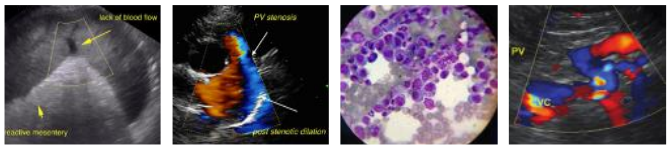
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™




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

**PATIENT**

Nuni Chardhary

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

3 Years

**WEIGHT**

4.75 kg

**INTERPRETED BY**

Eric Lindquist, DMV DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Dr. Belan

**HOSPITAL NAME**

McKnight 24 Hour

**REFERRING VET**

Dr. Gruffyyd

**INVOICE**

13803

**DATE**

2/6/22

## PRESENTING CLINICAL SIGNS

History: Inappetent last 3 days Scant Peritoneal fluid on AFAST

Abnormal PE/Chem/CBC/UA Results: Mild leukocytosis and lymphocytosis. Mild elevation GGT and Bil. UA taken at time of scan - pending FIP and FLV snap negative.

## 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** appear subjectively swollen yet retain structure. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 3.8 cm. The right kidney measured 4.39

### *Adrenal Glands*

The **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 left adrenal gland measured 0.34 cm.

The region of the **right adrenal gland** revealed no evident pathology.

### *Spleen*

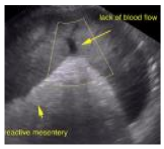
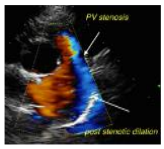
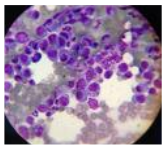
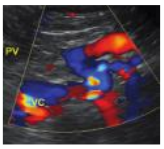
The **spleen** was mildly enlarged with subtle micronodular changes. The spleen measured up to 1.14 cm. Regional free fluid was present.

### *Liver*

The **liver** revealed slight swollen contour. The gallbladder and common bile duct were unremarkable. Portal vein to vena cava ratio was 1:1.

### *Gastrointestinal*

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. No concerning lymphadenopathy was visible. No evidence of obstruction was present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as lymphoma. Full thickness tissue biopsies via open laparotomy, ideally guided by intraoperative ultrasound in order to obtain the most representative mural sample, would be necessary to rule out this possibility. This is a mild change. The stomach revealed a minor amount of stasis. Reactive mesentery was noted around the stomach and gastric walls, measurably normal at 0.2 cm. Reactive mesentery was noted around the small intestines with localized free fluid was present.

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### *Pancreas*

The **pancreas** was hypoechoic with undulating contour.

### *Free Abdomen*

The mesenteric **lymph nodes** (up to 0.6 cm) presented normal length to width ratio with slight, swollen contour. There was no loss of parenchymal detail. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.

## ULTRASONOGRAPHIC FINDINGS

- Variable intestinal thickening
- Reactive lymphadenopathy
- Periserosal inflammation around the stomach and small intestine
- Slight splenic enlargement with regional free fluid
- Hypoechoic pancreas
- Subjectively swollen kidneys- assessment for any inflammatory sediment warranted.
- Liver, swollen contour

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominocentesis of the free fluid with cytospin recommended to ensure exfoliating neoplasia such as mast cell is not an issue. FNA of the spleen could be considered as well as the accessible lymph nodes. Likely acute on chronic inflammatory bowel with pancreatitis and reactive spleen/splenitis, mild potential for emerging round cell neoplasia. Further diagnostics recommended. A clinical trial of the following may prove effective. Pain management recommended.

**Triaditis/Pancreatitis protocol**

Part or all of this protocol may be considered based on your clinical impression of the patient:

Recommend pain management when anorexic with **Buprenorphine** (0.01-0.02 mg/kg IM or SC), clinical trial of **Zithromax** (50 mg sid/cat x 10 days, 3 weeks if bartonella +), **Prednisolone** (0.5-2 mg/kg tapering over 1 week to minimal effective dose), and **B12 injections** if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet (***Hydrolyzed diets have been shown to be more effective in dietary intolerance case management compared to hypoallergenic diets***)** or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes a persistent issue then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. One diet does not work for all patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.

