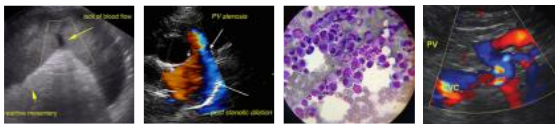


PATIENT

Sugar Lazzareschi

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

10 years

WEIGHT

5.5 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Silver Creek AC

REFERRING VET

Dr Ceremuga

INVOICE

15851

DATE

1/17/23

PRESENTING CLINICAL SIGNS

Pt has 4 day history of decreased appetite and intermittent vomiting. Seen at emergency clinic 2 days ago and abdominal palpation was suspicious for abdominal mass. Pt was treated with SQ fluids, cerenia inj, and oral clavamox. o reports that vomiting has since stopped, but still not eating.

Abnormal PE/Chem/CBC/UA Results: CBC and Chem wnl Current Medications Cerenia 24mg tablets 1/2 po q24, Clavamox 62.5mg orally BID

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Minor nondependent particulate sediment, which may indicate cellular debris / protein, crystalline debris, or mucus, was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural 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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.0 cm in length. The right kidney measured 4.5 cm in length. Pinpoint to focal areas of dystrophic medullary mineral with focal caudolateral right kidney cortical infarct were noted.

Adrenal Glands

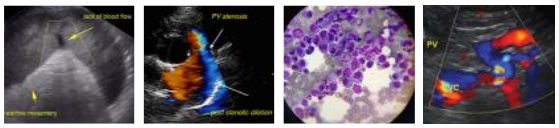
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.42 cm width. The area of the right adrenal gland was free of overt pathology.

Spleen

The spleen was mildly prominent in size secondary to sedation exhibiting a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. 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 inflammation, neoplastic criteria, or benign parenchyma changes were not noted. The spleen measured 1.1 cm diameter.

Liver/ Gallbladder

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



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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 visualized gastric walls were sonographically unremarkable exhibiting intact gastric wall layering. The lumen of the stomach contained echogenic, nonshadowing ingesta most consistent with post prandial presentation without signs of ileus, obstruction or foreign material. The ventral gastric body wall width measured 0.28 cm. No overt evidence of a mechanical obstructive pattern.

The small intestine presented generalized intact, variably prominent wall layering owing to propensity for variably prominent muscularis layer. Within the mid to caudal abdominal intestinal segments, mild to moderately thickened walls exhibiting mildly decreased mural echogenicity and indistinct to loss of discernable wall layering with concurrent nonobstructive segmental intestinal ileus were noted. Intact small intestinal wall measured 0.29 cm width. Segmental mild to moderately thickened intestinal walls measured up to 0.36 cm wall widths respectively. No overt pathology was noted at the level of the ileocolic junction, exhibiting intact wall layering measuring 0.31 cm wall width.

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

Pancreas

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

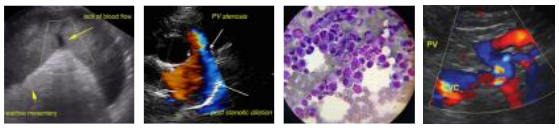
Regional mid-abdominal peri intestinal to peri-ileocolic mild hyperechoic mesentery with intermittent jejunocolic lymphadenopathy was present. An example of a jejunocolic lymph node measured 1.0 cm diameter. No evidence of peritoneal effusion was noted.

