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Clinical Sonography & Telecytology
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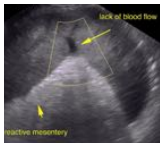
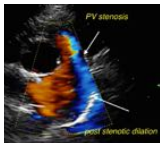
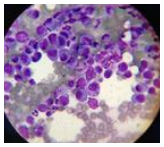
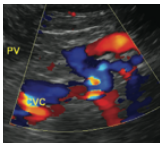

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1-800-838-4268 info@sonopath.com

PATIENT
Sirius Crowell

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
11 years

WEIGHT
9.1 lbs

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

IMAGING PERFORMED BY
Kelly Vasquez

HOSPITAL NAME
Brenda King VS

REFERRING VET
Dr. King

INVOICE
43996

DATE
4/25/23

PRESENTING CLINICAL SIGNS

History: Patient with previous history of weighing 15 lbs when adopted in 2021 and constipation/hard stools, presents today for weight loss, constipation, recurring G.I. issues. R/O IBD vs. lymphoma vs. other. No current meds.
Abnormal PE/Chem/CBC/UA Results: T4/FreeT4/maldigestion panel all WNL.

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 4.22 cm. The left kidney measured 3.92 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 0.63 cm in length and 0.33 cm at the caudal pole. The right adrenal gland measured 0.83 cm in length and 0.43 cm at the caudal pole.

Spleen

The spleen was normal in size with a slightly mottled parenchyma and slightly irregular capsule. Normal splenic vasculature with no signs of congestion or thrombosis.

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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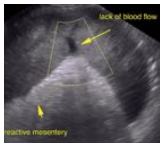
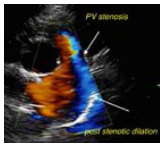
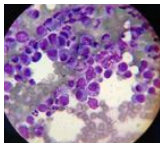
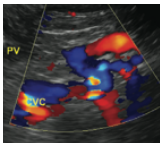

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Gastrointestinal

The stomach contains gas shadowing obstructing visualization of contents with some fluid visualized. 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.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with multiple areas of fluid and gas distension. Some SI loops are fluid distended with back and forth fluid motion giving the impression of reduced peristalsis. No luminal shadowing foreign material. 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 ileocecal junction was visualized and exhibited normal intact wall layering but is thickened.

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.

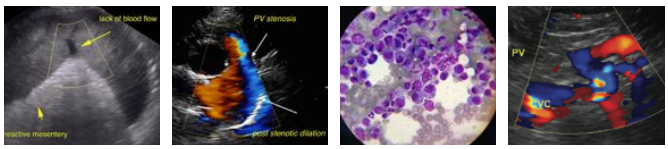
ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Thickened small intestines, prominent muscularis layer, reduced peristalsis
2. Splenic parenchymal changes with smooth capsule
3. Urinary bladder debris

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 curvilnear 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



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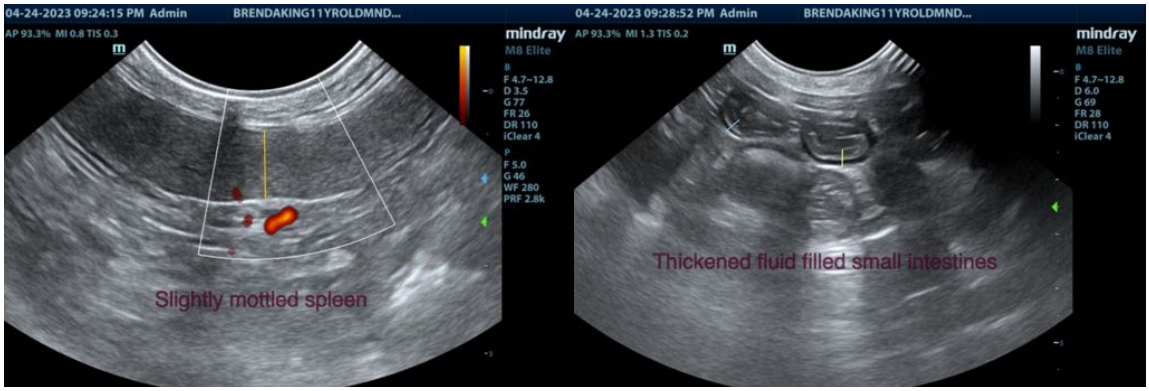
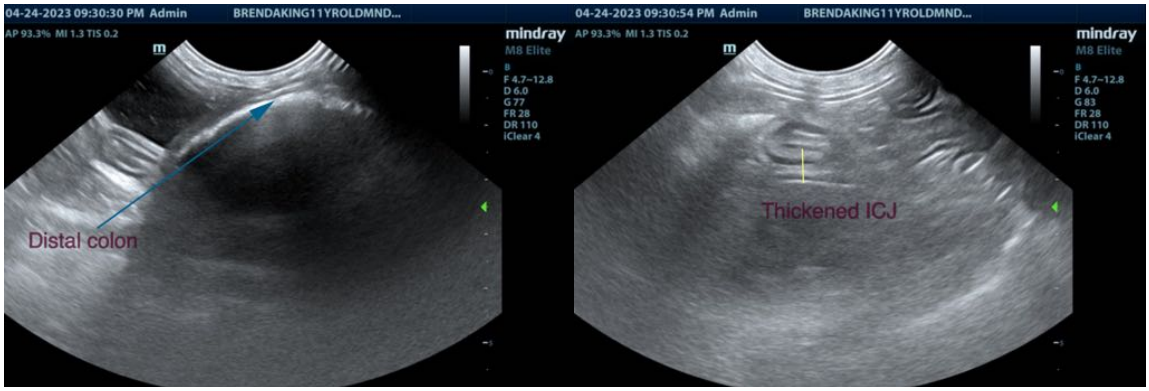
inability to sample more than top 1-2 layers of GI tract and inability to obtain samples from all sections of the GI tract. Surgical biopsies are more likely to be diagnostic but are more invasive. A GI panel (PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin 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.