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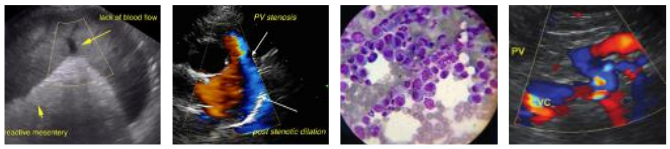

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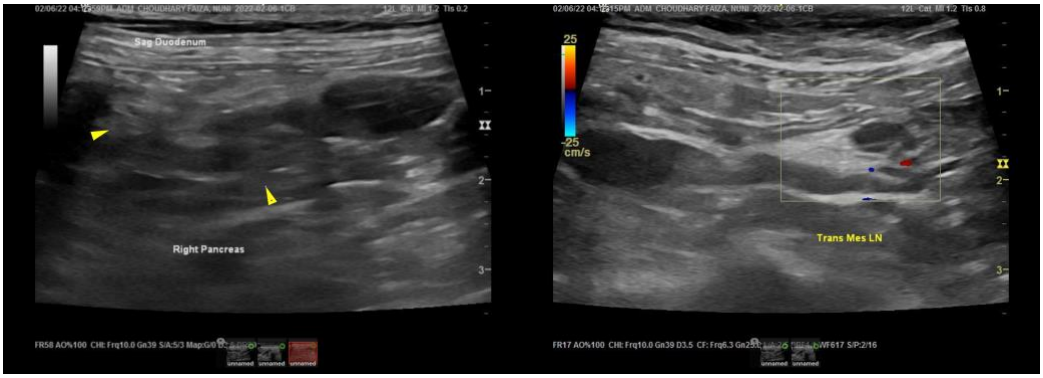


