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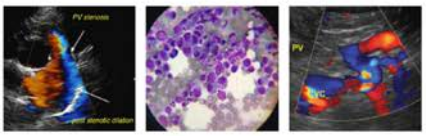

SonoPath
Clinical Sonography & Telecytology
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1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Stevie Ackerman

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
13 Years

WEIGHT
12 Pounds

INTERPRETED BY
Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Kuenzie Family PH
Dr. Dwyer

INVOICE
40070

DATE
8/2/22

PRESENTING CLINICAL SIGNS

Chronic diarrhea and intermittent vomiting for 4 months. Minimally responsive with antibiotic therapy and steroid therapy. No steroids given for about 2 months. Currently receiving metronidazole and fortiflora with minimal response.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is well distended. 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 3.34 cm (3.80-4.40 cm). The capsule is smooth. Its overall architecture, including the definition of the cortico-medullary junction, is preserved. However, the cortex is hyperechoic, i.e., it is hyperechoic to the spleen. There are no signs of nephroliths or pyelectasia. A round, anechoic structure, with a smooth, thin wall, measuring 0.37 cm, is visualized within the cortex. A second similar, but smaller structure (0.15 cm), is also observed. Their appearance is most consistent with benign cysts. The surrounding mesentery is not hyperechoic.

The **right** kidney measures 3.88 cm (3.80-4.40 cm). The capsule is smooth. The cortex is hyperechoic, however, its overall architecture, including the definition of the cortico-medullary junction, is preserved. There are no signs of nephroliths or pyelectasia. A round, anechoic structure, with a smooth, thin wall, measuring 0.21 cm, is visualized within the cortex. The surrounding mesentery is not hyperechoic.

Aortic bifurcation/trifurcation No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.36 cm. 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 0.48 cm. 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 8.2 mm (normal = 10 mm), echotexture, and echogenicity. 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 and its borders are smooth and sharp. The liver's echotexture is homogeneous and it is within normal limits in echogenicity. Focal lesions are not observed and no abnormalities are observed with the hepatic vessels.

The **gallbladder** (GB) is moderately distended with a small amount of free floating and gravity-dependent echogenic material (sludge). The GB wall is within normal limits in thickness and echogenicity. The portions of the cystic duct observed is not dilated or tortuous, however, sludge is present at the neck of the GB and the proximal cystic duct. The common bile duct is not well visualized. There are no signs of an obstruction.

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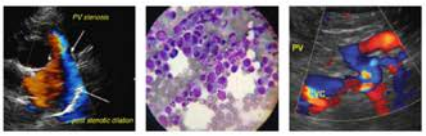

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Gastrointestinal

A significant amount of gas is present within the lumen of the stomach. The gastric wall is within normal limits in thickness, and the wall layers are well defined. However, the muscularis and submucosa are mildly to moderately prominent, respectively. A focal hypoechoic round structure is noted intramurally at the pyloric antrum. It measures 0.46 cm x 0.46 cm and appears to be originating from the muscularis, yet in another view, it measures 0.67 cm x 0.28 cm and may involve the serosal, muscularis and submucosal layers. It is difficult to determine whether this is focal thickening due to an emerging mass, polyp or a cyst or very localized irritation. However, the surrounding region is not hyperechoic. No obvious abnormalities are observed with the stomach's peristalsis.

Duodenum: wall thickness is within normal limits and the definition of the wall layers is preserved. Gas is present within the lumen.

Jejunum: wall thickness is within normal limits and the definition of the wall layers is preserved. The submucosa of a few segments is prominent.

The ileo-cecal-colic junction is within normal limits.

Although wall definition is conserved, the ascending and transverse colon are thickened. Significant thickening of the wall is noted at the transition from the ascending to the transverse colon (0.29 cm – 0.38 cm).

The colonic wall is mildly thickened (0.20 cm, 0.21 cm). Mural detail is preserved, however, subjectively, the mucosa and submucosa appear more prominent than usual. Gas and formed stools are present in the colon.

Pancreas

The proximal **left limb** is mildly enlarged and prominent, yet has smooth borders and a homogeneous echotexture. It is not overtly hypoechoic, nor is the surrounding mesentery hyperechoic, i.e. signs of active pancreatitis are not appreciated. However, fibrosis due to previous episodes cannot be excluded. There are no obvious signs of neoplasia.

