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Clinical Sonography & Telecytology
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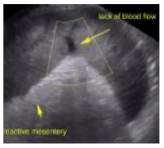
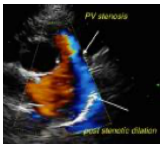
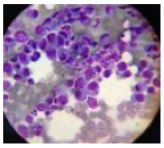
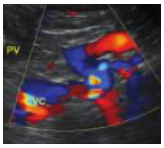





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Kaitlin Reid

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

14 years

WEIGHT

9.24 lbs

INTERPRETED BY

Karen Ebersole, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Marti Williams

HOSPITAL NAME

Limestone VH

REFERRING VET

Katie Williams

INVOICE

14028

DATE

8.10.23

PRESENTING CLINICAL SIGNS

History: Kaitlin, a 14 yr FS DSH, presented for a weeklong duration of vomiting. She was vomiting clear liquid/foam twice daily and did not seem to be holding food down. Weight loss (9.24 lb, was 11.43 lb). Physical exam unremarkable. Ate following Elura and kept contents down while on Cerenia. On radiographs, stomach is mildly gas-distended and there was concern for small intestinal thickening. Otherwise the radiographs (full-body) were unremarkable.

Abnormal PE/Chem/CBC/UA Results: Assessment: Anemia, otherwise NSF ALT: 118 (10-100); SDMA 22.5 (<15); Na/K ratio 31 (32-41); CPK 1253; HCT: 26 (29-48); Hgb 8 (9.3-15.9); RBC 5.6 (5.92-9.93). Platelet Count 148 (200-500) - adequate count. Lymphocytes: 636 (1200-8000)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in size and shape. The serosal and mucosal surfaces were smooth and curvilinear. The bladder wall was normal in thickness for the volume of urine present. The urine was anechoic with no visible sediment or uroliths. The ureters were not visible, which is normal. The trigone was normal. The pelvic urethra was visualized to a depth of 2.00 cm and was normal in thickness and tone.

Both kidneys were of a normal size, shape, and position. The capsule was mildly irregular with no capsular expansion. There was mild to moderate increase in cortical echotexture. A slightly asymmetrical 1:3 cortex to medulla ratio was present, with a mild loss of corticomedullary distinction. These changes are largely as expected for the age of the patient. There was no pelvic dilation. The left kidney measured 3.00 cm in length. The right kidney measured 3.20 cm in length. There were diffuse pinpoint hyperechoic densities in the renal cortex. These may represent cortical mineralization, fibrosis or microinfarcts.

The iliac trifurcation has normal vascular perfusion with no evidence of thrombus formation. There was no iliac lymphadenopathy.

Adrenal Glands

Both adrenal glands were visualized and normal in size, ovoid shape and homogenous parenchyma. There was no visible capsular expansion or pericapsular inflammation. The left adrenal gland measured 3.00 mm in width. The right adrenal gland measured 3.00 mm in width.

Spleen

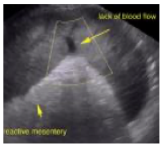
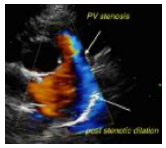
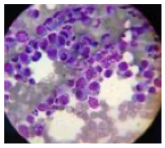
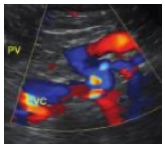
The spleen was mildly enlarged in size with a mildly rounded capsule contour. The parenchyma was finely-to-coarsely textured with no overt nodules or masses. The spleen was 8.00 mm wide at the hilus.

Liver/Gallbladder

The liver was normal in size and shape, with a smooth capsule contour. The hepatic parenchyma displayed normal echotexture and normal portal markings. The hepatic vasculature was normal in volume and structure. There was no evidence of inflammatory, neoplastic, infectious, or infiltrative disease. The gallbladder was normal in size and contents. The cystic and common bile ducts were normal with no evidence of obstruction or inflammation.

