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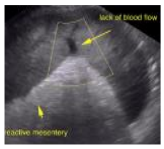
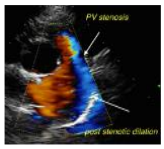
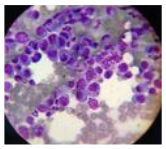
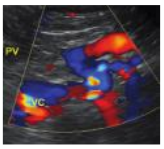
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Joy Roberts

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

19 Years

WEIGHT

5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Judy Schroeder

HOSPITAL NAME

Animal Health Associates

REFERRING VET

Dr. Judy Schroeder

INVOICE

37365

DATE

5/4/22

PRESENTING CLINICAL SIGNS

History of chronic diarrhea (years). In past 4 months this has become chronically bloody, with mucus and straining. Hx of CRD (mild, stable) Weight loss over past 2 yr. Recent prednisolone trial, no improvement in symptoms.
Abnormal PE/Chem/CBC/UA Results: Extremely thin body condition. Firm colon on palpation, suspected due to inflammation but can't rule out feces. BUN 37 mg/dl Creatinine 2.6 mg/dl Albumin 2.5 g/dl Nonregenerative anemia 28.5% PCV Mild neutrophilia/monocytosis.

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 (3.2 cm) with mild pyelectasia at 0.23 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (3.14 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.36 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 0.42 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.

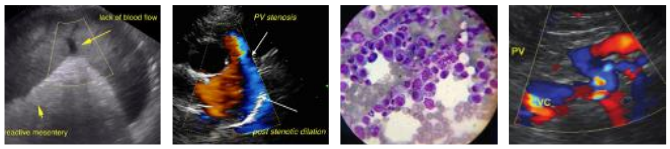
Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a small 0.30 cm hyperechoic nodule visualized within the parenchyma.

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 primarily anechoic. The bile duct is visualized and is somewhat tortuous and dilated, measuring 0.26 cm. No obstruction is visualized.



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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 measured 0.22, 0.26 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. As the colon moves more distally, it becomes progressively more thickened and irregular. The descending colon is severely thickened and irregular with complete loss of layering and irregular wall. In this area, the colon wall measured 0.62 cm and the colon itself is 1.0 cm in diameter. This appears to extend to the level of the rectum.

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 significant sublumbar lymphadenopathy present with sublumbar lymph nodes measuring at 0.90 and 0.98 cm in diameter. The omentum is of increased echogenicity around the colon.

ULTRASONOGRAPHIC FINDINGS

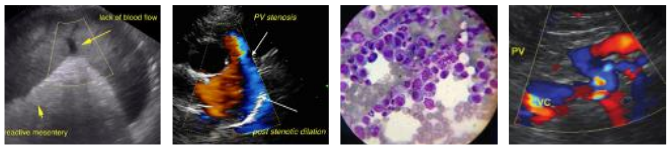
- Severely thickened, irregular colon with regional lymphadenopathy - Neoplasia would be a primary concern, but inflammatory or infectious colitis can show severe thickening.
- Decreased corticomedullary distinction in both kidneys with left-sided pyelectasia – The bilateral renal findings are consistent with age-related change. Pyelectasia of the left kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Hyperechoic nodule within the spleen – This lesion has the appearance of a benign nodule, but unfortunately a neoplastic process cannot be 100% excluded as possibility. Recommend continued monitoring.

SECONDARY FINDINGS

- Dilated common bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The colon is very large with severe wall thickening and complete loss of layering. These changes correlate with the clinical signs reported in the history. There is a strong suspicion of an underlying



