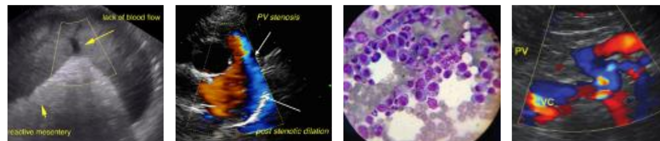
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Sideways Esteves

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
10 Years

WEIGHT
4.92 kg

INTERPRETED BY
Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY
Crystal Hill

HOSPITAL NAME
BPH Burlington

REFERRING VET
Dr. Al-Sultan

INVOICE
37750

DATE
5/18/22

PRESENTING CLINICAL SIGNS

5/14/2022 P back for recheck today as V/D started again this morning. Vomited 3-4 times this am. Had bloody/mucoid diarrhea 3 times since this am. Has been eating a lot last few days and energy was back to normal. Licking at anus a lot. No C/S/PU/PD or any health concern. Not E/D well. QAR, MM: pale pink, moist CRT: 2 sec. Mild dehydrated. Mod discomfort upon abdominal palpation in general, no focal pain. Vomiting & bloody diarrhea --- First presented to us on 5/6/2022 for excessive V/D, panting, and crying. O had woken up to black diarrhea and vomit/bile all over her house. Has a Hx of eating things she shouldn't but doesn't think she ate anything this time. Rectal exam - large stool stuck right at the anus, and p straining in exam room (while straining, open mouth and labored breathing). Manually removed ~4cm of semi firm than softer stool with mod fresh blood. Pulled a smaller nugget from rectum after. P did appear more comfortable once feces was removed QAR/distressed, mm pink mildly tacky, crt <2s Normal skin tent, ~5% dehydrated Was normal yesterday, this morning o woke up to piles of suspect vomit and diarrhea - was unable to tell exactly which one QAR/distressed, mm pink mildly tacky, crt <2s Normal skin tent, ~5% dehydrated Was normal yesterday, this morning o woke up to piles of suspect vomit and diarrhea - was unable to tell exactly which one Meowing lots and seems uncomfortable, seemed like p was panting as well Don't think p got into anything - possible kidney supplement from other cat? P has tendency of chewing thing (i.e lego) but nothing o can think of and o is pretty careful On renal - because other cat has kidney dz Meds:Metro, Cerenia, Sulcrate, Gabapentin
Abnormal PE/Chem/CBC/UA Results: The cardiac silhouette is of normal size and shape. The pulmonary vessels, the caudal vena cava and the aorta are of normal size and shape. No lesion is detected in the lungs. In the esophagus, there is a small amount of gas which is most likely incidental aerophagia. The trachea is radiographically normal. No mediastinal mass or lymphadenopathy is detected. No lesion is detected in the pleural space. The stomach contains gas and some homogeneous soft tissue opacity material. The small intestines are all of normal size and shape. The larger loops identified are consistent with the cecum and colon. They contain gas and some heterogeneous material compatible with feces. Peritoneal and retroperitoneal serosal details are adequate. No lesion is detected in the liver, the spleen, and the urinary bladder. The right kidney is severely small. The left kidney is irregular. In the spine, incidental spondylosis deformans is identified.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is well distended with anechoic contents. The wall is smooth and regular. No abnormalities are present with the trigone or proximal urethra. A very small amount of free floating sediment is present, however, there is no evidence of cystoliths, polyps or a mass.

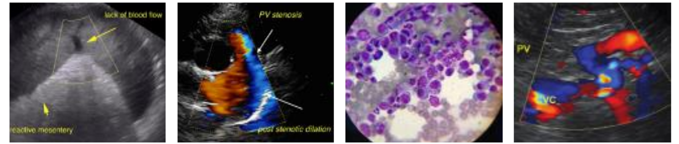
Kidneys

The **left** kidney measures 3.78 cm (3.80-4.40 cm). The capsule is very mildly irregular and the cortex is mildly hyperechoic. A mild to moderate loss of the normal definition of the cortico-medullary junction is present. Mineralizations of the diverticulae are present without evidence of nephroliths or pyelectasia. Blood flow is adequate. The surrounding mesentery is not hyperechoic.

