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DATE PRESENTING CLINICAL SIGNS

10/18/22 Straining to defecate for a few weeks with vocalization. Stools are small/compressed and ribbon like. Having BMs outside the box. Pet still eating but appetite down. Physical exam was overall unremarkable. Rectal exam was wnl, anal glands were normal.

PATIENT

Boots Grabowski Current Medications: None listed.

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

7/19/10

WEIGHT

14 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brillhart RDMS

HOSPITAL NAME

Greenbrier Vet Clinic

REFERRING VET

Dr. Boccanfuso

INVOICE

42128

Lab Results: CBC/Chem unremarkable.

Radiographs: overall unremarkable, maybe some narrowing of the colon around the level of the bladder but no obvious mass effect or obstruction.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.42 cm). Overall echogenicity is normal with adequate 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 has a normal shape and size (4.23 cm). Overall echogenicity is normal with adequate 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 0.40 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 0.50 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 subjectively normal in size (0.95 cm in width at the level of the hilus), 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.

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 appears bilobed. The lumens are moderately distended. The walls of the gall bladders are not thickened and have 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. The duodenum measured as normal (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) 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. There is a section of distal colon starting around the trigone or just distal to the trigone where the wall of the colon becomes severely thickened. Normal colon thickness proximal of this area is 0.22 cm. In the thickened region the colon wall measures 0.62 cm, and diameter of the colon is 1.33 cm. There is loss of layering in this region and the wall appears hypoechoic.

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. There is a lymphadenopathy in the caudal abdomen. The sublumbar lymph nodes are prominent and hypoechoic, measuring 0.82 cm and 0.84 cm. The omentum is hyperechoic in the caudal abdomen.

PRIMARY FINDINGS

- Thickening and loss of layering of the distal colon wall – Findings are concerning for infiltrative disease such as round cell neoplasia, carcinoma, etc., although severe colitis, fungal disease, etc. cannot be excluded as a possibility.
- Caudal abdominal lymphadenopathy – The moderate mesenteric lymphadenopathy is most concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick born disease-such as bartonella, fungal infections, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.

