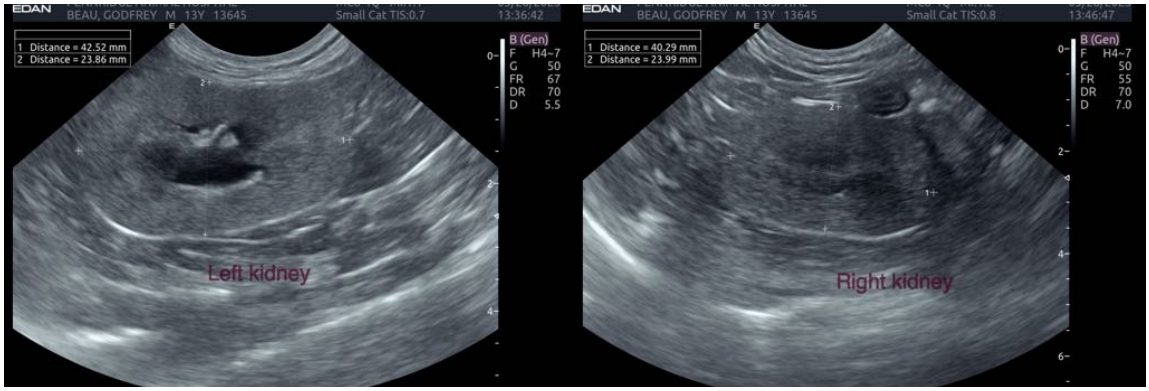
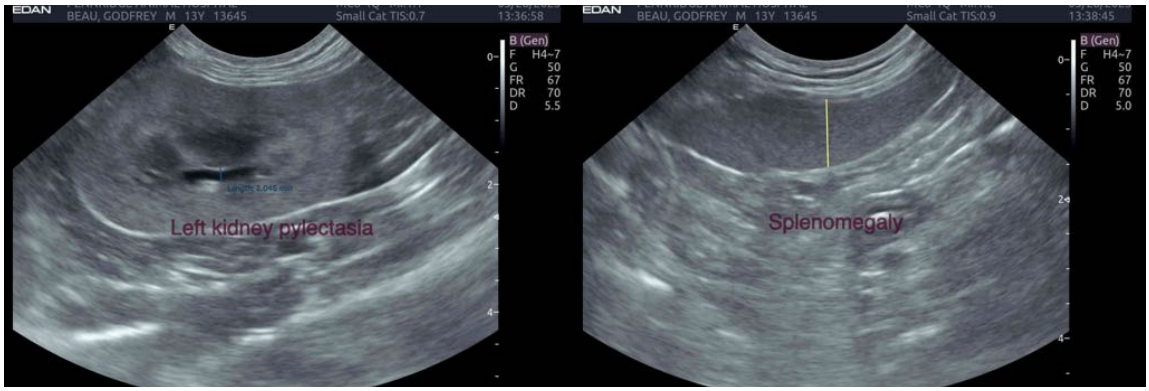
Splenomegaly with hyperechoic parenchyma is concerning for infiltrative disease such as lymphoma or mast cell tumor, and splenic aspirate is recommended. This may be a benign reactive or inflammatory change, or could reflect extramedullary hematopoiesis.

Pyelectasia is concerning for acute pyelonephritis. It can also represent obstructive ureterolithiasis, either present or resolved, leptospirosis, toxin exposure, increased urine production from fluid diuresis, or other causes of polyuria/polydipsia. Urine culture is recommended with broad spectrum antibiotic coverage while awaiting results. Renal FNA could be considered to screen for round cell neoplasia.

Scant pleural effusion is visualized across the diaphragm. If reportedly normal thoracic radiographs were not taken concurrently with ultrasound, recheck thoracic radiographs are warranted. Despite normal ProBNP, an echocardiogram to assess cardiac function is recommended as false negatives are possible with this screening test. If cardiac disease is not present, primary thoracic cavity disease – pulmonary, pleural space is present and should be further investigated with thoracic ultrasound, lung FNA, bronchoscopy/BAL or as otherwise clinically indicated.





