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Clinical Sonography & Telecytology
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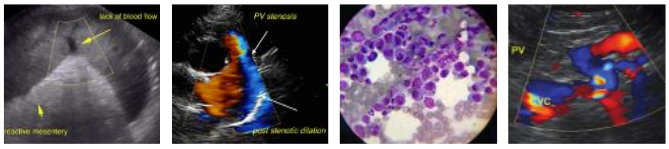

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Ziggy Jocham

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

5 Years

WEIGHT

4.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

La Paw AH

REFERRING VET

Stephanie Sur. DVM

INVOICE

20650

DATE

1/19/23

PRESENTING CLINICAL SIGNS

History: -Patient has demonstrated intermittent vomiting (extremely large volumes of liquid-type vomitus) and borborygmi for ~ 2 years. -No CSD in the history. -Patient has slowly been losing weight -No improvement with hypoallergenic diet Patient sedated with dexdomitor/torb/ketamine for AUS due to poor compliance

Abnormal PE/Chem/CBC/UA Results: PE: thin, fractious. NSF Previous full blood work (uncertain date): reportedly WNL Previous GI panel (uncertain date): -- WNL 1/6/2023: Pre-op screen Antech: -- GLOB: 2.2 g/dL (2.3-5.3) -- remainder (BUN, Creat, ALT, ALP, Alb, BG, SDMA) are WNL CBC: -- WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Minor nondependent particulate sediment was present, which may indicate minor cellular debris/protein, crystalline debris, lipid or mucus, 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 and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. A mild hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. Both kidneys exhibited mild uniform increased cortex hypertrophy. The left kidney measured 4.4 cm. The right kidney measured 4.1 cm.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.36 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.29 cm.

Spleen

The spleen exhibited borderline enlargement (secondary to sedation) with a 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 inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 1.1 cm in width.

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.

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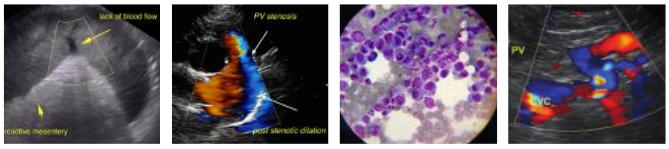

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The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach exhibited generalized mild variable prominent to thickened gastric walls, exhibiting regional subjective indistinct wall layer detail, primarily in the area of the ventral gastric body. The stomach contained a moderate amount of retained anechoic fluid without evidence of retained ingesta, foreign material or mechanical pyloric outflow obstruction. The gastric body wall measured 0.4 - 0.60 cm.

The small intestine presented intact wall layering with maintained 1:3 muscularis/mucosa ratio. No evidence of intestinal mural hypertrophy. Minor segmental nonobstructive intestinal ileus pattern was noted. The jejunum wall measured 0.24 cm. The ileocolic wall measured 0.30 cm.

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

Pancreas

The left pancreatic limb was mildly prominent to irregular in appearance, exhibiting mild capsule asymmetry and subtle hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

A small pocket of scant periintestinal free fluid in the mid abdomen. Intermittent isoechoic subjective benign/reactive mesenteric lymphadenopathy. An example measured 1.6 cm x 0.48 cm.

ULTRASONOGRAPHIC FINDINGS

- Minor urinary bladder sediment
- Bilateral nonspecific mild renal medullary rim sign. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.
- Generalized mild to variably thickened gastric walls with moderate retained gastric fluid
- Intact small bowel walls with mild nonobstructive ileus
- Suspect low grade pancreatitis
- Intermittent subjective benign/reactive mild mesenteric lymphadenopathy and scant mid abdominal periintestinal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically, the gastrointestinal tract is suggestive of inflammatory criteria with mild metabolic gastric and segmental intestinal ileus. Potential for infiltrative disease, such as lymphoma, is considered less likely yet cannot be definitively excluded. Dietary intolerance/food hypersensitivity, occult parasitism, as well as suspected low grade to chronic pancreatitis may be additional contributing clinical factors.

