SonoPath
Clinical Sonography & Telecytology
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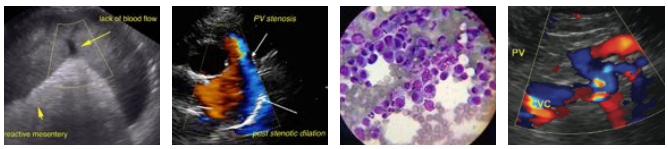

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Oscar Froehlich

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
6 years

WEIGHT
15 lbs

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

IMAGING PERFORMED BY
Dr. Carpenter

HOSPITAL NAME
Pennridge AH

REFERRING VET
Dr. Carpenter

INVOICE
43547

DATE
3/28/23

PRESENTING CLINICAL SIGNS

History: 7 yo MN DSH 15# Hx of constipation/poss FLUTD like signs. Presented 1 month ago straining repeatedly per O to defecate in the litter pan and crying in pain with subsequent vomiting. NSF with rads, not constipated, no urinary obstruction. Tx with cerenia, metro. No response and re-presented 2 days later with 104.6 temp. B/w WNL. triple snap neg x 3. Hospitalized x 2 days on IVF and supportive care and tx with azithromycin/orbax for FUO. Patient resolved 100%. 1 week off antibiotic therapy, re-presented with straining to defecate, vomiting, and crying in pain in the litter pan. PE WNL. temp 104.0. Repeat bw NSF. Rads taken and increased LN or mass like effect noted dorsal to colon. FUO PCR panel on hold at lab. AUS performed today. Patient improving on cerenia, orbax, SQF. Temp today was 102.7.

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 4.3 cm. The left kidney measured 4.2 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 0.72 cm in length 0.24 cm at the caudal pole. The right adrenal gland measured 1.0 cm in length and 0.33 cm at the caudal 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

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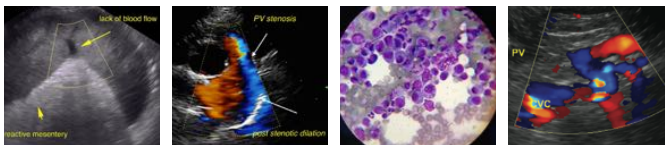

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Gastrointestinal

Sections of colon are visualized with formed fecal material and gas shadowing distally. Only the ventral wall of the colon is visible in the area of interest due to shadowing from gas and feces. On the radiographs the disease appears to be within the dorsal wall of the colon, or deep to the dorsal wall and limitation of ultrasound being unable to penetrate through these material is limiting for evaluation.

There is no observed focal or generalized colon wall thickening or loss of layering. There is no visualized mass effect or lymphadenopathy visible near distal colon on ultrasound.

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.

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

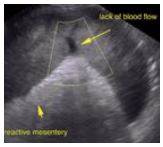
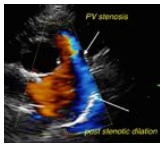
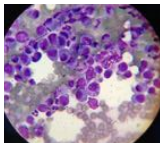
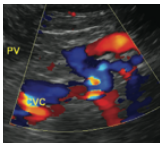
Primary Findings

1. Normal distal colon and surrounding area – visualization limited by fecal shadowing
2. Thickened SI loops with prominent muscularis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No visible cause of reported colonic signs and radiographic abnormalities on ultrasound. This area of the colon is generally difficult to visualize with ultrasound due to shadowing from feces and gas, and distally from overlying pelvis. Re-evaluation after colonic evacuation could be considered. Ultimately CT may be required to fully assess this region for colonic/rectal mural wall disease such as abscess or mass. Colonoscopy can visualize the lumen but may miss deeper lesions.

