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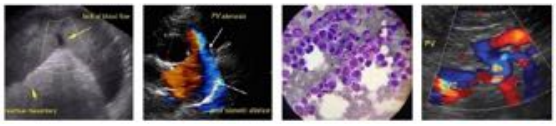

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Belle Durst

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

11 years

WEIGHT

3.66 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Beatties PH Stoney Creek

REFERRING VET

Dr. Salib

INVOICE

43242

DATE

3/13/23

PRESENTING CLINICAL SIGNS

Patient physical exam unremarkable. Vomited 10 times per day and 2 nights ago the vomit appeared pink in colour. Eating and drinking but not as much as normal for her. Has been on Metronidazole and Sulcrate.
Abnormal PE/Chem/CBC/UA Results: Lym 0.37, Chol 5.93, K 3.3, U/A shows RBCs 18/hpf. Rads report : Bilateral chronic degenerative nephropathy with evidence of nephrolithiasis. Possible urinary bladder distension. Gas in small bowel may indicate a mild ileus no obvious obstruction. Some lower airway disease present likely bronchitis or asthma.

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 an irregular capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Hyperechoic shadowing in both renal pelvises with no dilation consistent with non-obstructive nephrolithiasis. The left kidney measured 2.99 cm and the right kidney measured 3.34 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 0.54 cm in length and 0.37 cm at the caudal pole. The right adrenal gland measured 0.46 cm in length and 0.23 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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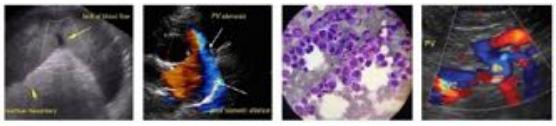

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Gastrointestinal

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 visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. 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.

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

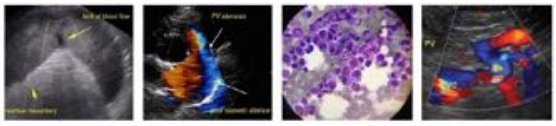
Primary Findings

1. Degenerative renal changes with nephrolithiasis
2. Prominent muscularis layer in small intestine

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

GI changes are consistent with nonobstructive gastroenteritis and in the absence of chronic GI signs, acute gastroenteritis is most likely. While the pancreas appeared sonographically normal, pancreatitis cannot be definitively ruled out. The prominence of the muscularis layer may indicate infiltrative disease of the small intestine such as inflammatory bowel disease or GI lymphoma. No overt neoplastic criteria present in the bowel given that curvilnear layering is still intact. 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.

Treatment is supportive and involves fluid support, GI support (anti-nausea, appetite stimulant), analgesia and enteral nutrition as needed. Antibiotics are generally not warranted. If initial treatments are unsuccessful, treatment for IBD could be considered which includes diet trial with either hydrolyzed



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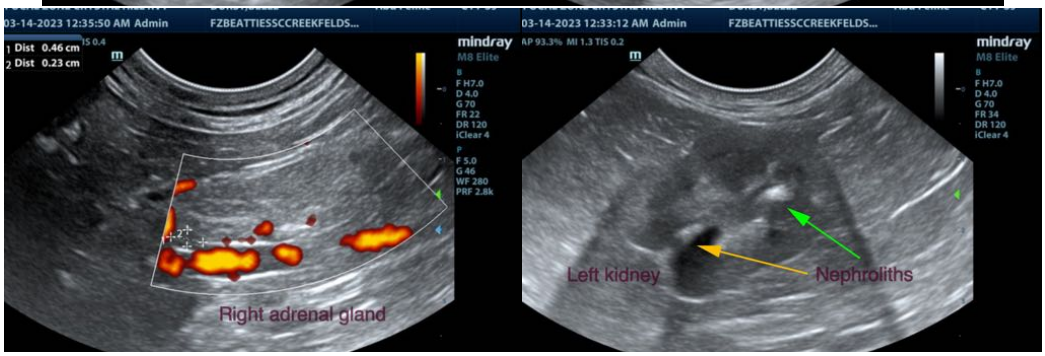
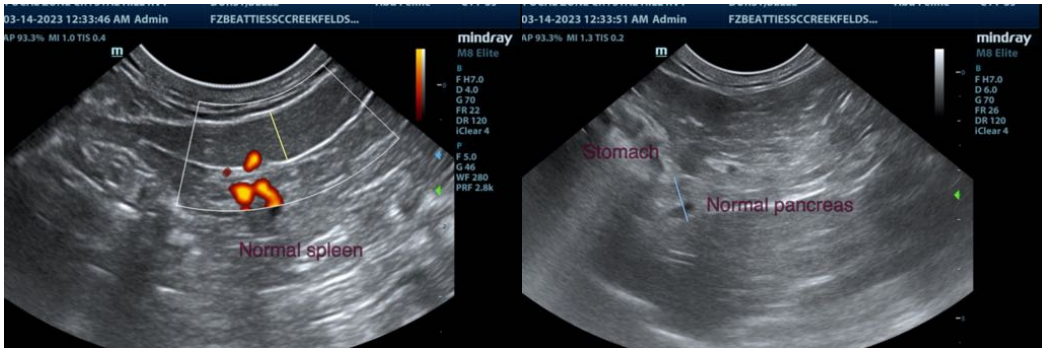
or select protein diet, vitamin b-12 supplementation, and continued GI support as needed. Treatment with steroids (budesonide vs prednisolone) may be required – biopsies should be acquired prior to treatment with steroids.

Renal changes are likely age related degenerative changes. Correlate clinical significance with blood work/urinalysis findings and clinical signs. Nephroliths may act as a nidus of infection and predispose to urinary tract infections. They have the potential to move into the ureters or bladder causing obstructive nephropathy.





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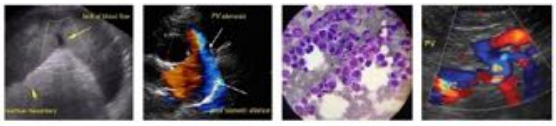

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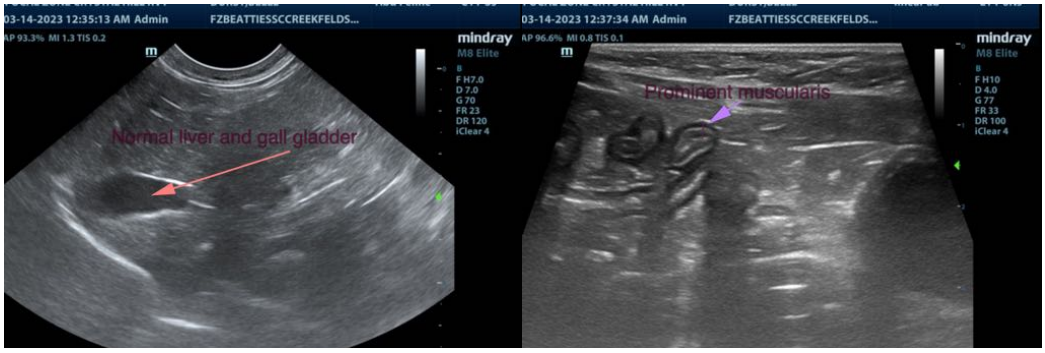

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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