Recheck GI panel to include PLI/TLI/Cobalamin/Folate is recommended. A hydrolyzed diet trial with potential long term dietary therapy, gastroprotectants and empirical deworming if clinically applicable and assessment of clinical response would be reasonable. Intestinal biopsies are likely required for a definitive diagnosis and may be considered specifically if continued progressive weight loss.

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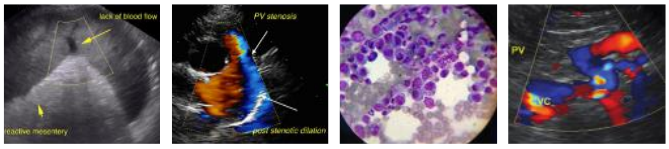

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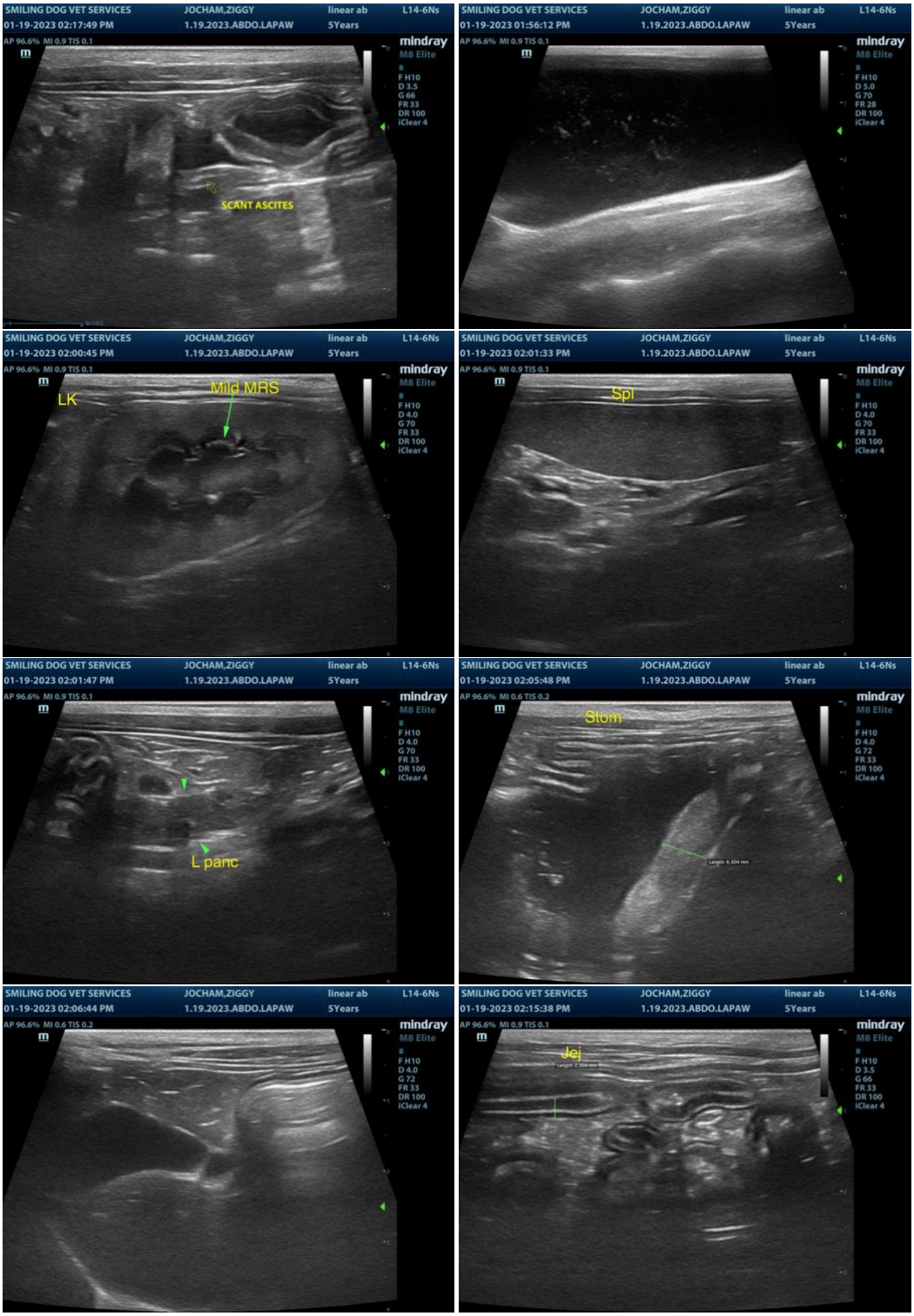