Gastrointestinal

The stomach was empty with normal wall thickness and layering. The pylorus was visualized and was empty and appeared normal in structure. The small intestinal walls were diffusely thickened with a prominence of the muscularis layer. Wall layering was maintained except for a small section, where the wall layering may be lost. In this area, the wall thickness measured 5.00 mm thick and extended for approximately a distance of 1.80 cm. This may represent Inflammation or early neoplastic changes. The mesentery around the midabdomen small intestines was hyperechoic, likely representing inflammation. There were several

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mesenteric lymph nodes that were enlarged at the mesenteric root. The mesenteric lymph nodes were hypoechoic and mildly rounded. The visible colon wall was normal in wall thickness and layering.

Pancreas

The pancreas was mildly prominent with a mildly irregular capsule contour. The parenchyma was largely heterogenous. The pancreatic duct was mildly tortuous. There was a section of the base of the left pancreas that was hypoechoic, possibly representing more acute inflammation. There were no overt nodules or masses present in the pancreas.

Free Abdomen

FINDINGS

- Diffuse intestinal wall thickening with segmental potential for loss of wall layering
- Mild mesenteric lymphadenopathy
- Mild splenomegaly with rounded capsule – ddx splenitis or potential for emerging neoplasia
- Aging changes in both kidneys

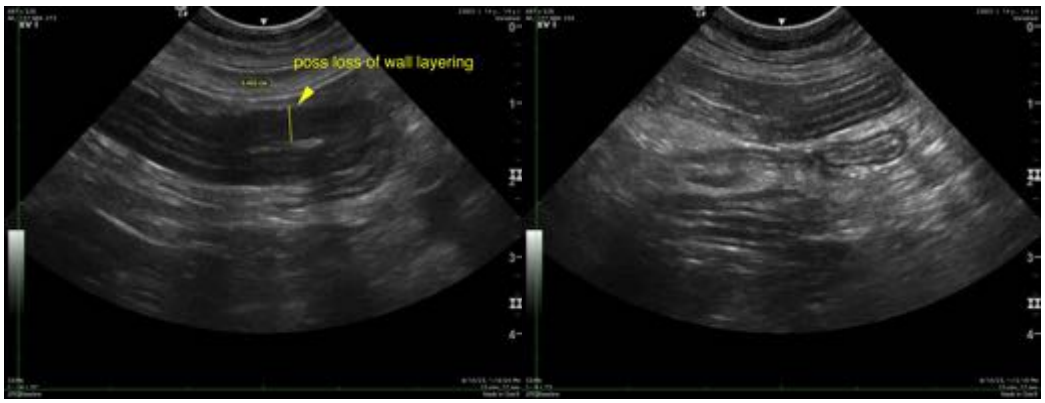
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The clinical and sonographic presentation is most consistent with IBD; however, biopsies would be needed to confirm (either endoscopy if able to reach the affected area or surgical full thickness biopsies). Other potential causes, such as lymphoma and FIP can also present in this way at times, though they are considered less likely in this case given the lack of significant weight loss. A GI panel is recommended (PLI, TLI, Cobalamin and Folate; TAMU GI assays)

The segment of small intestine that has potential for wall layering could represent focal inflammatory disease or potential for emerging neoplasia. Ideally, sampling would be done, particularly on this section.

Treatment options may include any or all of the following:

- GI support as needed (Cerenia, Miratazpine, etc)
- Hydrolyzed diet trial
- Cobalamin supplementation (0.25 mg/250mcg SQ q 7 days x 4 weeks)
- Prednisolone 1-2 mg/kg per day or Budesonide 0.5 - 0.75 **mg/cat** PO SID (not per mg/kg)
- High potency probiotics (Visbiome or Fortiflora SA).



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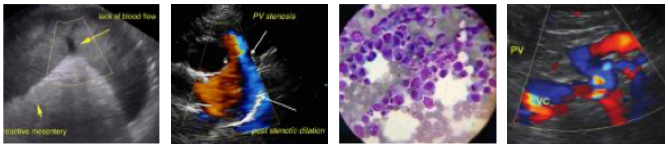

