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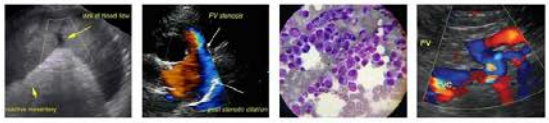

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Samantha Welles

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

Geriatric

WEIGHT

8 Pounds

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

VCA Feline AH

REFERRING VET

Dr. Vincent Fleming

INVOICE

34153

DATE

1/11/22

PRESENTING CLINICAL SIGNS

r/o IBD or other (no records sent to me)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen. Minor potentially adhered sediment or mucus noted along the apical luminal surface. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.2 cm. The right kidney measured 3.9 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.39 cm. The right adrenal gland measured 0.44 cm.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The spleen measured 0.84 cm in width. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. Pylorus wall measured 0.27 cm.

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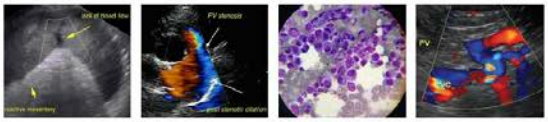

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The small intestine presented intact wall layering with segmental to generalized propensity for mild mural hypertrophy owing to prominent muscularis layer. No overt evidence of loss of intestinal wall layering or intestinal masses. Jejunum wall measured 0.29 cm. Ileocolic wall measured 0.32 cm.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. Mild pancreatic duct dilation noted. No signs of active inflammation or neoplasia.

Free Abdomen

Intermittent, enlarged mid abdominal jejunal to jejunocolic lymph nodes were present. Example measured 0.43 cm in width. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident.

Mild peri intestinal reactive mesentery also noted. No free fluid.

ULTRASONOGRAPHIC FINDINGS

- Minor urinary bladder sediment or mucus
- Enteropathy exhibiting mild altered muscularis/mucosa ratio
- Associated probable jejunocolic lymphadenitis
- Possible chronic pancreatitis
- Bilateral chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

The appearance of the small intestine is consistent with infiltrative enteropathy with considerations including inflammatory (IBD/eosinophilic enteritis) or neoplasia enteropathy with round cells such as lymphoma. Dry form FIP is considered a less likely differential diagnosis. Diagnosis would require for thickness intestinal biopsies +/- lymphatic biopsies. Potential for early neoplastic lymphadenopathy cannot be definitively excluded. However, the lymph nodes were not overtly consistent with neoplastic criteria.

Empirically, IBD protocol, which may include hydrolyzed diet, cobalamin supplementation, as needed gastrointestinal support and Prednisolone trial at lowest effect dose to control clinical signs would be reasonable. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. If not done, 3-view chest radiographs could be considered to rule out occult pathology if weight loss is present.

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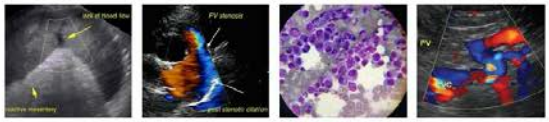

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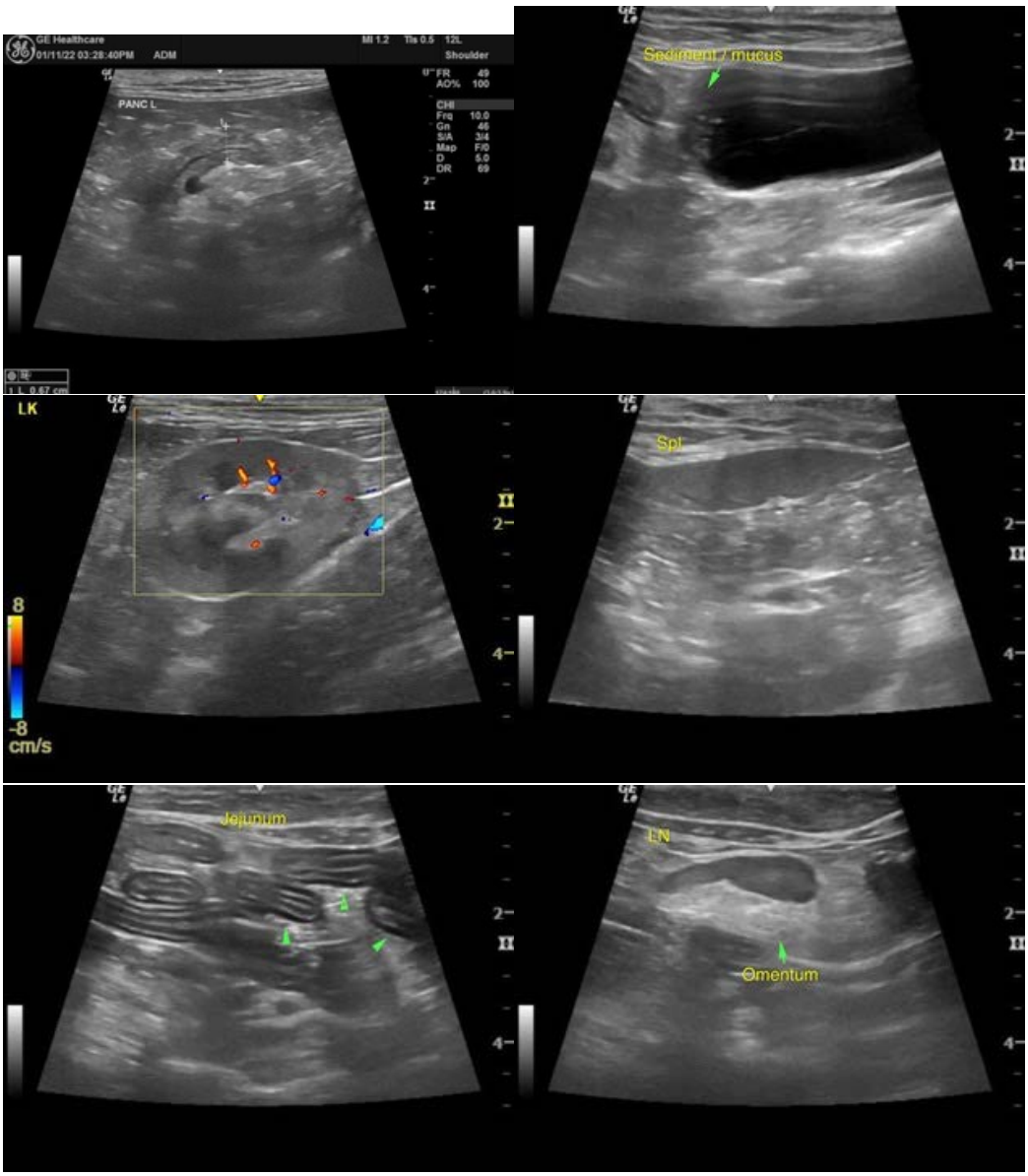