ULTRASONOGRAPHIC FINDINGS

- Segmental to generalized enteropathy exhibiting segmental variably thickened intact to indistinct / loss of intestinal wall layer detail
- Associated peri intestinal to peri ileocolic regional hyperechoic mesentery and intermittent mild jejunocolic lymphadenopathy
- Gastric ingesta, overtly normal gastric walls
- Bilateral mild chronic renal changes with minor medullary mineral and right kidney infarct

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The segmental to generalized small intestine suggestive of infiltrative enteropathy criteria with considerations including inflammatory infiltrative enteropathy i.e., IBD/eosinophilic enteritis, or potential neoplastic infiltrative enteropathy with round cells, i.e., lymphoma, mast cell neoplasia, other, both of which may present in a similar sonographic manner. Dry form FIP is considered a less likely



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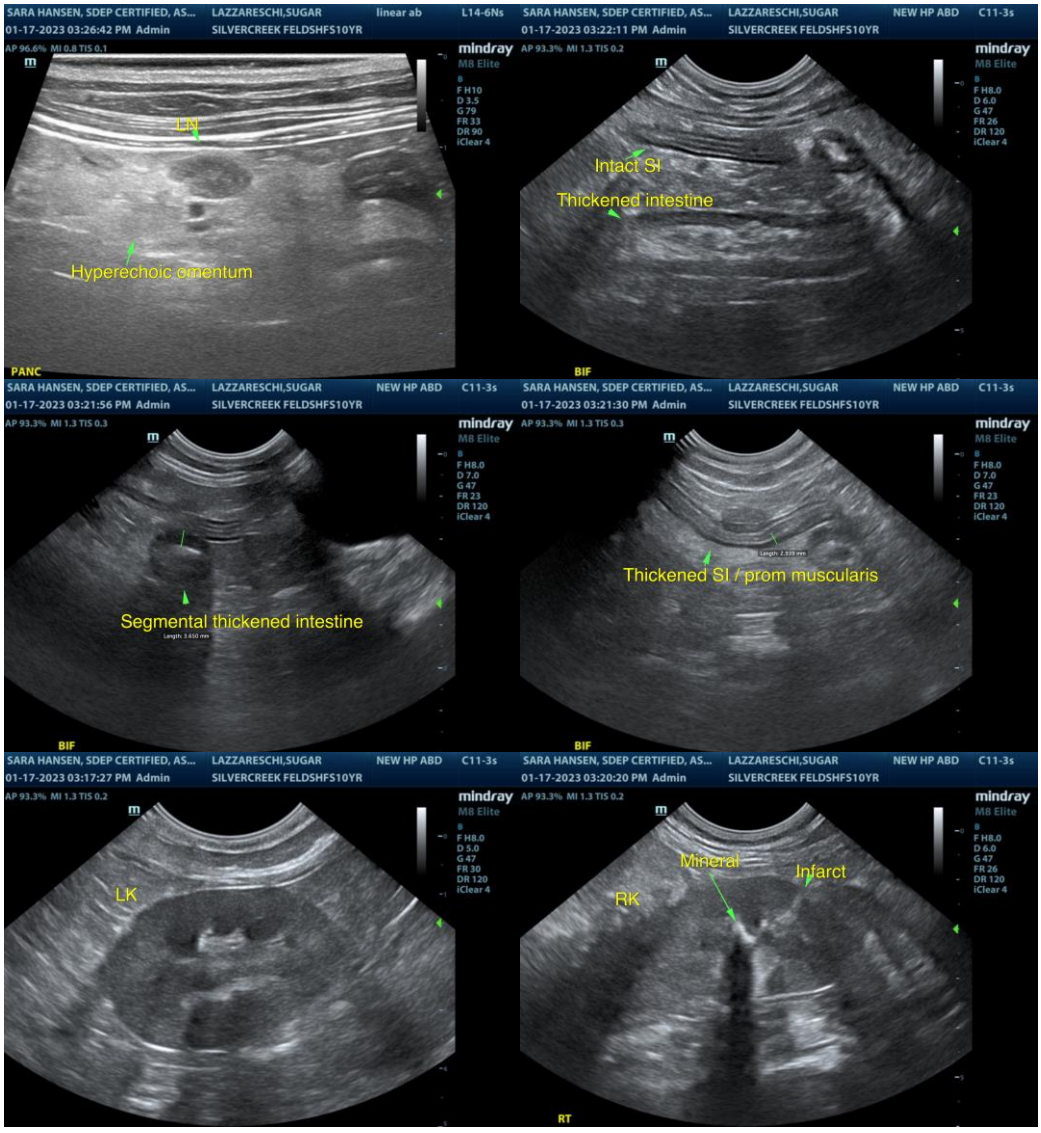
differential diagnosis. Suspect associated jejunocolic lymphoid hyperplasia or mild reactive lymphadenitis with emerging neoplastic lymphadenopathy considered less likely based on the sonographic appearance at this stage. Full-thickness intestinal biopsies are required for a definitive diagnosis. Some degree of concurrent nonobstructive gastric stasis could be possible if documented NPO.