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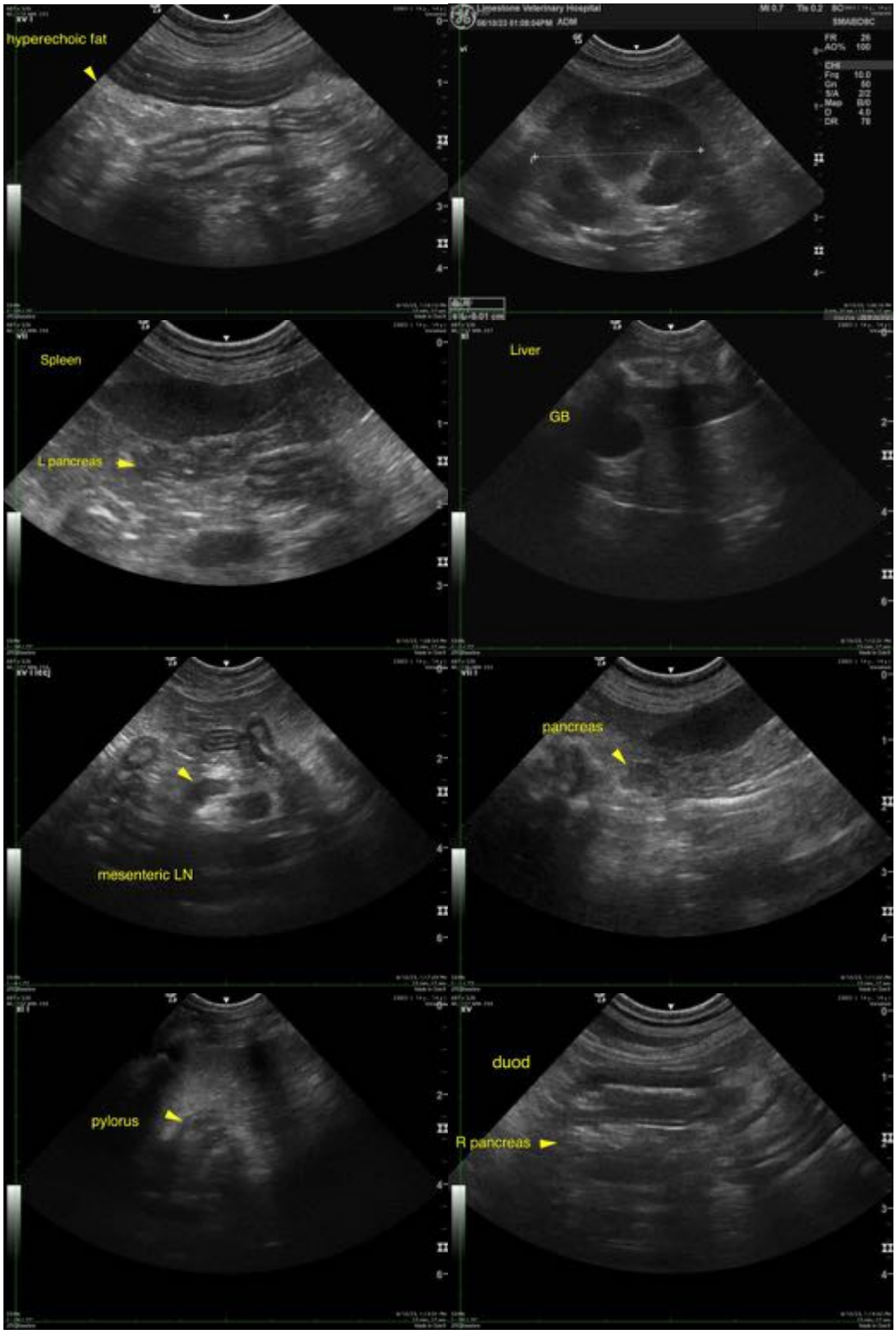

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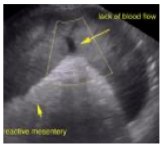
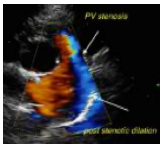
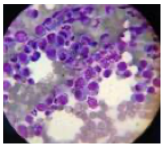
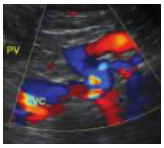

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Karen Ebersole, DVM, DABVP (Canine and Feline practice)
info@SonoPath.com