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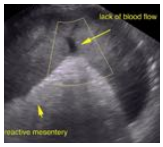
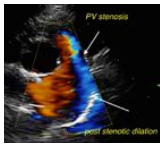
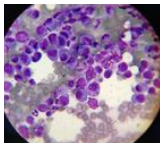
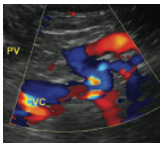

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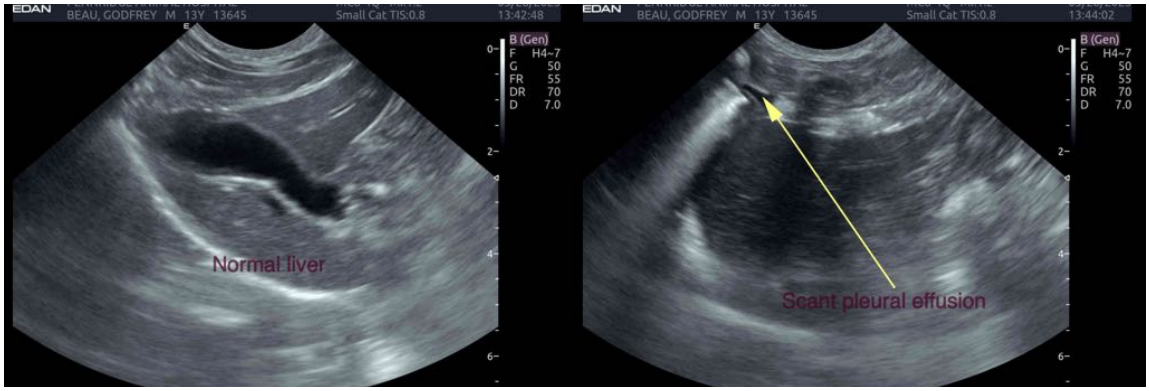

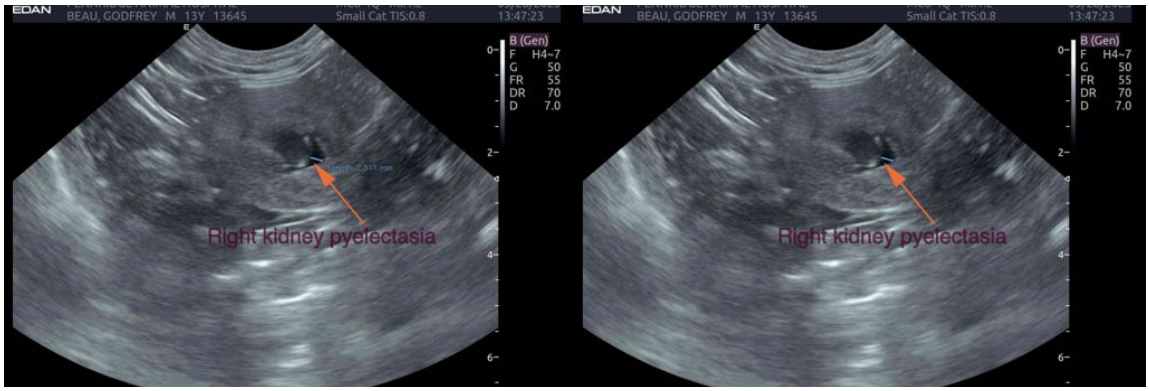

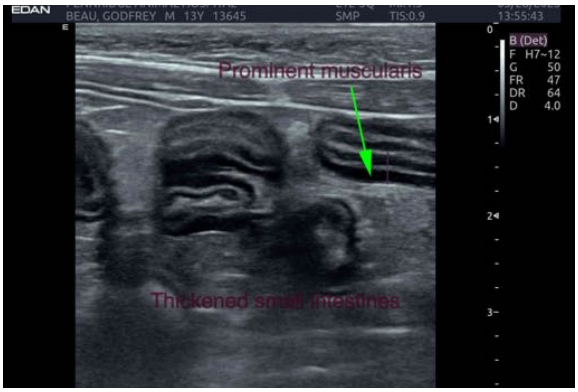

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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