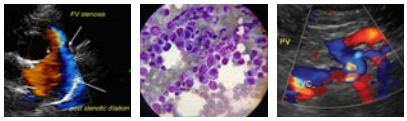
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

11/29/22

PATIENT

Oreo Hays

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2/10/06

WEIGHT

6.7 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Andi Parkinson RDMS

HOSPITAL NAME

Perry Hall AH

REFERRING VET

Dr. Breidenbaugh

INVOICE

43012

PRESENTING CLINICAL SIGNS

P presented for history of weight loss and diarrhea that has not responded to diet or medication. Recent bloodwork and radiographs. Previous hypercalcemia (now resolved). Additional history includes managed hyperthyroidism and heart murmur, suspect possible HCM. O declined Echo at this time.

Current Medications: Miratax transdermal- SID since 11/25/22, Tylan powder- 1 pinch BID since 11/23/22, Proviable paste- since 11/23/22, Fortiflora- since 10/31/22, Felimazole 2.5mg AM, 1.25mg PM- chronic
Previously metronidazole with no benefit. Gabapentin for vet visits (100mg)
Lab Results: 10/31/22: CBC: Low hemoglobin: 9.9 (10.3 - 16.2), elevated reticulocytes: 61 (3 - 50), low retic hgb: 12.8 (15.3 - 22.9), monocytosis: 0.688 (0.04 - 0.53), false thrombocytopenia: 135 (155 - 641)
CHEM: elevated BUN (normal SDMA/Creat): 42 (16 - 37), elevated amylase: 2,635 (623 - 2,239), Spec fPL: 2.7 WNL, UA: cysto, usg 1.015 pH 6.0, negative sediment, T4: 2.6 WNL
Radiographs: Thoracic 10/31/22 Mild feline asthma. Suspect fluid occluded airways. The possibility of metastatic disease cannot be ruled out. Mild cardiomegaly likely due hypertrophic cardiomyopathy. Loss of detail. This is a nonspecific finding. Neoplastic effusion or feline infectious peritonitis would be possible causes. Ascites due to hypoalbuminemia or steatites as a result of pancreatitis are additional possibilities. Suspect chronic renal infarcts on the right.
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 (2.93 cm) with mild pyelectasia at 0.19 cm. 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.33 cm) with mild pyelectasia at 0.27 cm. 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is borderline large (1.01 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.

Liver
The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. 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. 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 area of the ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. As the colon extends more distally, the colon wall becomes thickened and irregular with decreased distinction of wall layering and narrow lumen. In this region, the colon measures 2.48 cm in diameter, and the wall thickness measures 0.73 cm.

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
There is a large amount of echogenic free fluid. No lymphadenopathy is noted. The omentum appears generally thickened/almost nodular and diffusely hyperechoic.

Other
Ringdown artifact is visualized at the level of the diaphragm.

A brief view of the heart was submitted. There is the impression of a scant amount of pericardial effusion visualized. Recommend cardiac ultrasound.

ULTRASONOGRAPHIC FINDINGS

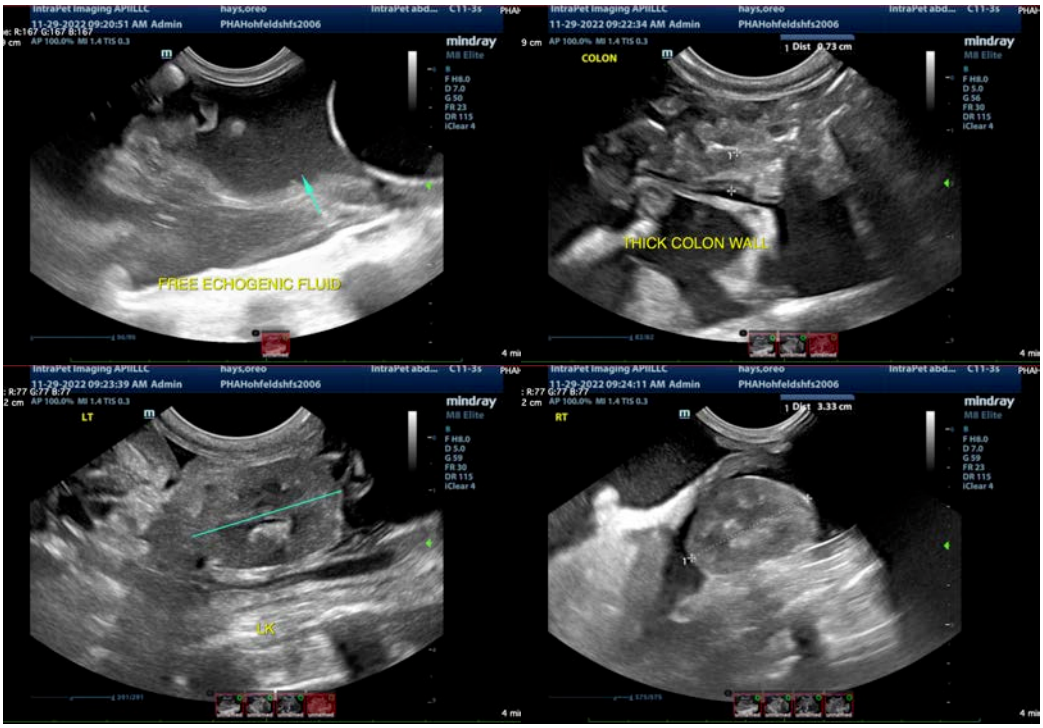
- Decreased corticomedullary distinction in both kidneys with mild pyelectasia – The bilateral renal findings are consistent with age-related change.
- Borderline large spleen – This could be normal for a larger cat. Other differentials include congestion or infiltrative disease. A fine needle aspirate could be considered.
- Heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Severely thickened, irregular/mottled wall in the descending colon – Differentials include severe colitis or infiltrative disease (granuloma, neoplasia, etc.).