Other

Lymph nodes

One of the mesenteric lymph nodes is very mildly enlarged (0.53 cm), rounded and hypoechoic. The surrounding mesentery is not hyperechoic.

Abdominal effusion is not visualized.

ULTRASONOGRAPHIC FINDINGS

- **Gastrointestinal (GI) tract**:
  - Inflammation of the GI tract is noted.
  - The significance of the focal polyp-like structure or thickening of the pylorus is unknown.
  - A chronic enteropathy is suspected, (steroid responsive diarrhea (inflammatory bowel disease), food-responsive diarrhea or food intolerance, dysbiosis, etc.) are possible differential diagnoses. Although the definition of the wall layers is preserved, neoplasia, such as lymphoma, or other round cell tumour, cannot be excluded without performing tissue biopsies, and in some cases, immunohistochemistry and PARR.

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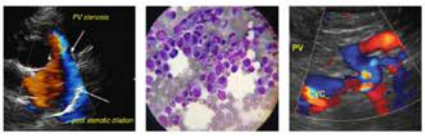

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- **Gallbladder**:
  - Small amount of gallbladder sludge; most likely clinically insignificant. However, gastroesophageal reflux disease (GERD), can occur in some patients.
  - Signs of cholecystitis are not appreciated.
  - Obtaining a history regarding signs of GERD from the client is suggested.
  - Treatment with an anti-acid or proton pump inhibitor may be required.
- **Pancreas**:
  - Previous episodes of pancreatitis possible.
  - No active signs of pancreatitis or neoplasia
- **Kidneys**: The hyperechogenicity of both cortices cannot be ignored. Subclinical pyelonephritis cannot be ruled out, nor can glomerulonephritis.
- **Lymph nodes**: Possible mild reactive hyperplasia of one of the mesenteric lymph nodes
- **Urinary bladder**: Although the free floating sediment is most likely clinically insignificant, it should not be disregarded due to the renal changes noted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture and sensitivity are recommended to exclude a urinary tract infection and pyelonephritis.

If the urine culture is negative, a urine protein: creatinine ratio is suggested to exclude glomerulonephritis.

Analgesia (buprenorphine (0.005-0.01 mg/kg, sublingually, every 8-12 hours) with or without gabapentin. Continue for 3-4 weeks, or longer, as needed. Administer even if does not appear painful.

A synbiotic and a clay based paste, containing montmorillonite, are suggested to help treat the diarrhea.

Addition of soluble fibre (psyllium) or a diet high in soluble fibre, e.g. Hill's Biome diet

A diet trial (veterinary prescription brand hypoallergenic, i.e., ideally, a *hydrolyzed*); ensure appetizing to prevent hepatic lipidosis, sarcopenia and cachexia. Additional soluble fibre (psyllium) may be required.

Deworm (fenbendazole) depending on risk of exposure, including other pets in house that go outdoors

Obtaining a history regarding signs of GERD from the client is suggested. Treatment with an anti-acid or proton pump inhibitor may be required.

If signs of GERD present, 10-14 day trial with famotidine or omeprazole (0.7-1 mg/kg PO **q12h**). Note, omeprazole can cause nausea, vomiting, cramps and diarrhea in some patients, therefore, use lowest dose.

If no improvement with fibre supplementation, diet trial and deworming, endoscopy and biopsies of the stomach, and both the small and large intestines.

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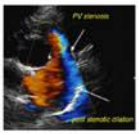
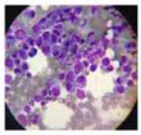
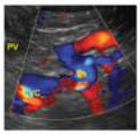

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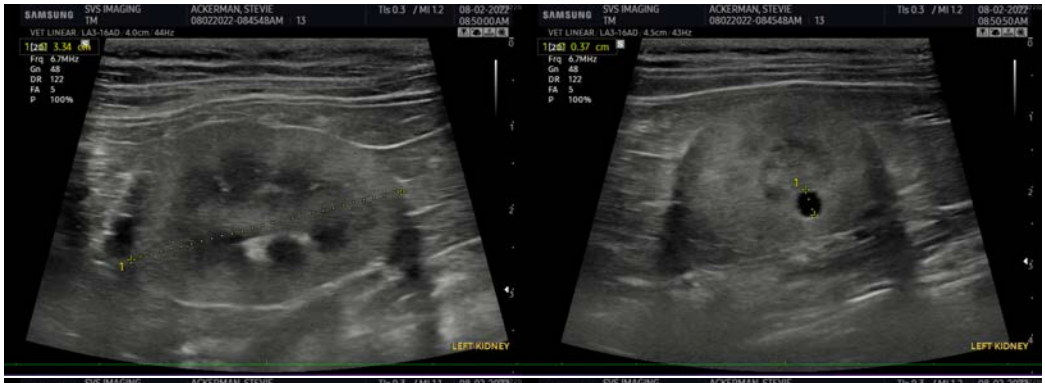

