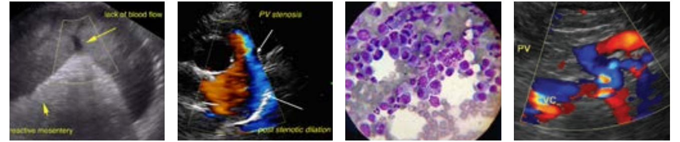


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Lucy Streiling

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

19 Years

WEIGHT

3.7 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Singh

HOSPITAL NAME

Balmy Beach PH

REFERRING VET

Dr. Singh

INVOICE

45948

DATE

3/15/23

PRESENTING CLINICAL SIGNS

Owner found a large amount of fresh blood near Lucy - she was taken to an emergency clinic and told that the bleeding may have been from her mouth from a rotten tooth. She has continued to deteriorate though there has been no further bleeding. On PE today, she had marked anemia, which was regenerative, and her protein fractions are suggestive of blood loss anemia. She has occult blood/melena.

Abnormal PE/Chem/CBC/UA Results: Her hematocrit is 12%, no icterus. No UTI, no blood in urine. She was negative for retroviruses.

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 (3.37 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 (3.25 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

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 is visualized.

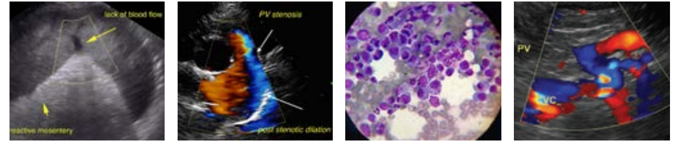
Spleen

The spleen was not clearly visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is a small hyperechoic nodule visualized within the parenchyma measuring 0.85 cm.

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.



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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.26 cm 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 0.23 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. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The area of 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 are occasional prominent mesenteric lymph nodes. Examples of these measure 0.43, 0.31, 0.35, and 0.32 cm. The omentum is slightly hyperechoic around the prominent lymph nodes.

ULTRASONOGRAPHIC FINDINGS

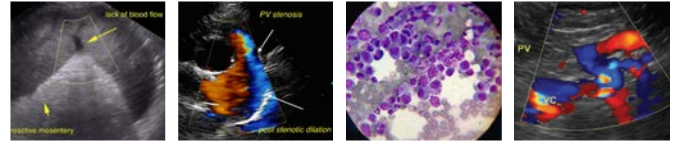
- Mildly heterogeneous liver with hyperechoic nodule – The hepatic changes are consistent with age-related parenchymal remodeling and are not considered clinically significant at this time. The appearance of the hyperechoic nodule trends towards a benign lesion, although an underlying neoplastic lesion cannot be ruled out.

- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A focal lesion visualized associated with the bleeding is not visualized. Based on the history, it seems like either hematemesis or hematochezia would be most likely. I do not see any evidence of any significant gastric wall thickening or bowel wall thickening, although there are some mildly prominent mesenteric lymph nodes, which are of questionable significance. Unfortunately, it is not unusual to have a relatively normal scan despite these changes, as small erosions, etc. are not always evident on ultrasound.

Consider anti-ulcer therapy, possibly a hypoallergenic (novel protein or hydrolyzed protein) prescription diet. Recommend chronic probiotic therapy. You could consider a GI panel to Texas A&M for qualitative PLI, TLI, cobalamin and folate, looking for additional evidence of possible underlying gastrointestinal disease. Additionally, recommend full body 3-view radiographs, looking for any opacities, pulmonary lesions, etc. If this problem persists or you can document hematemesis or hematochezia, then I would consider either upper GI endoscopy or colonoscopy (or both). Stabilization with a blood transfusion, etc. may be necessary prior to considering general anesthesia.



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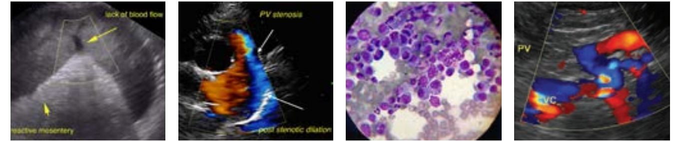

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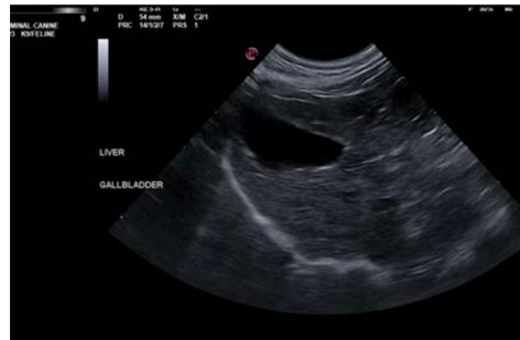

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com