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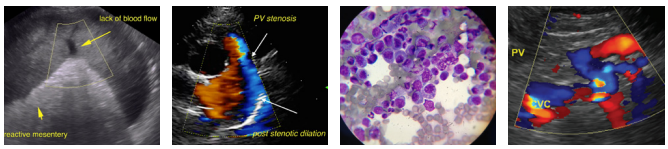

PATIENT

Porchetta Allen

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

11 Years

WEIGHT

7.9 Pounds

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Sarah Green

HOSPITAL NAME

Healing Spirit

REFERRING VET

Dr. Izaan du Toit

INVOICE

35198

DATE

1/30/22

PRESENTING CLINICAL SIGNS

Referred by another practice due to vomiting, decreased appetite and weight loss
Abnormal PE/Chem/CBC/UA Results: mild hyperglycemia CBC, chemistry, T4 otherwise unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 3.0 cm.

Adrenal Glands

The regions of the **adrenal glands** were unremarkable.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

Gastrointestinal

The upper **gastrointestinal tract** revealed stasis with a stricturing mass in the jejunum. The obstructive pattern was followed by empty small intestine.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

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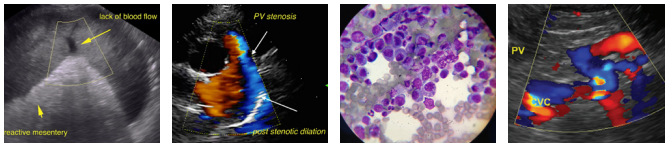

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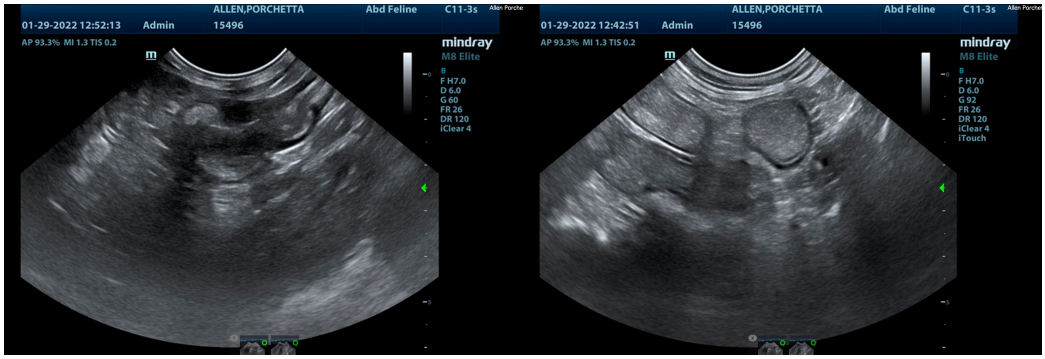
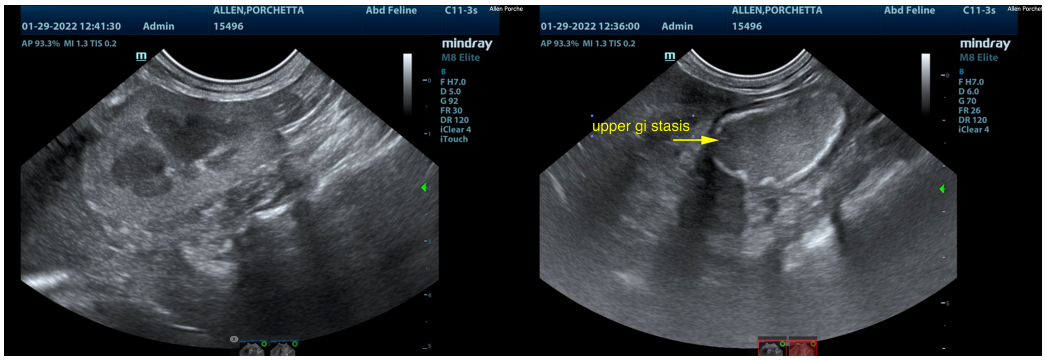
ULTRASONOGRAPHIC FINDINGS

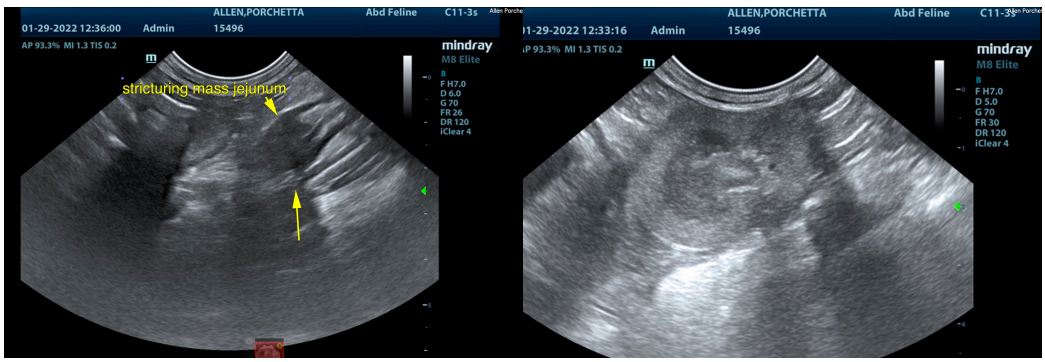
- Stricturing small intestinal mass, presumed to be jejunum, obstructive – carcinoma versus focal lymphoma or stricturing granulomatous disease all possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Surgical intervention with expectation towards resection and anastomosis warranted. Some material in the upper GI lumen was shadowing. Concurrent foreign matter may be present. 3-view chest radiographs warranted prior to surgical intervention. Structurally, the lesion appears to be isolated. The ileocecal region was not identified. However, given the position and the pattern of the stricturing structure, it is presumed to be jejunum. The portion of intestine in question measured approximately 3.0 cm. Therefore, a 4-6 cm resection and anastomosis warranted. I cannot completely rule out that this area is actually the ileocecal junction. However, it appears abnormal and should be resected regardless.







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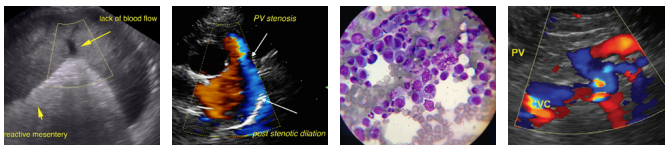

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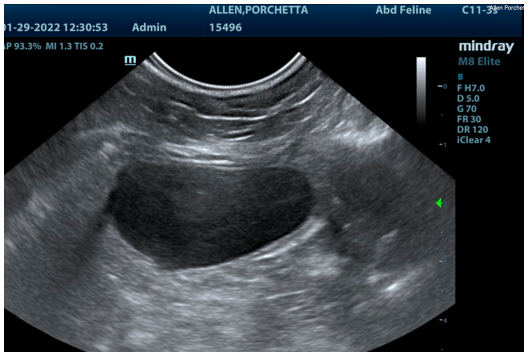

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com