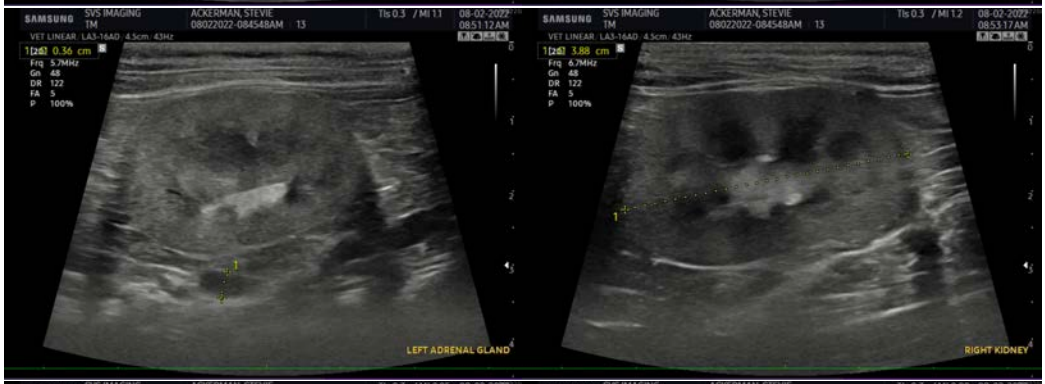

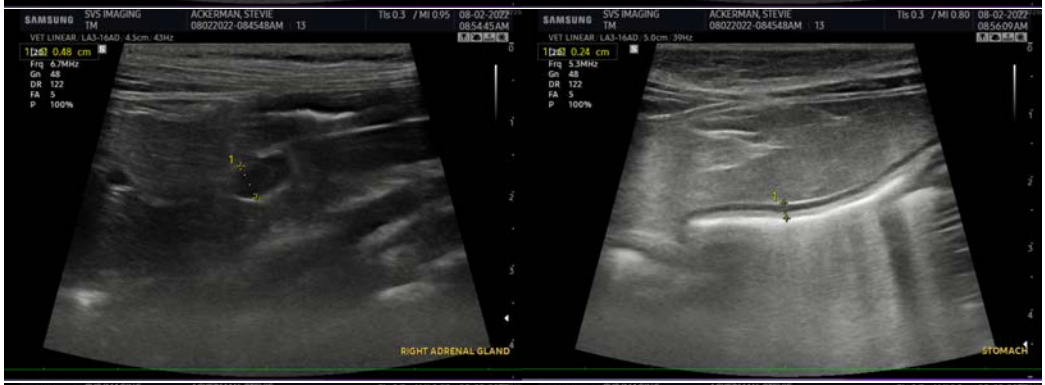

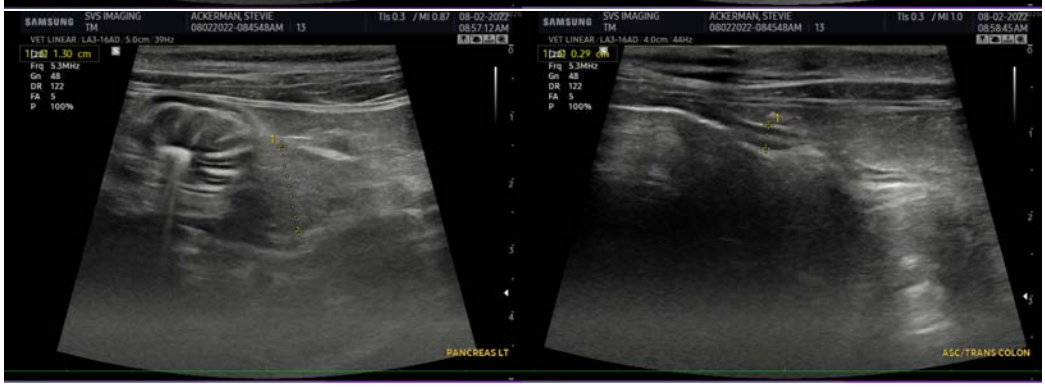

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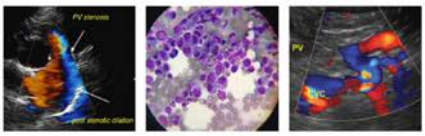

