



PATIENT

Tulo Adams

SPECIES

Feline

BREED

Siamese Cross

SEX

Neutered male

AGE

8 years

WEIGHT

3.5 kg

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons), DACVECC

IMAGING PERFORMED BY

Kelly Reshny, RVT

HOSPITAL NAME

Beattie Pet Hospital
Burlington

REFERRING VET

Dr. Murota

INVOICE

43029

DATE

2/28/23

PRESENTING CLINICAL SIGNS

History: lost a good amount of weight and muscle mass since last visit in Nov. BAR/nervous, mm pink, crt <2s Euhydrated, normal skin tent Intermittent V/D Energy is not bad, still plays but is off No coughing, sneezing eat well

Abnormal PE/Chem/CBC/UA Results: November 2023: BW- Mild increase WBC, Neut, SDMA (16), ALT (1470) , fPL WNL -Otherwise NSF, Normal T4, UA- waiting for sample

ULTRASONOGRAPHIC EXAMINATION OF THE

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 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 3.72 cm and the right kidney measured 3.93 cm.

Adrenal Glands

Left adrenal gland was 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 right adrenal gland was not definitively visualized. The left kidney measured 0.54 cm in length x 0.28 cm at the caudal pole and 0.28 cm at the cranial pole.

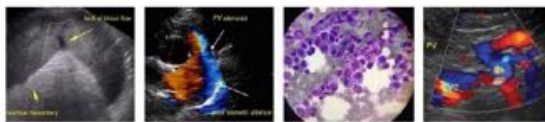
Spleen

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. The parenchyma is hyperechoic to heterogenous with a coarse appearance. 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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Gastrointestinal

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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.

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

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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.

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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.

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Lymph Nodes

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No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

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No masses or free fluid were noted.

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ULTRASONOGRAPHIC FINDINGS

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1. Small intestinal thickening with prominent muscularis
2. Coarse liver parenchyma
3. Degenerative renal changes

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

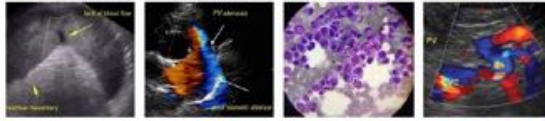
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Small intestinal thickening is most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or GI lymphoma being the top differentials. No overt neoplastic criteria present in the bowel given that curvilinear layering 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.



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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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Liver changes are a common benign age related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. In the face of elevated liver enzymes, fine needle aspirate is recommended to further characterize parenchymal changes, and bile acid profile to assess liver function, especially if any weight loss is noted or for baseline cytological assessment. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.

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

SEX

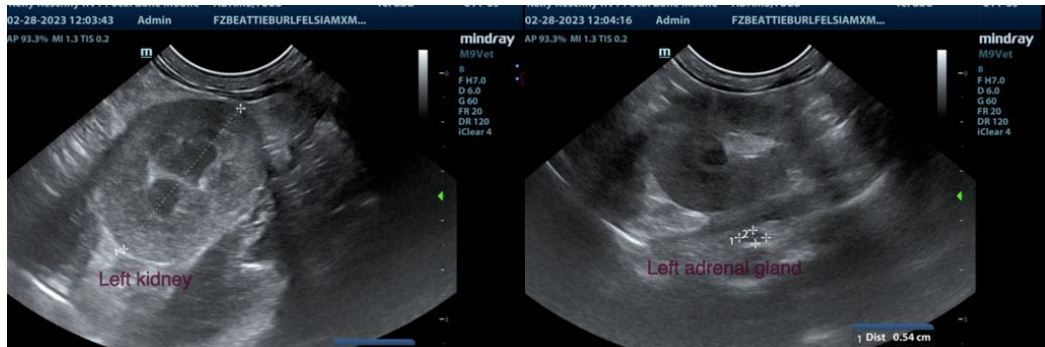
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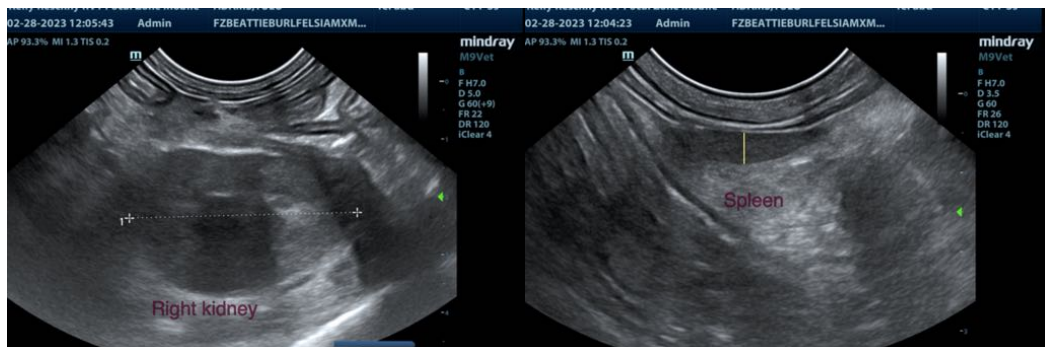
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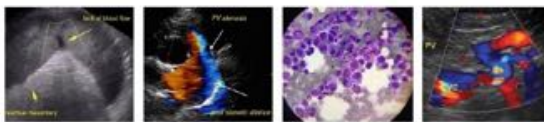


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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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