The **right** kidney measures 2.15 cm – 2.23 cm depending on the angle (3.80-4.40 cm). The kidney is small in size and a marked loss of the normal definition of the cortico-medullary junction is present. Its contours are mildly irregular. Mineralizations of the diverticulae are present without evidence of nephroliths or pyelectasia. There are no signs of nephroliths or pyelectasia. Blood flow is decreased. The surrounding mesentery is not hyperechoic.

Aortic bifurcation/trifurcation

No abnormalities observed.



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Adrenal Glands

The **left** adrenal gland measures 0.32 cm in diameter. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

The **right** adrenal gland measures 0.36 cm in diameter. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Spleen

The spleen is within normal limits in size 5.3 mm (normal = 10 mm). The linear probe shows a diffuse miliary, moth eaten echotexture. It is within normal limits in echogenicity and the capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

Liver

There are no obvious signs of hepatomegaly. The liver's borders are smooth, but mildly rounded. A diffuse, mildly coarse or granular echotexture is observed, which may be due to a reactive hepatopathy. No obvious abnormalities are noted with the hepatic vessels.

The gallbladder wall is within normal limits in thickness and echogenicity. A small amount of echogenic material is present within the GB. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction.

Gastrointestinal

Gas, fluid, and a small amount of ingesta are present in the lumen of the stomach. The gastric wall is within normal limits in thickness and the wall layers are well defined, except for a possible mucosal defect. An erosion cannot be excluded. A component of the gastric contents may be hemorrhage. Delayed gastric emptying is suspected if Sideways was fasted.

Ingesta and fluid are present in the duodenum. Mild fogging of the mucosa is present.

The small intestinal wall thickness, including the duodenum, is within normal limits and the definition of the wall layers is preserved. However, mild fogging of multiple loops of jejunum is present. No abnormalities are observed with the ileocecal colic junction.

Gas is present within the transverse colon.

The colonic wall is not thickened and mural detail is considered normal. Gas is present in the descending colon.

Pancreas

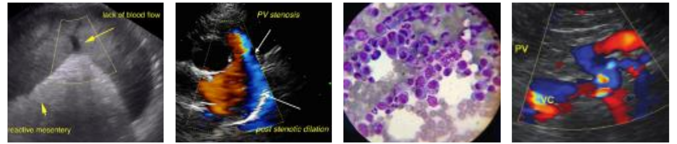
No overt abnormalities are observed with the echogenicity or echotexture of the **left limb**.

The **right limb** is mildly hypoechoic and the surrounding mesentery is mildly hyperechoic. There are signs suggestive of active pancreatitis. There are no obvious signs of neoplasia.

Other

Lymph nodes (LN)

The gastric LN is mildly enlarged and "plump", and the surrounding mesentery is mildly to moderately hyperechoic.



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Multiple LNs in the region of the right limb of the pancreas are more prominent than usual.

Multiple mesenteric lymph nodes are mildly more prominent than usual to very mildly enlarged and slightly hypoechoic. The surrounding mesentery is mildly hyperechoic.

A jejunal LN with smooth contours is enlarged. It is very mildly hypoechoic and measures 0.70 cm in diameter by 0.99 cm in length.

Abdominal effusion is not visualized.

ULTRASONOGRAPHIC FINDINGS

- Infiltrative disease of the spleen, specifically, a round cell tumour, lymphoma, mastocytoma, and histiocytic sarcoma, is suspected. All could cause could cause melena and vomiting, with or without hematemesis. However, splenitis, reactive hyperplasia and extramedullary hematopoiesis cannot be excluded without performing a fine needle aspirate.

- The gastric abnormalities may be due to an ulcer and intraluminal hemorrhage, as well as delayed gastric emptying and presence of ingesta. An obvious mass or foreign body is not observed, however, one can be difficult to identify, particularly in the stomach. The remaining intestinal changes may be due to vomiting and diarrhea, however, inflammatory bowel disease cannot be excluded.

- Mild lymphadenomegaly of multiple lymph nodes is present. Neoplasia may be the cause of enlarged LNs, however, reactive hyperplasia, cannot be excluded.

- Active pancreatitis is suspected based on the changes observed with the right limb.

- A reactive hepatopathy is suspected based on the mildly coarse, granular echotexture. There are no obvious signs of neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirates of the spleen and lymph nodes are recommended to exclude neoplasia as the cause of the clinical signs.