A GI panel to include PLI/TLI/Cobalamin/Folate for further assessment, as well as an assessment for concurrent low-grade pancreatitis as a contributing factor are recommended. Empirical IBD protocol with as-needed gastrointestinal support and sonographic monitoring of intestinal tract for evidence of progressive mural changes would be a more conservative approach.



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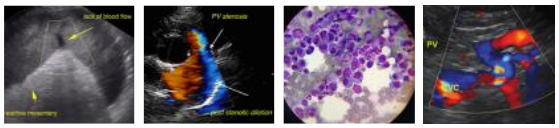

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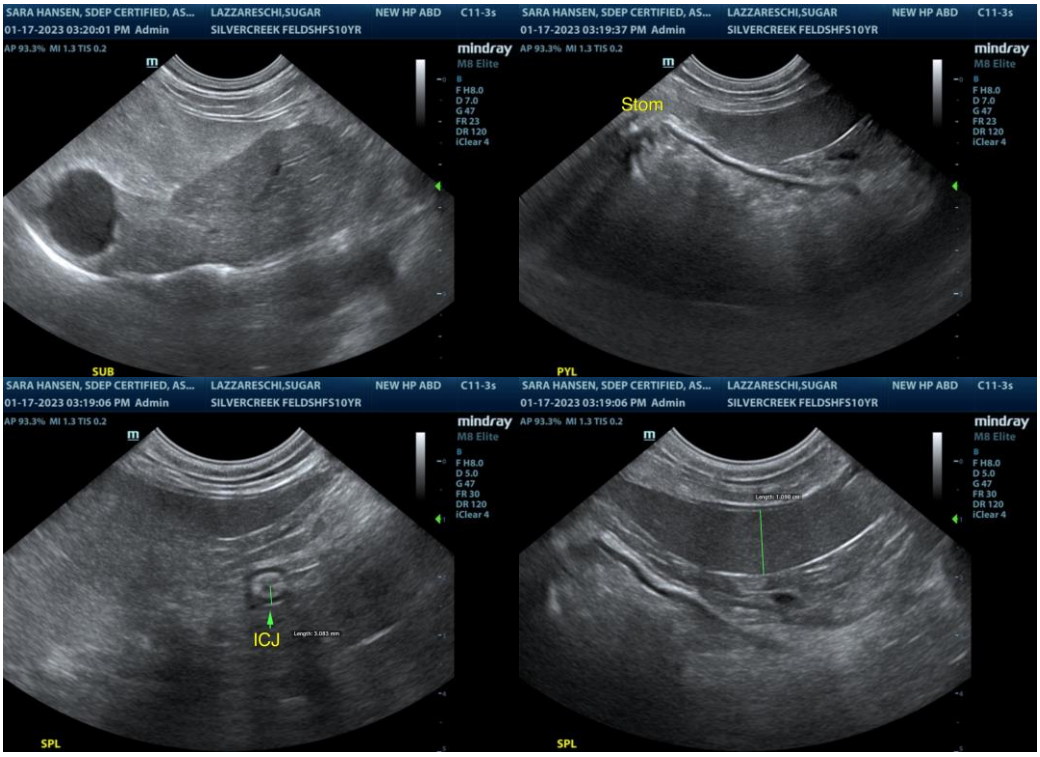

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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