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

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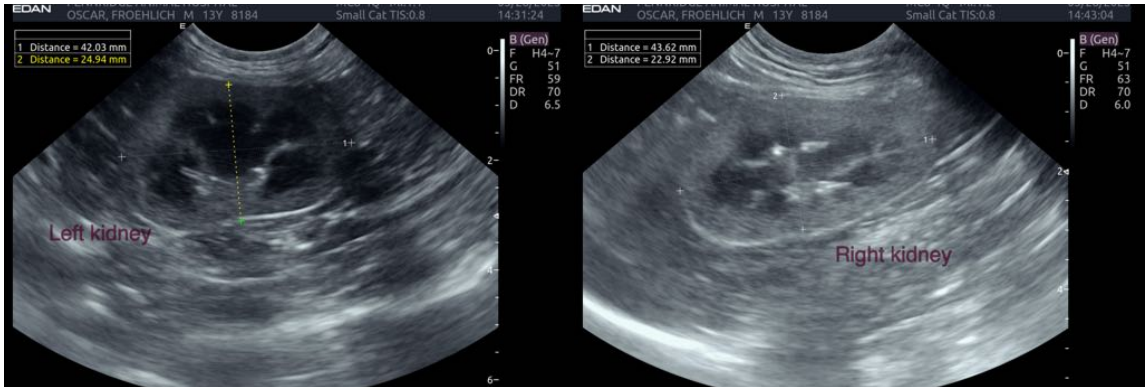
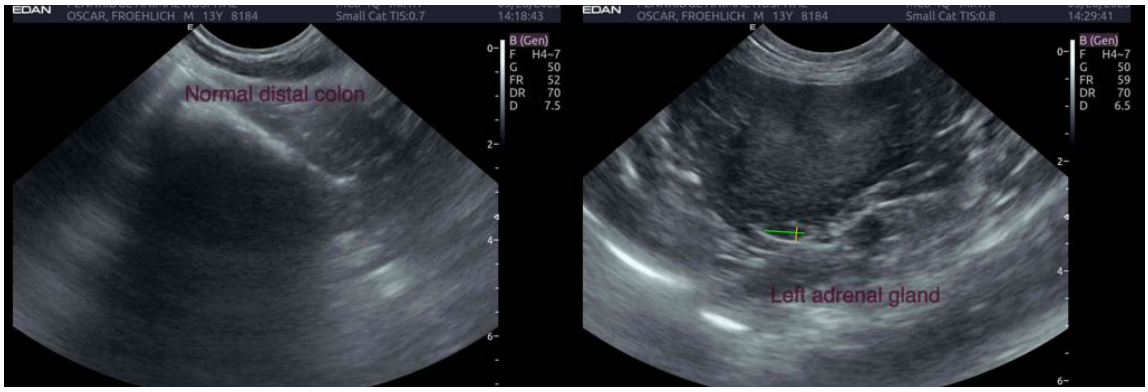
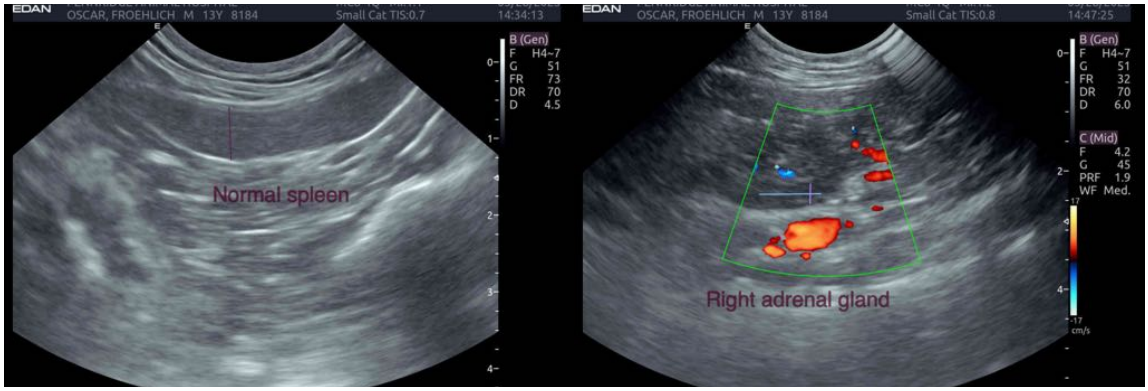
bowel as opposed to round cell neoplasia (LSA, MCT and similar). Intraoperative US-guided bx would be optimal in this patient to obtain the most representative samples in the GI tract. I cannot rule out a preneoplastic (LSA) state however and follow-up sonograms recommended especially If the patient 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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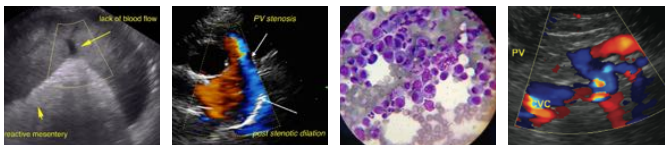

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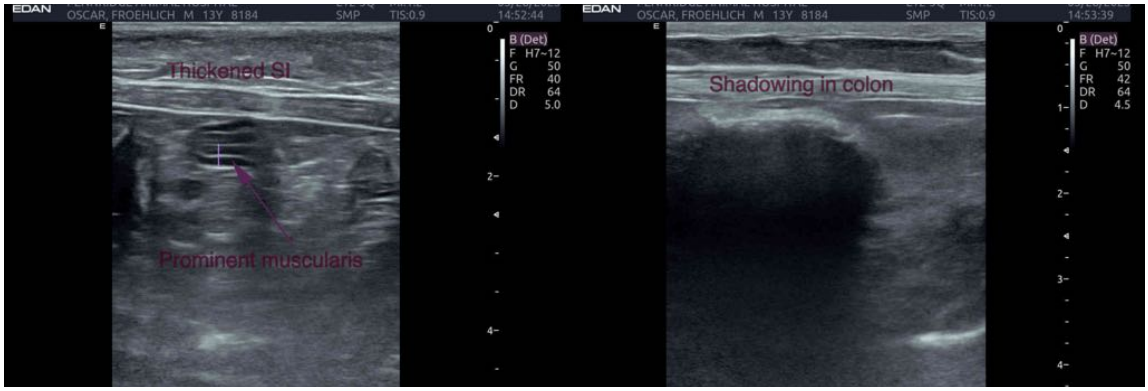

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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