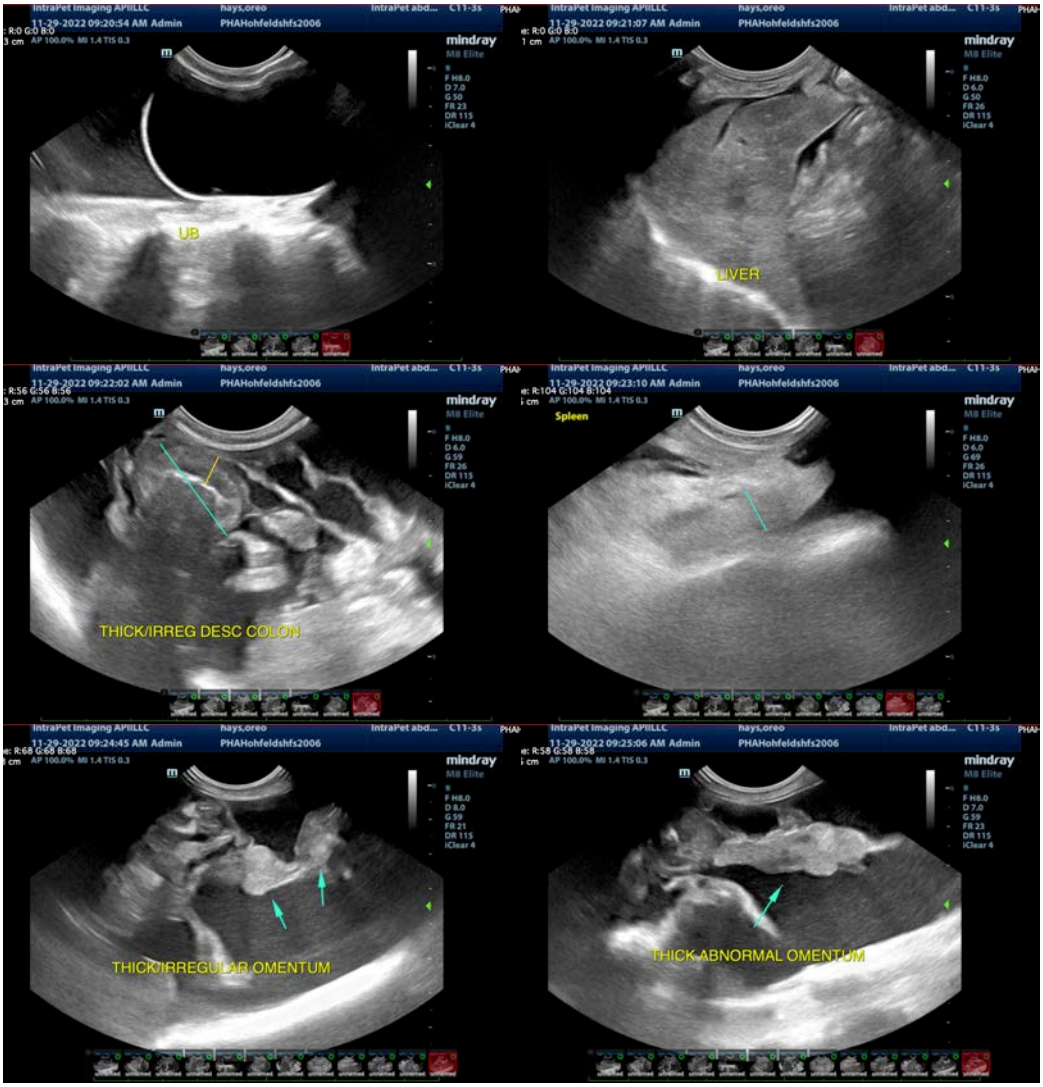
- Large volume free abdominal fluid – Recommend fluid analysis and cytology.
- Thickened, irregular omentum – This could be consistent with chronic inflammation or possibly carcinomatosis.
- Scant pericardial effusion visualized – Recommend cardiac ultrasound.
- Ringdown artifact visualized at the level of the diaphragm – Findings are consistent with the pulmonary parenchymal disease described.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The distal colon appears severely thickened and irregular. Findings are very concerning for an infiltrative process. Differentials would include carcinoma, lymphoma, FIP, or severe inflammatory colitis. A fine needle aspirate of the colon wall could be considered. Additionally, there is a large amount of free abdominal fluid and irregular omentum, so carcinomatosis would be of concern. Recommend fluid analysis and cytologic evaluation.

The liver is heterogeneous, and the spleen appears somewhat prominent. If a cytologic diagnosis cannot be obtained based on a fine needle aspirate of the colon wall and analysis of abdominal fluid, you could consider a fine needle aspirate of the liver and spleen, provided coagulation parameters are normal. Exploratory surgery with biopsies may be necessary if cytologic evaluation is non-diagnostic. Prior to this, I would recommend cardiac ultrasound to further evaluate for underlying cardiac disease.





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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