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Clinical Sonography & Telecytology

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**DATE**

4/6/22

**PATIENT**

Lily Harley

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

8/8/07

**WEIGHT**

7.17 Pounds

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Rachel Brilhart RDMS

**HOSPITAL NAME**

Cat Hospital at Towson

**REFERRING VET**

Dr. Slaughter

**INVOICE**

36781

**PRESENTING CLINICAL SIGNS**

Weight loss, vomiting hairballs.

Current Medications: None.  
Date of Previous IntraPet Ultrasound: No previous.  
Sedation: Declined.  
Stat Report: Not requested.

**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. The left kidney measured 3.77 cm with pyelectasia of 0.41 cm. A pelvic calculus was noted in the left kidney. The right kidney measured 3.44 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 right adrenal gland measured 0.41 cm.

**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. A hypoechoic left cranial liver nodule noted, measuring 0.96 cm x 0.57 cm. 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 **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with 1:1 muscularis/mucosal ratio. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. Wall thickness measured 0.31 cm. 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. Reactive mesenteric lymph nodes measured 2.16 cm x 0.73 cm and 1.13 cm x 0.68 cm.

### **Pancreas**

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

### **ULTRASONOGRAPHIC FINDINGS**

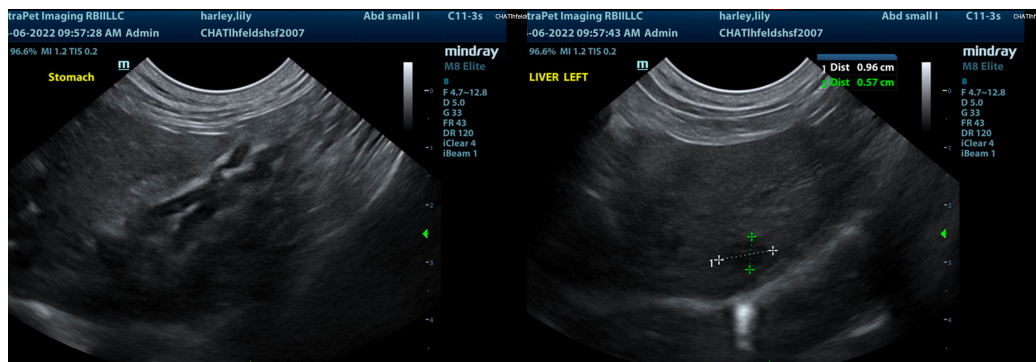
- Diffuse intestinal thickening without neoplastic criteria
- Reactive mesenteric lymph nodes
- Hepatic nodules
- Age related renal changes with pyelectasia

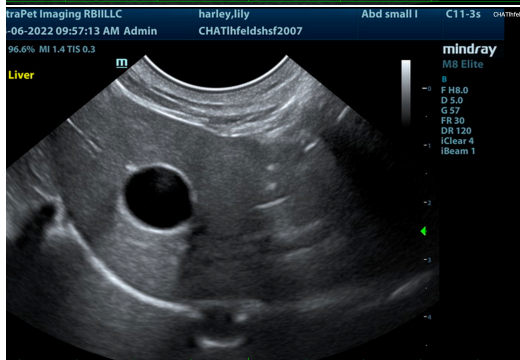
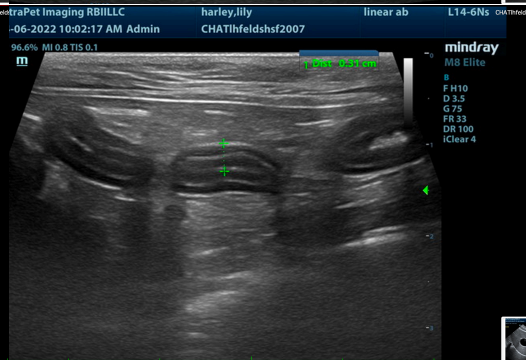
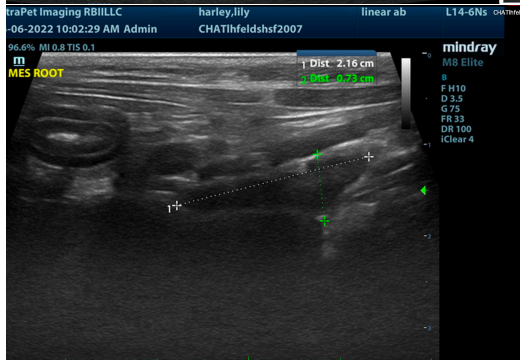
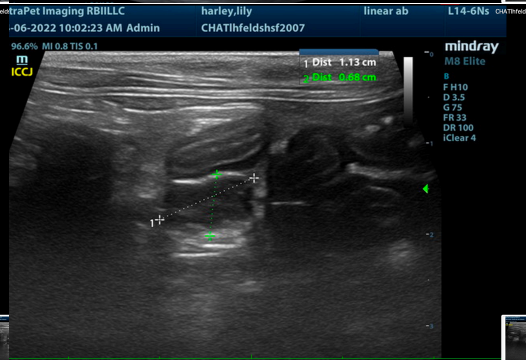
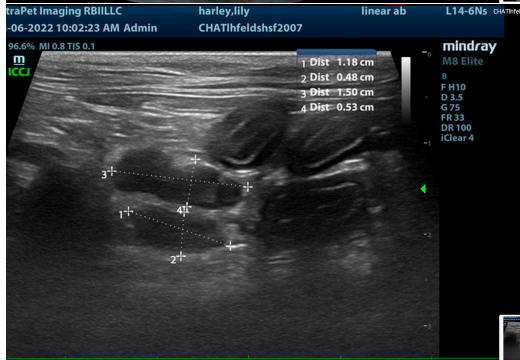
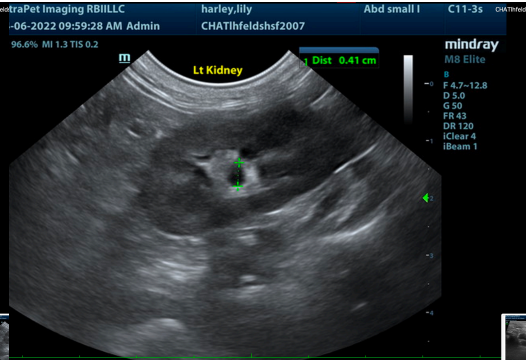
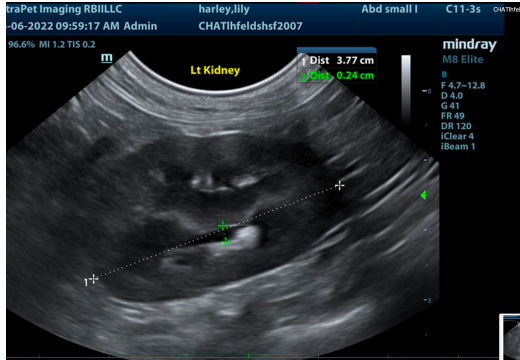
### **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Inflammatory bowel with lymphadenitis probable. Emerging round cell neoplasia possible. A clinical trial of the following may prove effective. However, diet change and anti-parasitic protocol are likely most appropriate. Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

### **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.





**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  
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