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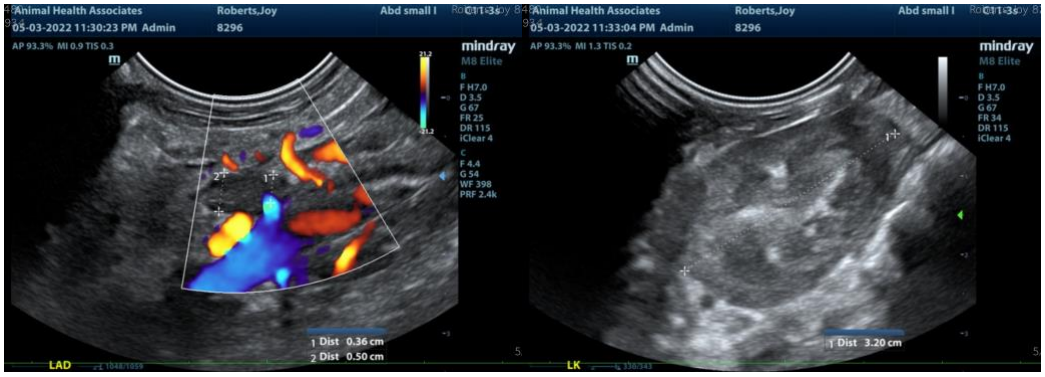
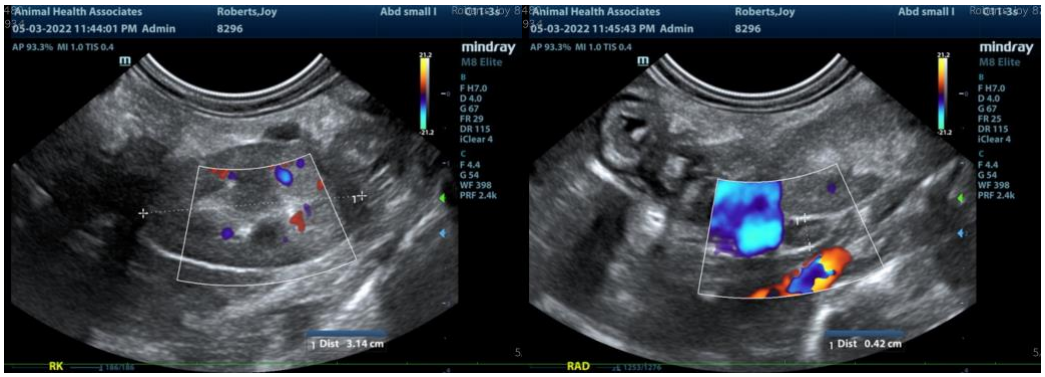
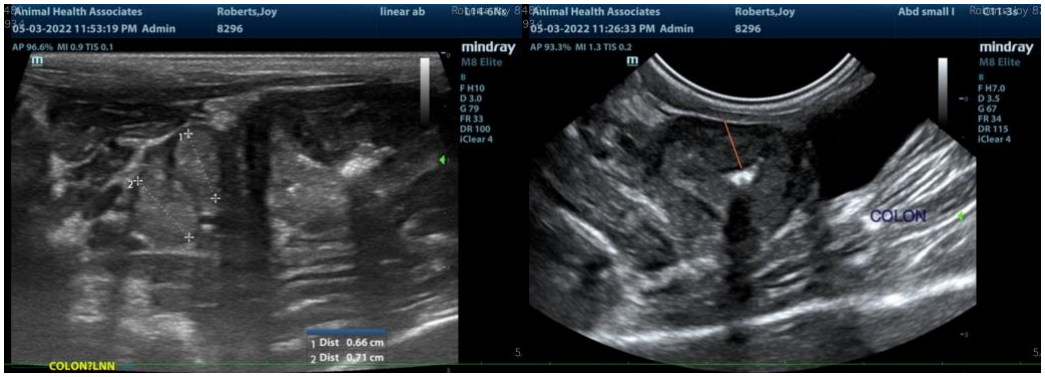
neoplastic process, but other etiologies exist and can cause severe wall thickening as well. Consider a fine needle aspirate of the colon wall or sublumbar lymph node if a good angle can be obtained avoiding the major vessels. Recommend 3-view thoracic radiographs. If a cytologic diagnosis cannot be obtained, then consider a colonoscopy to further evaluate. These changes appear distal and may be palpable with a digital rectal exam. If there is no other recourse, blind biopsies could be considered with a small endoscopic biopsy instrument.







