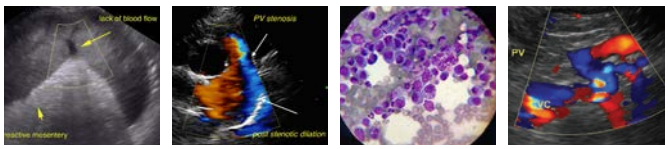
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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PATIENT
Orange Letendre

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
11 Years

WEIGHT
10.5 Pounds

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

IMAGING PERFORMED BY
Dr. Elaina Petrone

HOSPITAL NAME
Long Branch AH

REFERRING VET
Dr. Elaina Petrone

INVOICE
44540

DATE
8/9/23

PRESENTING CLINICAL SIGNS

History of diabetes-no longer on insulin due to multiple hypoglycemic episodes. Recently diagnosed with hyperthyroidism-regulated on methimazole. Iris Stage 1 CKD. Continued weight loss and vomiting and diarrhea.

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 (4.14 cm) with occasional small cortical cyst. 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 has a normal shape and size (4.24 cm) with occasional small cortical cyst. 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 is subjectively normal in size (0.73 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 large in size and hypoechoic 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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. 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.

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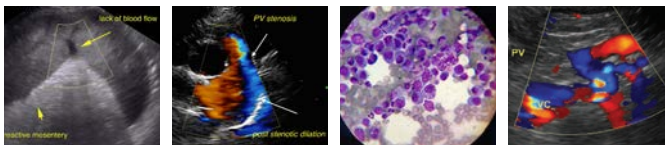

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The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measures 0.31 cm. Visualized peristalsis appears appropriate. While no focal lesions are visualized, the ileum does appear prominent, particularly at the ileocecal junction.

The ileocecal junction is visualized and appears relatively normal with intact wall layering. The ileum in this area appears subjectively thickened, measuring at approximately 0.36 cm. Sections of colon are visualized with formed fecal material and gas shadowing distally.

Pancreas

The left limb of the pancreas is prominent and mottled compared to the surrounding isoechoic 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 no significant lymphadenopathy noted. A mesenteric lymph node is visualized at 0.37 cm. The omentum is of normal uniform echogenicity.

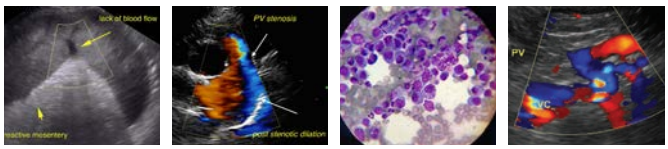
ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Prominent, mottled left limb of the pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Large, heterogeneous/hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. These changes could be age related or associated with a mild diabetic hepatopathy.
- Diffusely thickened small intestine with prominent muscularis layer and a prominent ileum – The small intestinal wall changes could be consistent with an underlying inflammatory process. These types of changes can sometimes be seen in normal older cats. Correlate with clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal mass lesions are visualized, and there is no evidence of overt pancreatitis. The pancreas is somewhat prominent and mottled. This could be due to mild active inflammation, but more likely previous episodes of inflammation and remodeling. Correlate with a quantitative fPLI level.

The small intestine appears mildly prominent with a prominent muscularis layer. This becomes more exaggerated at the ileocecal junction. Wall layering remains intact. These changes could be consistent with a primary enteropathy such as severe IBD, infiltrative disease (early lymphoma, etc.).