Splenic changes are a common benign age related change, or may represent reaction to immune stimulation, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. Fine needle aspirate could be considered to further characterize parenchymal changes if clinically indicated, especially as weight loss is noted or for baseline cytological assessment.

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





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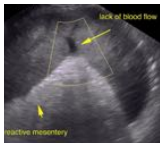
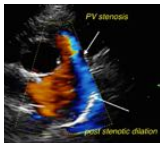
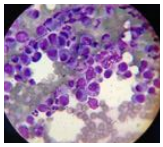
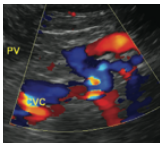

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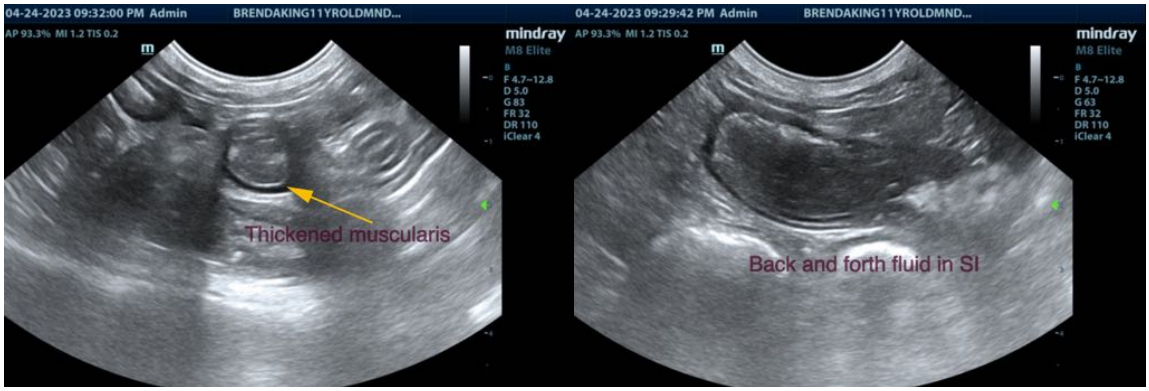

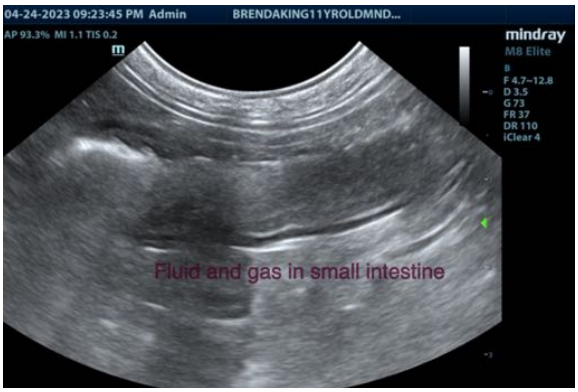

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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