Endoscopy and biopsies of the upper and lower GI tract are recommended if the fine needle aspirates are non-diagnostic.

A spec fPL may yield a false positive due to severe inflammation of the GI tract, however, pancreatitis is suspected.

Treatment for pancreatitis and gastric ulceration are recommended pending cytology results.

omeprazole at 0.7-1 mg/kg PO q12h for 10-14 days
Although sucralfate is indicated, it likely causes nausea and may contribute to vomiting and anorexia
Analgesia for visceral pain (buprenorphine), including gabapentin, if tolerated
Intravenous fluids (ideally) or subcutaneous fluids (at home, if IV fluids are not possible)
Small, frequent meals of a simple ingredient, easily digestible diet
Canned food may be more easily digestible

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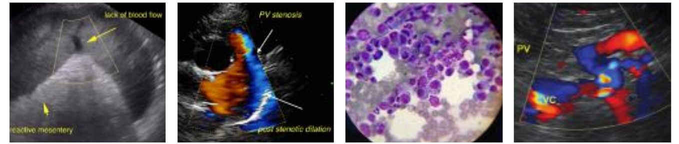

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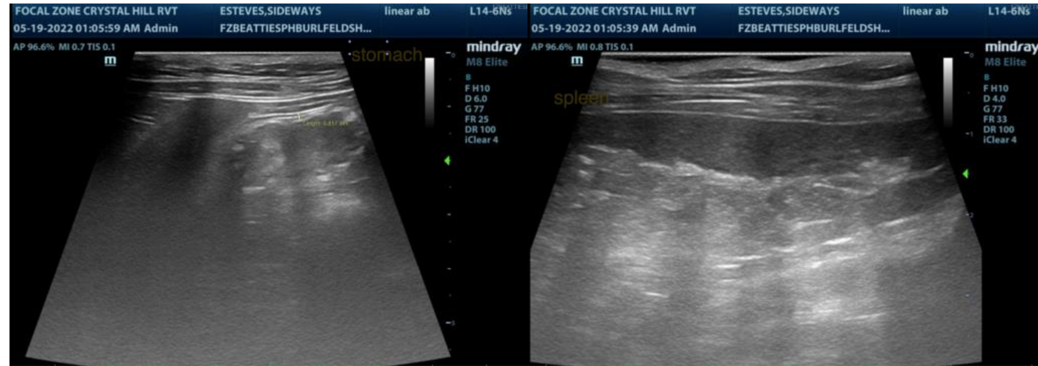
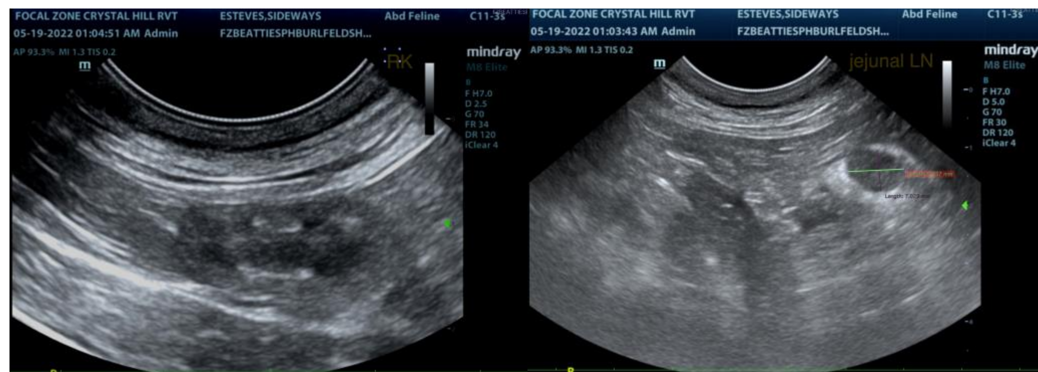
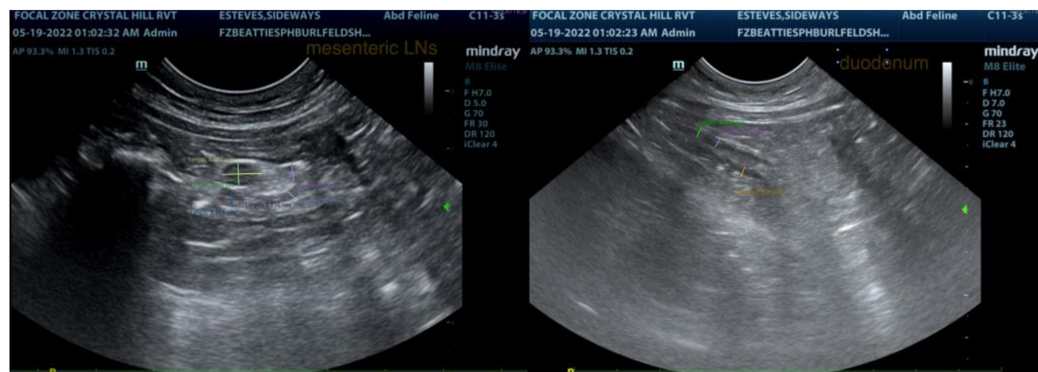
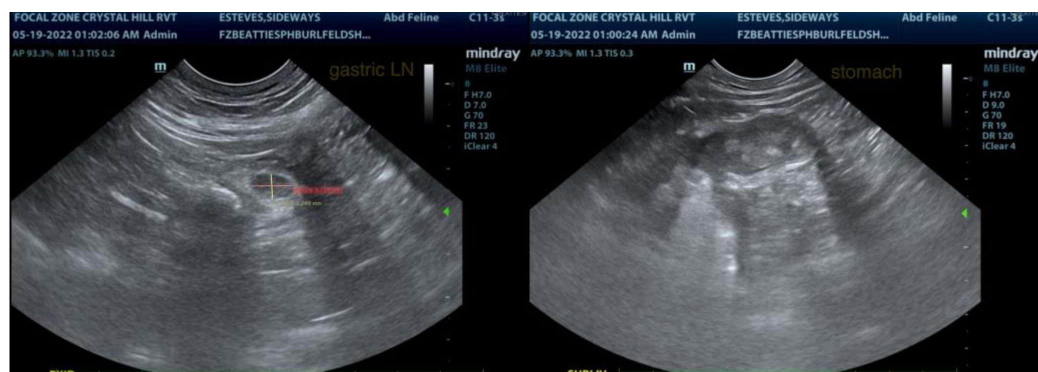
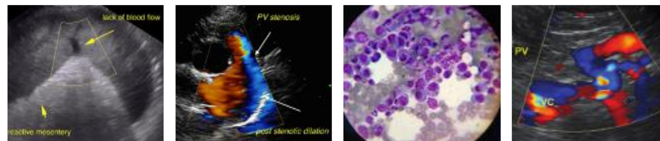
If further diagnostics are not pursued, treatment with steroids (anti-inflammatory) is suggested as they will address severe IBD, as well as a round cell tumour. If an improvement is observed, chlorambucil may be added to the treatment regime.