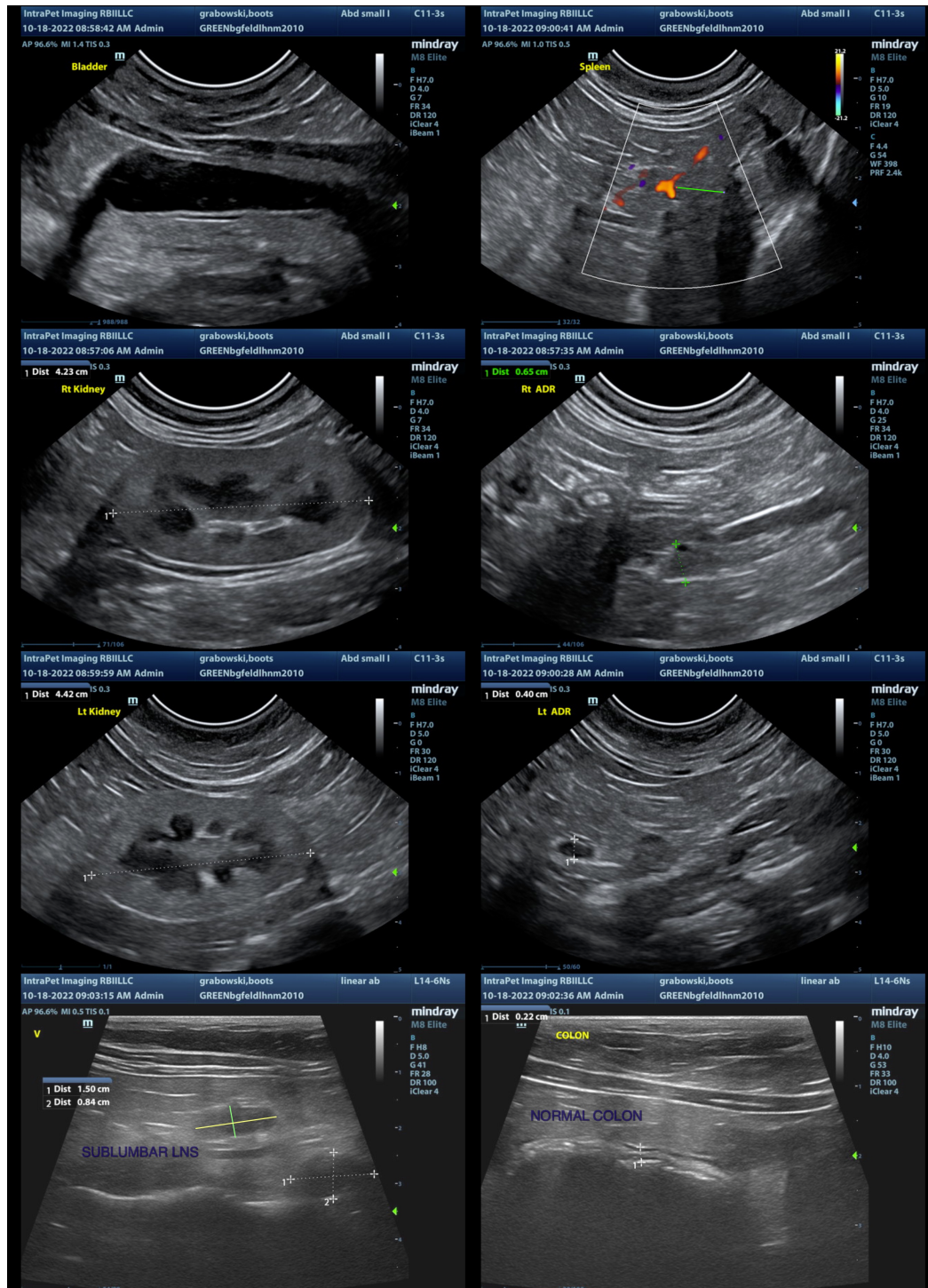
SECONDARY FINDINGS

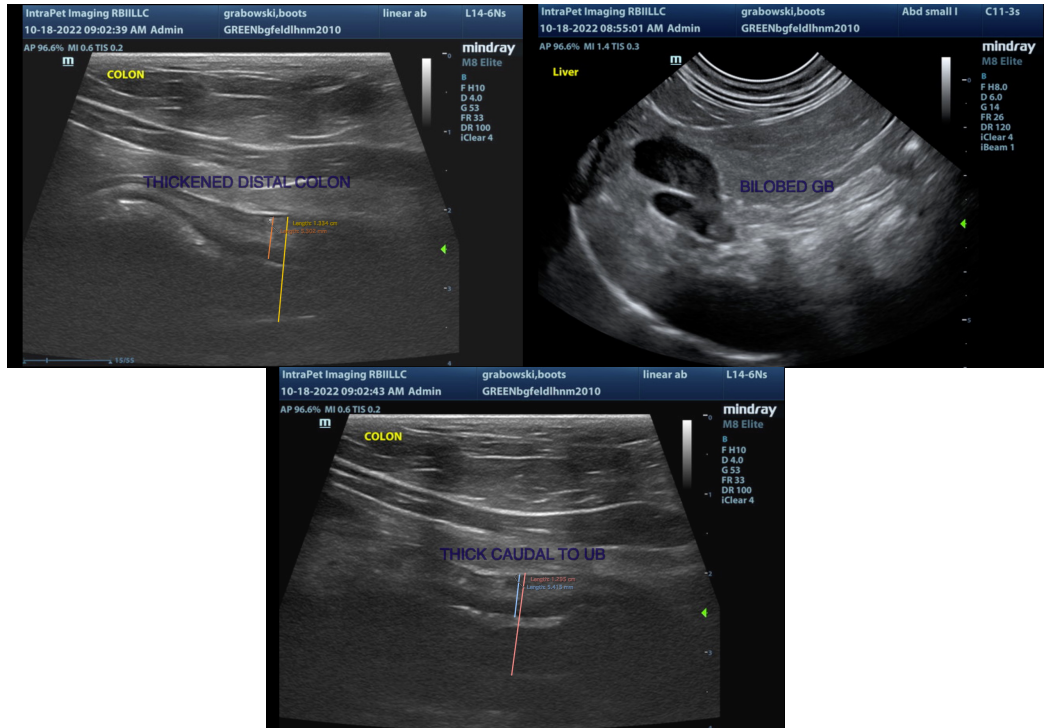
- Bilobed gallbladder – This is likely an incidental finding.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The very distal colon wall appears very thickened with a narrowed lumen. The colon wall appears to have decreased detail in wall layering/loss of layering. This could be concerning for infiltrative neoplasia, severe colitis, granulomatous colitis, etc. If there is a window, a fine needle aspirate of the colon wall could be considered, but I suspect this is too distal and would be very challenging to aspirate. Other options would include colonoscopy or surgical biopsies. There is some risk with endoscopic biopsies that if the lesion is deeper than the mucosal surface, a diagnosis could be missed.

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





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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