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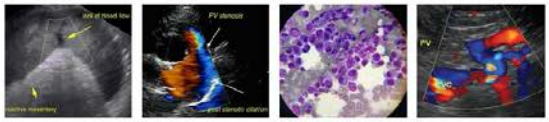

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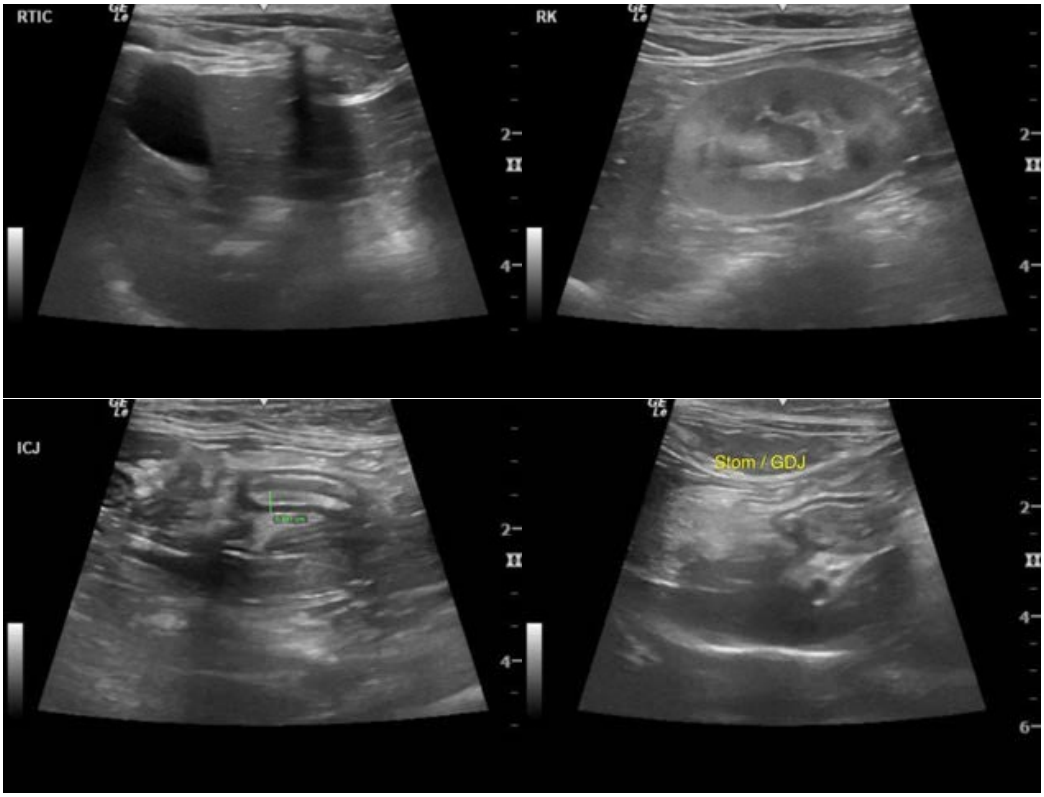

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com