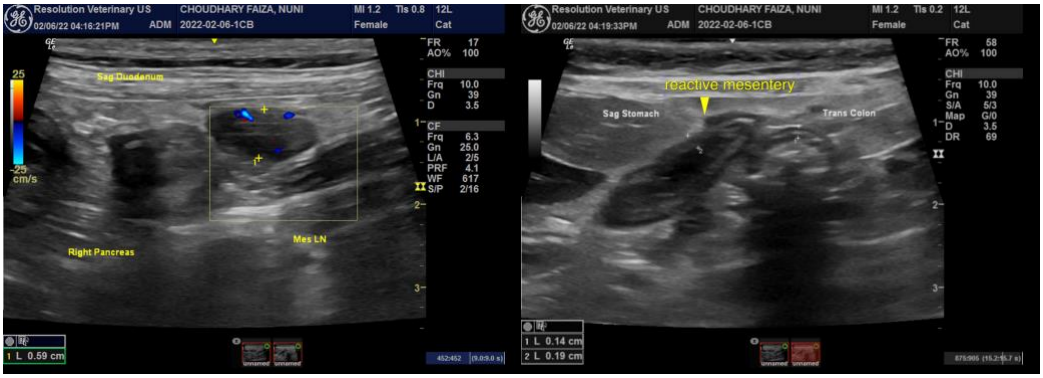


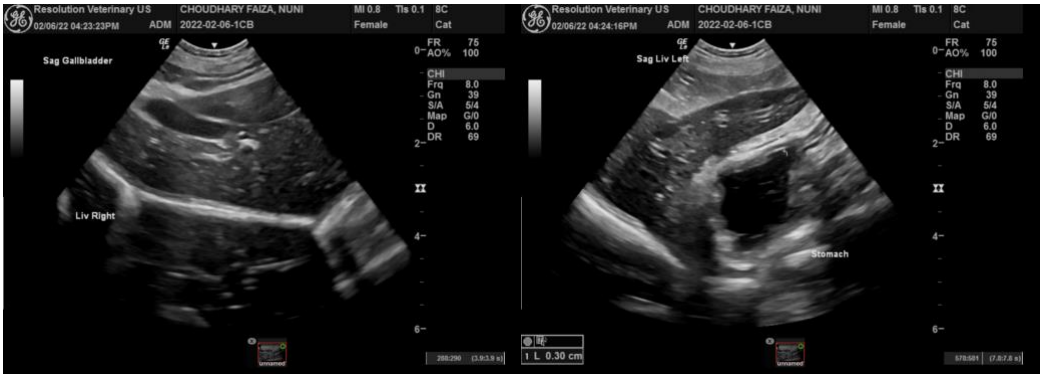


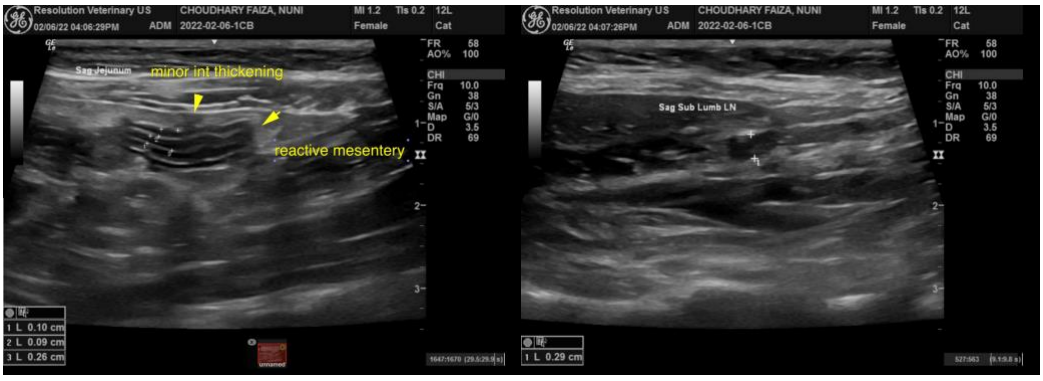

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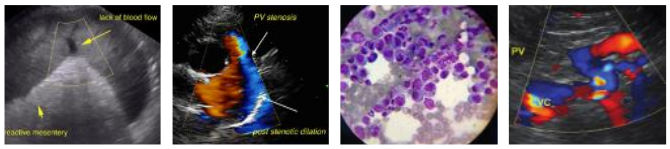

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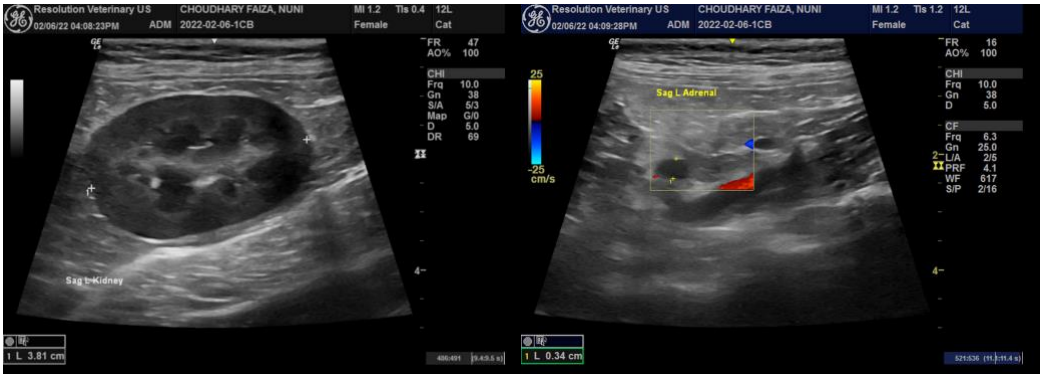


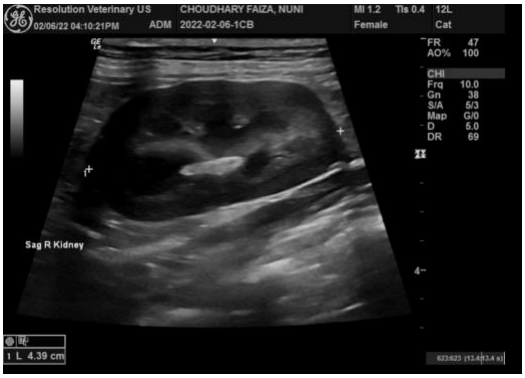


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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