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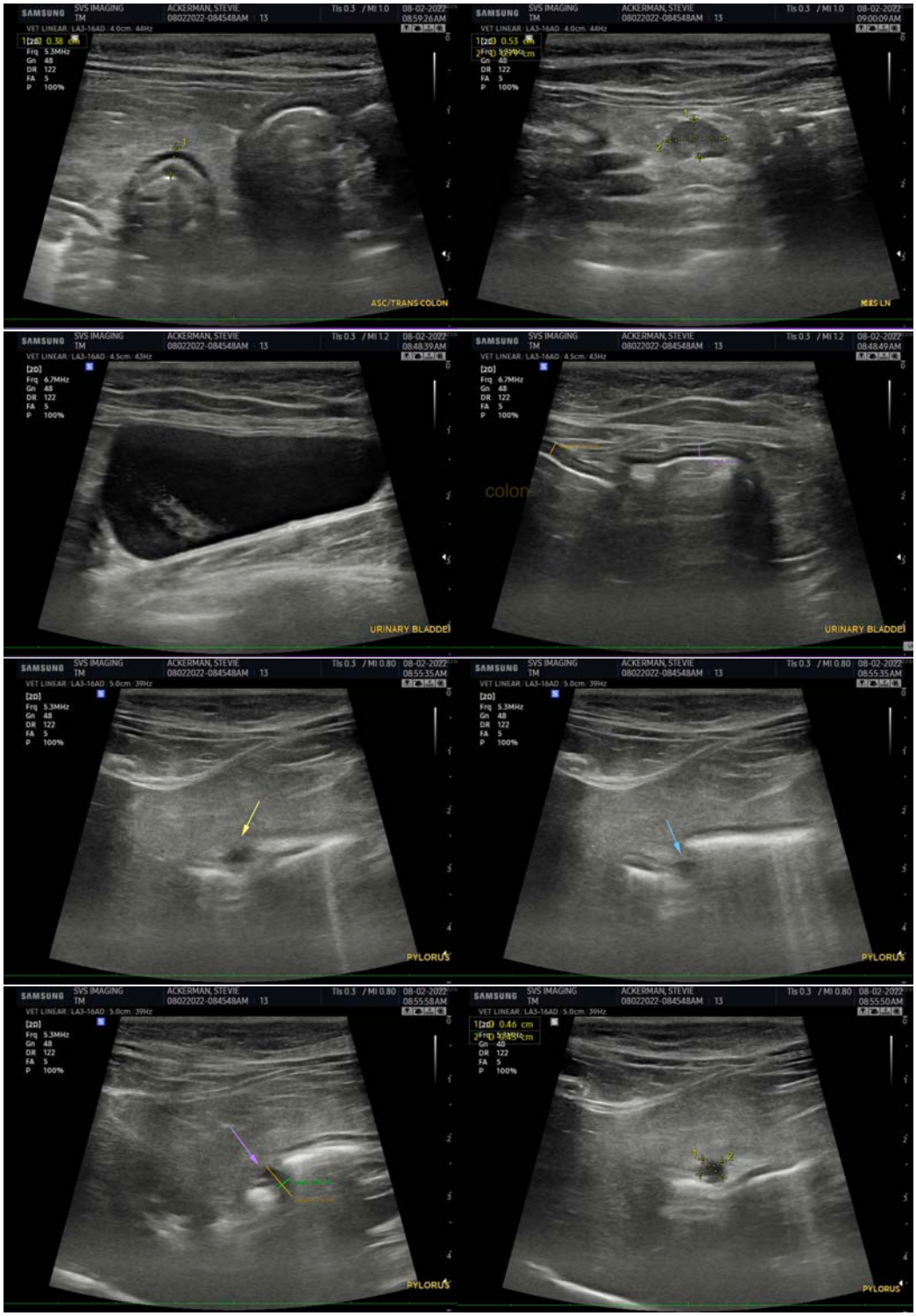

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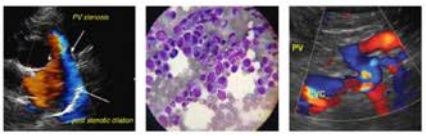

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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