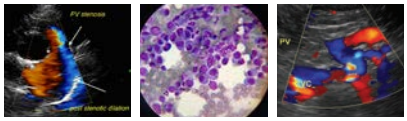
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

1/25/23

PATIENT

Josie O'Connell

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7/1/11

WEIGHT

9.9 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

PetVet of Clarksville

REFERRING VET

Dr. Martof

INVOICE

44514

PRESENTING CLINICAL SIGNS

Decreased appetite, straining to defecate, dull haircoat, possible desc musc mass (Os notice at home) - r/o flare up of chornic GI disease (IBD vs. other) vs. progression (GI lymphoma) vs. other systemic disease (primary vs. exacerbating GI dz) -- Stable weight (loss since 2020 but stable more recently). Hx chronic vomiting; Hx of frank blood on stool (occasionally), mucous on stool, malodorous stool, soft stool

Current Medications: None.
Lab Results: senior screen wnl, creatine kinase 532, AST 115 (16-67), pro bnp 24, no urine sent yet
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The Bladder wall is diffusely mildly thickened (0.46 cm), and the mucosa is mildly irregular. The trigone, ureteral papillae, and visible urethra (to a depth of 2cm) appear normal with no evidence of severe mucosal irregularities, masses or cystic calculi. Findings are most consistent with bacterial cystitis or lack of urine distension. Recommend urinalysis and culture.

The left kidney measures 2.88 cm and is irregular, likely due to previous infarcts. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney measures 4.0 cm and is irregular, likely due to previous infarcts. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.39 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.40 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is normal/borderline large in size (1.0 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized. This is likely normal for a slightly larger cat.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measures 0.28 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. The distal colon wall appears somewhat thickened and irregular, measuring at 1.4 cm in the sagittal view.

Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Subjectively mildly thickened urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.

- Decreased corticomedullary distinction in both kidneys with evidence of previous infarcts – The bilateral renal findings are consistent with age-related change.

- Focal thickening of the distal colon – There is no overt mass effect. Possible differentials would include inflammation, infection, or infiltration (neoplastic infiltration, granulomatous disease, etc.).

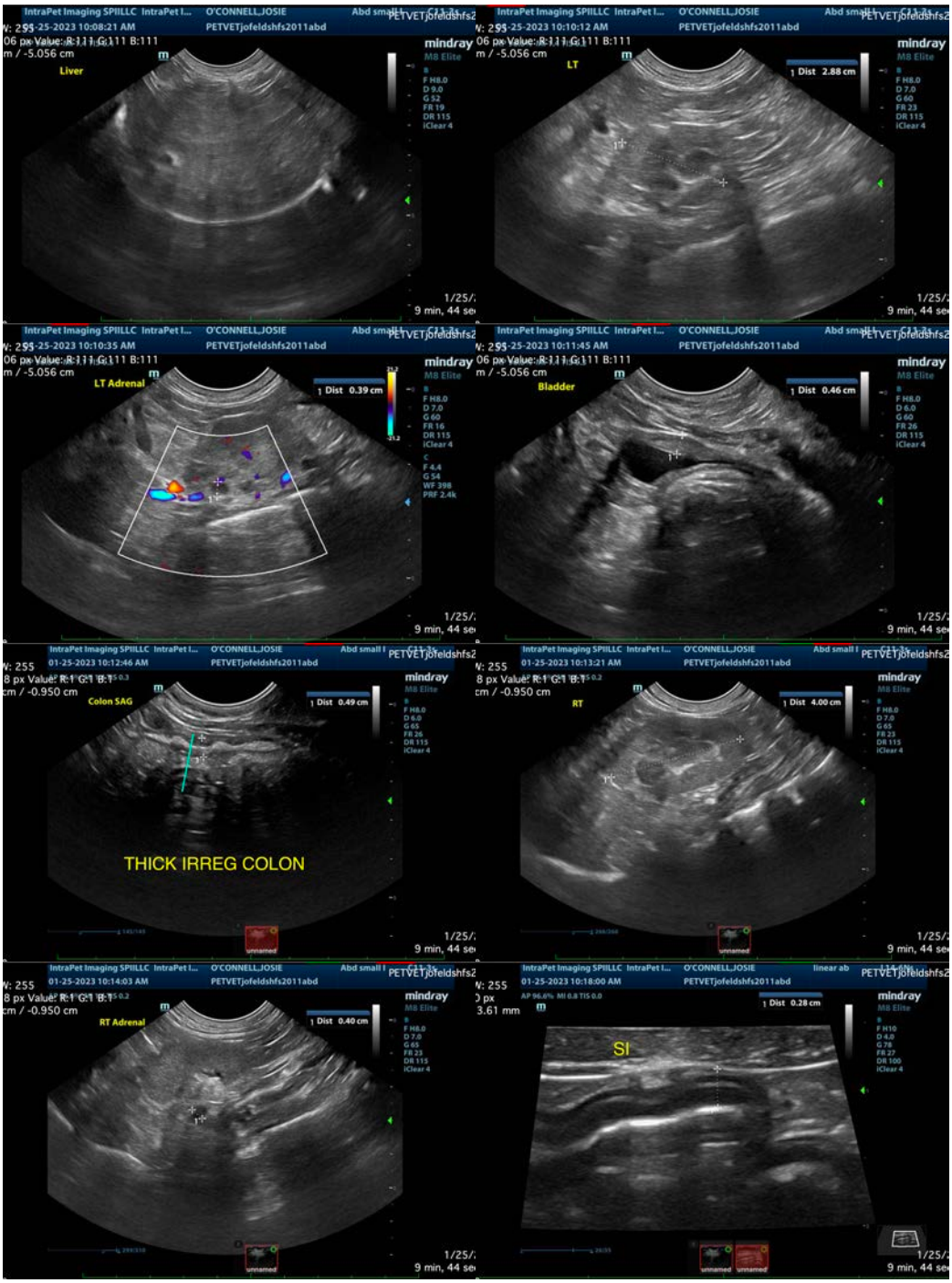
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