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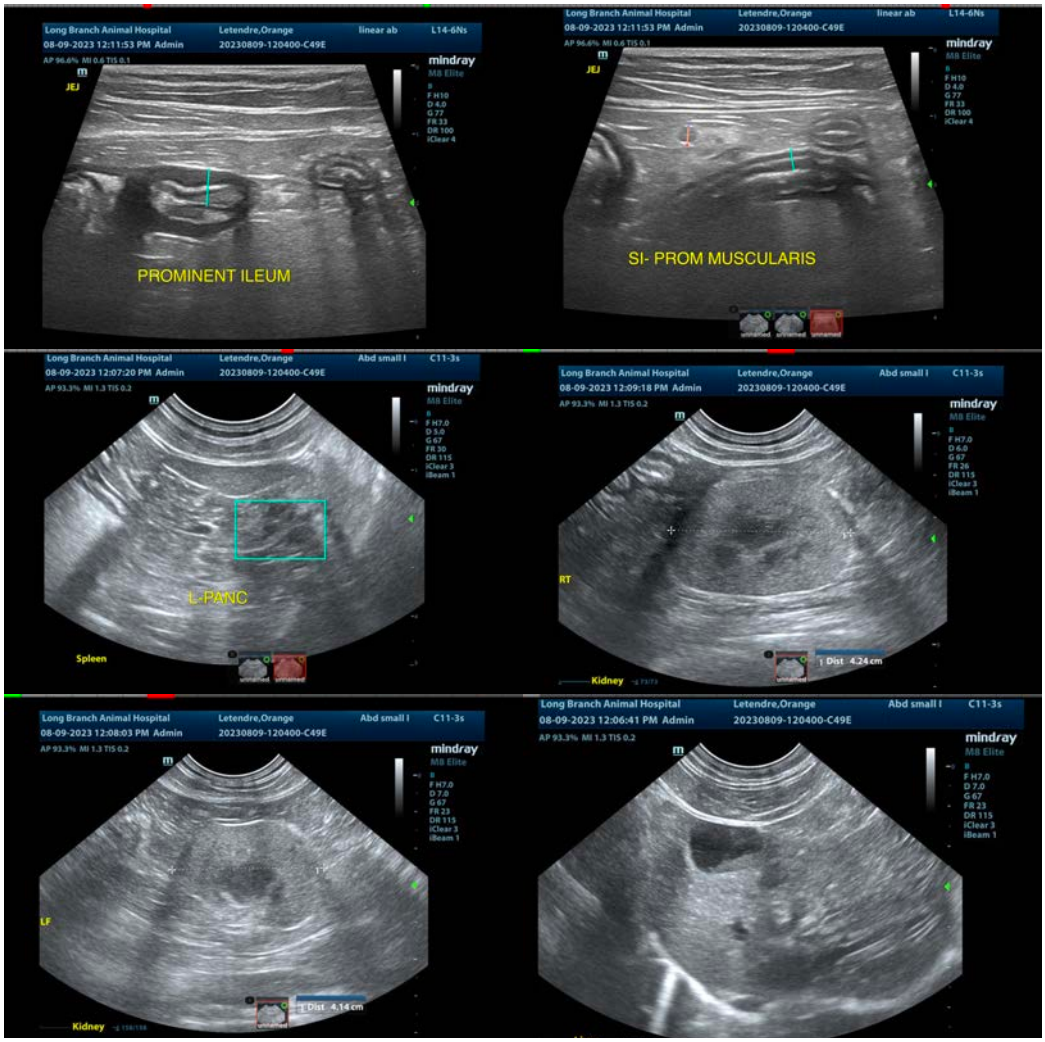
Consider the following if not already done:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

I suspect the changes associated with the ileum are benign, but a fine needle aspirate of this region could be considered. Alternately, biopsies of the GI tract in general including the ileum could be considered to obtain a definitive diagnosis.

If additional diagnostics are not possible and empirical therapy is necessary, you could consider an anti-inflammatory dose of steroids and chlorambucil as long as the owner knows that it is very likely that this patient will revert to a diabetic state and require insulin. Typically, chlorambucil works synergistically with steroids. If the owner is strongly averse to restarting insulin therapy, then I would try chlorambucil alone.



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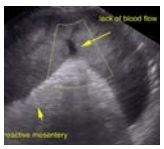
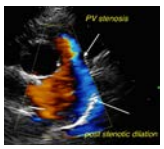
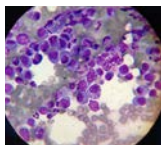
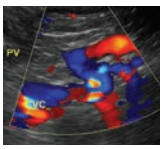

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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