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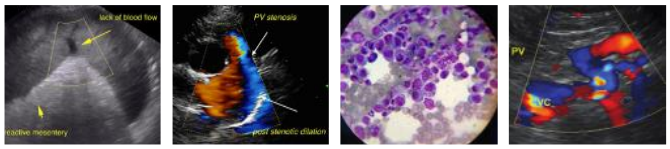

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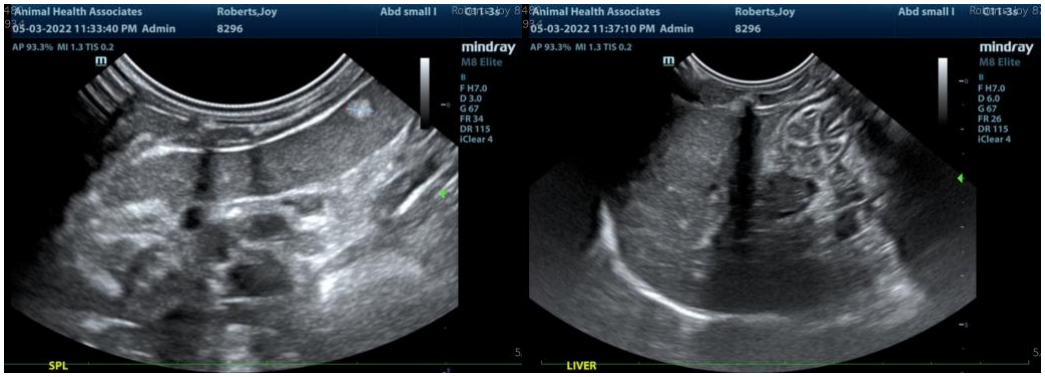

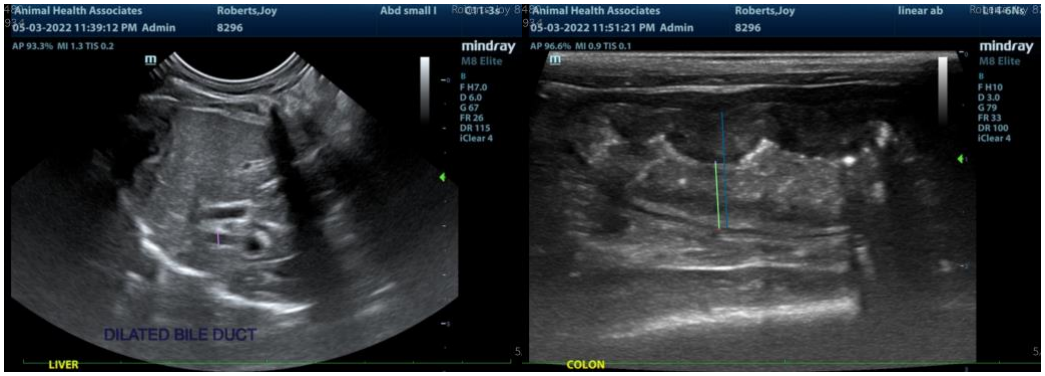

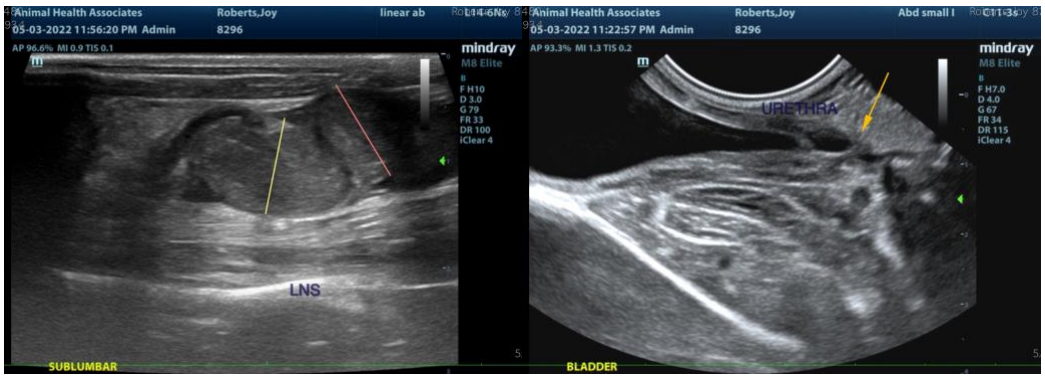

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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