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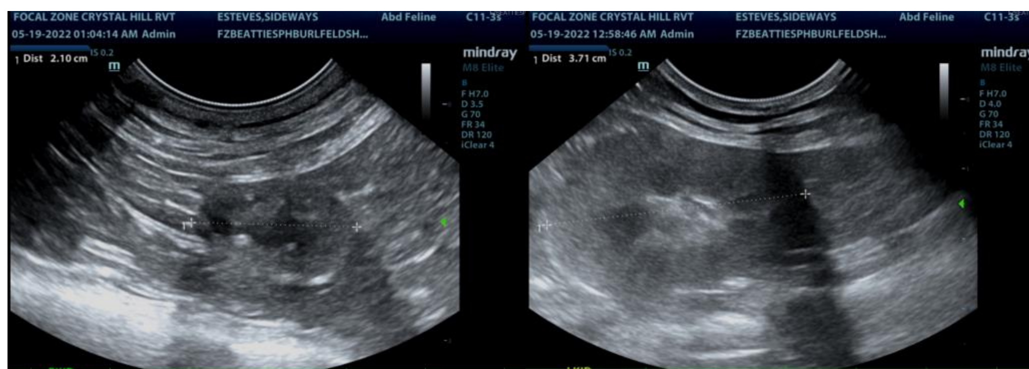

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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