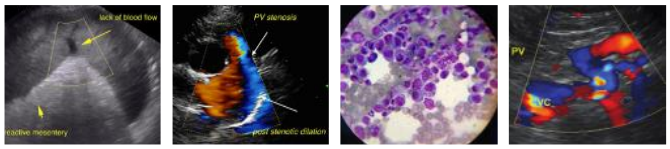
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Vivian Jaeger

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8 Years

WEIGHT

10.8 Pounds

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Mary Kermendy, CVT

HOSPITAL NAME

Wauwatosa VC

REFERRING VET

Kevin Kicker, DVM

INVOICE

22041

DATE

4/17/23

PRESENTING CLINICAL SIGNS

History: Recurrent vomiting, decreased appetite, previously responded to hydrolyzed protein diet.

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. Mobile and gravity dependent debris present in the urinary bladder. 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 3.78 cm. The left kidney measured 3.82 cm.

Adrenal Glands

Adrenal glands were not distinctly visualized. The area of the adrenal glands and surrounding vasculature were normal.

Spleen

The spleen has a generally smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. A solitary hyperechoic nodule was visualized, most consistent with benign myelolipomas. 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.

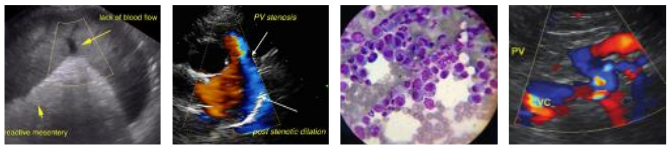
Gastrointestinal

The stomach contains 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.

Loops of small intestine were thickened 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.

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



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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

- Thickened small intestines, normal wall layering
- Splenic myelolipoma
- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

GI changes are consistent with nonobstructive gastroenteritis. In the face of chronic GI signs, a chronic underlying condition such as inflammatory bowel disease or less likely GI lymphoma remain possibilities, though these are not the classic ultrasonographic changes expected with these diseases. While the pancreas appeared sonographically normal, pancreatitis cannot be definitively ruled out. Treatment is supportive and involves fluid support, GI support (anti-nausea, appetite stimulant), analgesia and enteral nutrition as needed. Antibiotics are generally not warranted. Serial imaging is indicated if clinical signs are not resolving. Current chem/lytes/CBC, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen PCR, and empiric broad spectrum deworming and treatment with probiotics should be considered as clinically warranted. Ultimately GI biopsy may be required for more definitive diagnosis.

Empiric treatment for gastroenteritis includes maintenance of hydration with fluid support and GI support as needed (anti-nausea, appetite stimulant, analgesics if indicated). If initial treatments are unsuccessful, treatment for IBD could be considered which includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, and continued GI support as needed. Treatment with steroids (budesonide vs prednisolone) may be required – biopsies should be acquired prior to treatment with steroids.

Splenic changes are a common age related change and nodules are most consistent with benign myelolipomas. Fine needle aspirate could be considered to further characterize parenchymal changes if clinically indicated.

Correlate clinical significance of urinary bladder debris with bloodwork/urinalysis findings and clinical signs.

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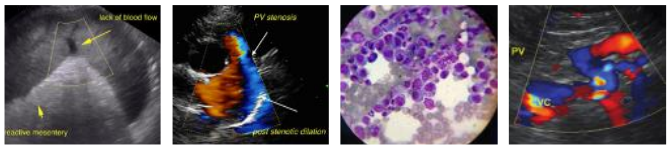

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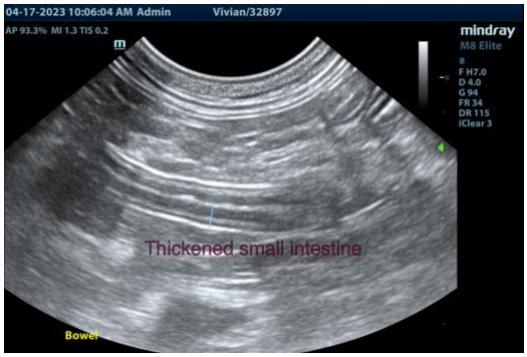

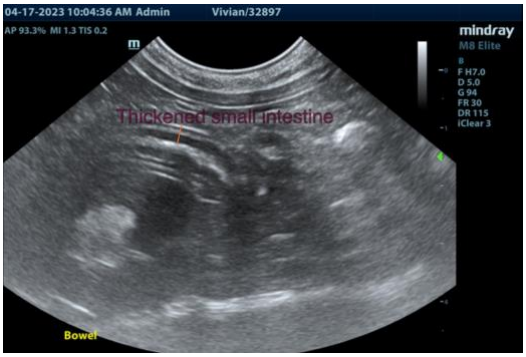

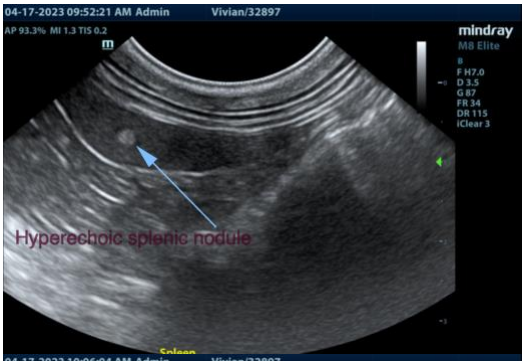

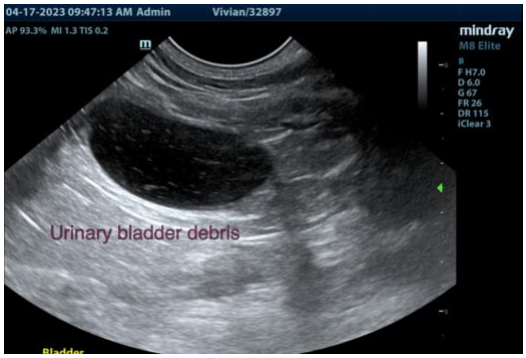

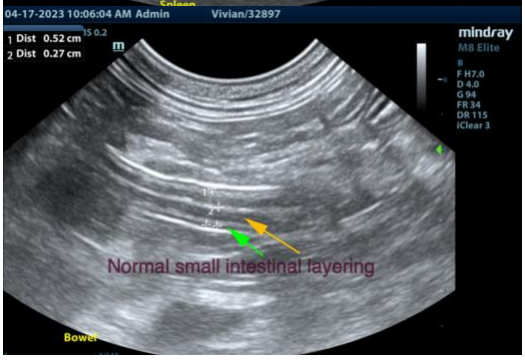

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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