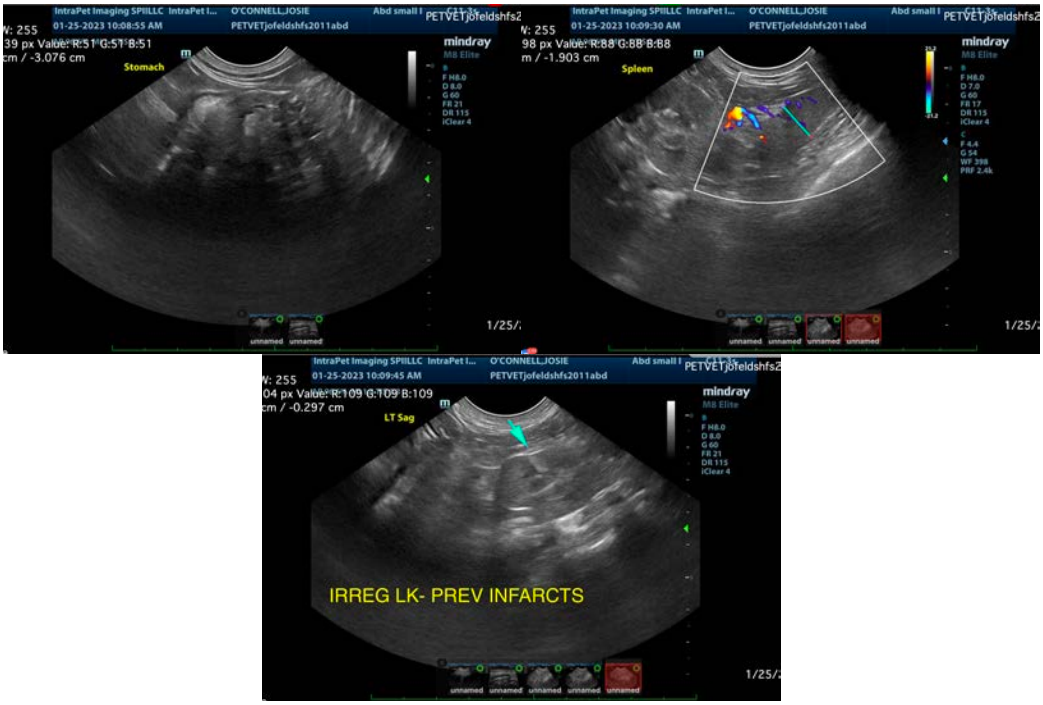
The distal colon appears somewhat thickened and abnormal. This could be due to chronic inflammatory changes, granulomatous disease, etc., or could be due to infiltrative disease such as neoplasia (carcinoma, round cell neoplasia, etc.). No focal lesions were visualized associated with the upper GI tract. Consider a colonoscopy to further evaluate the colon and obtain biopsies of the colon wall. Additionally, you could consider an upper GI endoscopy at the same time, looking for any evidence of gastric or small intestinal disease, which could be contributing to the vomiting.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

The changes observed associated with the urinary bladder and kidneys are likely incidental/age related at

this time. Recommend urinalysis and culture and reevaluation of the urinary bladder when it is more distended with urine.





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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