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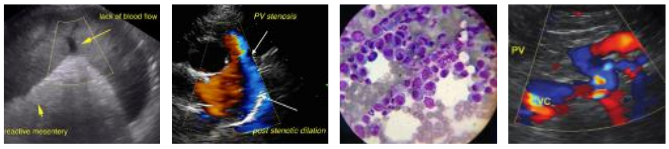

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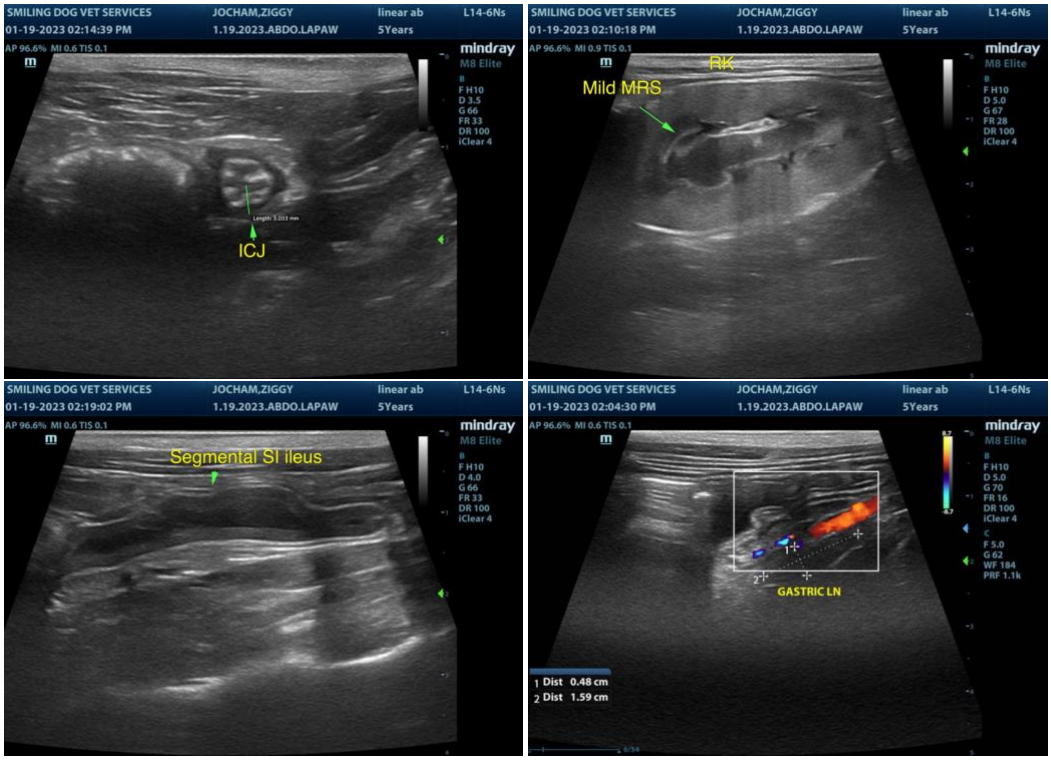

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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