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Clinical Sonography & Telecytology

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DATE

3/31/23

PATIENT

Topaz Rutherford

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

1/10/09

WEIGHT

5.7 Pounds

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

HOSPITAL NAME

Parkville AH

REFERRING VET

Dr. Jess

INVOICE

46361

PRESENTING CLINICAL SIGNS

Vomiting, diarrhea, weight loss, decreased appetite, polydipsia. Exam 3/39: underweight, lost an additional 0.2 lbs., dehydrated, some thickened small intestinal bowel loops.

Current Medications: Owner tried Vitamin B12 inj for 4-5 weeks starting 2/2. No improvement w/ symptoms. Also tried Hill's Z/D, pet refused.
Lab Results: 1/18/23 GI PANEL: CBC, CHEM, and Total T4 were WNL. Her Spec fPL was slightly elevated at 3.8 (range: 0-3.5 ug/L). Cobalamin (B-12) was <150 (range: 276-1425 ng/L). Folate was >24 (range: 8.9 19.9 ug/L).. 3/29/23: CBC/Chem 17/Lytes - Normal; T4 - 1.2; Unable to get a urine sample - bladder empty
Date of Previous IntraPet Ultrasound: No previous.
Sedation: sedation was declined.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

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 right kidney measures 3.5 cm. The left kidney measured 3.23 cm.

Adrenal Glands

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

Spleen

The **spleen** in this patient was uniform, yet volume contracted. Hydration status should be assessed.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

The **stomach** was severely overdistended with chyme. Mild pyloric thickening noted. Significant stasis noted in the gastric fundus to the level of the gastroesophageal inlet. The upper duodenum appeared to be mildly thickened without overt evidence of neoplasia. Minor variable intestinal thickening noted elsewhere. The gastric stasis appeared to finish at the upper duodenum with partial obstructive or delayed outflow pattern. Areas of mucosal fogging noted in the small intestine as well, which is an idiopathic finding but may be related to malabsorption.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat.

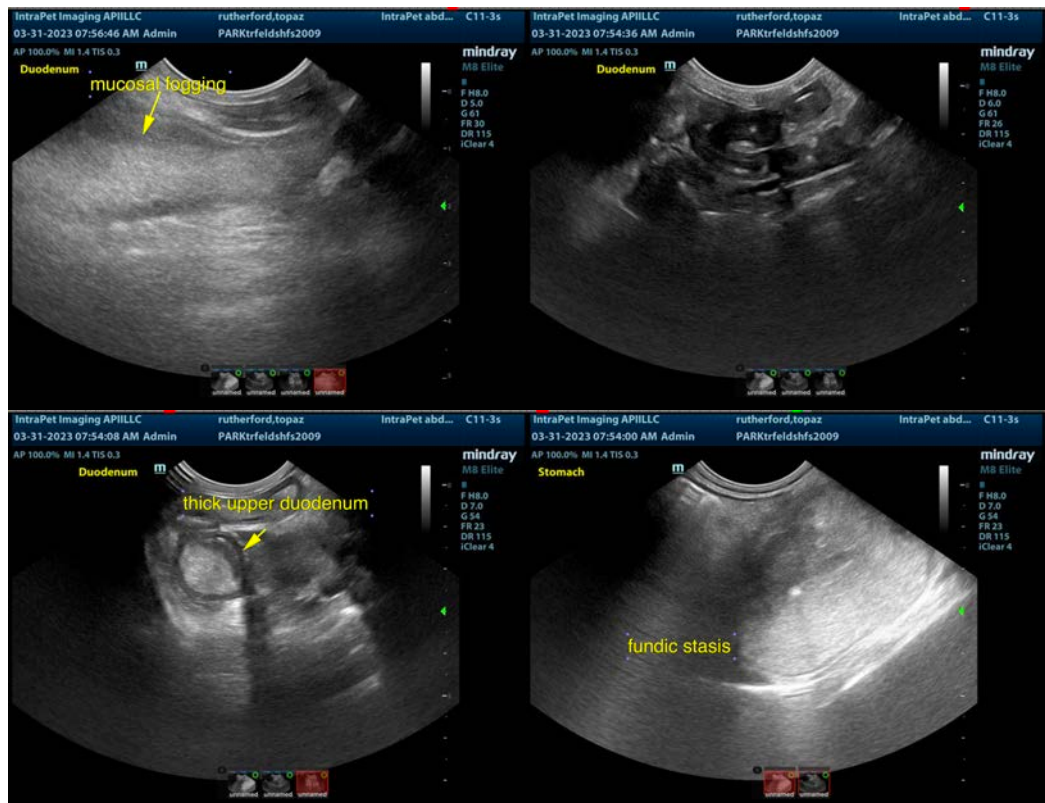
Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. Dilated pancreatic duct noted. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

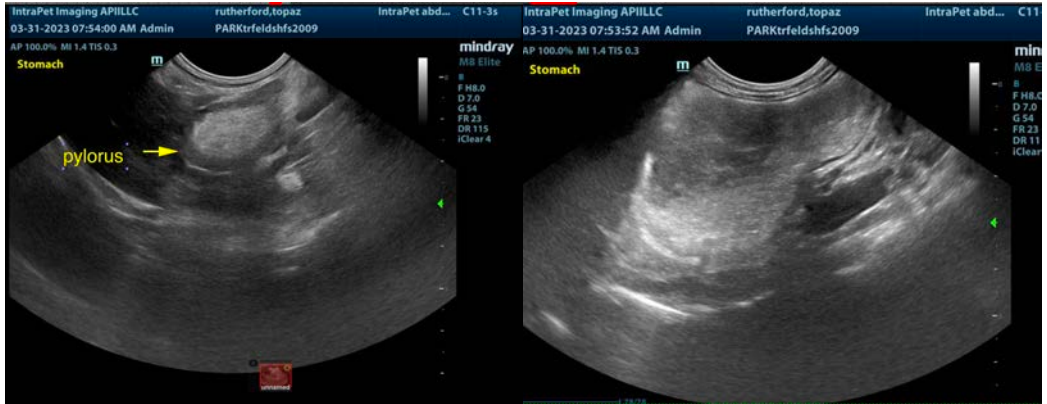
ULTRASONOGRAPHIC FINDINGS

- Pyloroduodenal thickening with gastric stasis/ileus presentation
- Chronic active pancreatitis suspected
- Regional dysfunctional bowel

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt evidence of neoplasia. However, emerging round cell neoplasia could not be ruled out. Full thickness GI biopsies warranted with manual palpation of the pyloric outflow. Pancreatic biopsies are also indicated to assess for emerging round cell neoplasia. Otherwise, chronic inflammatory bowel with malassimilation of nutrients possible with regional dysfunctional bowel causing delayed outflow pattern.





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.

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