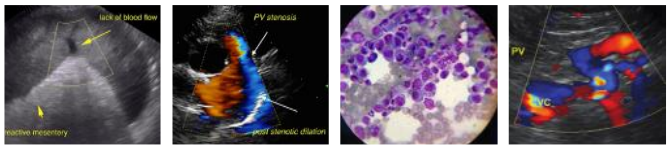
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Molly Enns

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

14

WEIGHT

4.82kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Westcott

HOSPITAL NAME

Dr. Westcott

REFERRING VET

Dr. Westcott

INVOICE

12848ag

DATE

01/31/2023

PRESENTING CLINICAL SIGNS

Molly presented for increased vomiting/regurgitation which is increased in frequency in the last 3 weeks. There was an episode of vocalization with defecation [soft but normally formed] in the middle of the living room. In the last 24 hours has been vomiting water but is able to eat and keep some food down. Is mostly an indoor cat. Has been no overt PU/PD and has had a good appetite. 3 years ago was diagnosed with an intestinal accident that "self corrected" without surgery/exploratory laparotomy

Abnormal PE/Chem/CBC/UA Results: A bit thin Mucous membranes pale pink Slight bloated field to the abdomen CBC and differential is unremarkable There is a suggestion of toxic neutrophils based on the histoplot There is a mild elevation in SDMA There is a elevation in GGT Mildly elevated amylase Normal FPL Normal total T4 Isosthenuria Notable pyuria with cocci evident and suspected rods

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal to borderline subnormal size and mild asymmetrical 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. Mild bilateral pyelectasia was present. The left kidney measured 3.2 cm in length. The right kidney measured 3.0 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.27 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.25 cm width.

Spleen

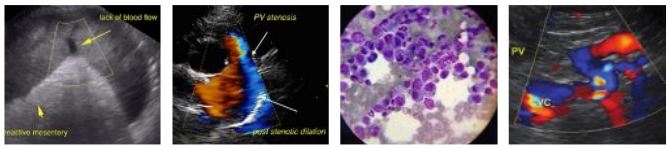
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.78 cm in width at the level of the hilus.

Liver/Gallbladder

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with primarily anechoic luminal content and minor echogenic luminal debris. The common bile duct was dilated and tortuous without overt post hepatic obstruction. The common bile duct measured 0.20 cm diameter.

Gastrointestinal



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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with mild luminal gas and no signs of ileus, obstruction or foreign material. A focal area of mild pyloric mucosal hyperplasia to non-obstructive pyloric polyp was present subjectively originating from the dorsal pyloric wall measuring 0.86 cm in diameter.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.22 cm width. The ileocolic wall measured 0.25 cm width.

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, likely consistent with age related changes and considered incidental. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses, significant/diffuse lymphadenopathy or peritoneal effusion was present.

A solitary minor benign/reactive gastric or pancreaticoduodenal lymph node was visualized.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic renal changes with minor pyelectasia
- Focal subjective non-obstructive pyloric mucosal hyperplasia/polyp-benign
- Overtly normal small bowel/pancreas
- Focal minor benign/reactive gastric or pancreaticoduodenal lymph node
- Mild non-obstructive proximal common bile duct dilation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bilateral pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Potential for low-grade chronic pyelonephritis is considered less likely. Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.

The finding of proximal common bile duct dilation may suggest age related changes or secondary to underlying cholangitis / cholangiohepatitis especially if previous or current liver enzymes elevations have been noted. No overt signs of post hepatic obstruction.

Given the size of the focal pyloric mucosal hyperplasia to polyp as well as lack of retained gastric ingesta, mechanical pyloric outflow obstruction is considered less likely yet some degree of delayed gastric emptying or secondary gastric irritation/mild gastritis could be possible. Smaller, more frequent feedings with a canned diet and as needed gastroprotectants may prove beneficial.

Sonographic monitoring of the gastric mucosal hyperplasia/polyp is recommended for evidence of progression specifically if evidence of regurgitation/vomiting.

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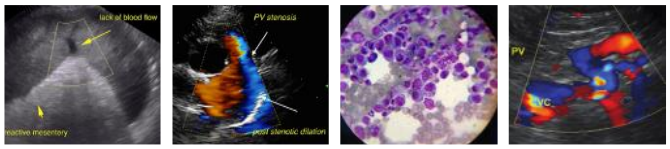

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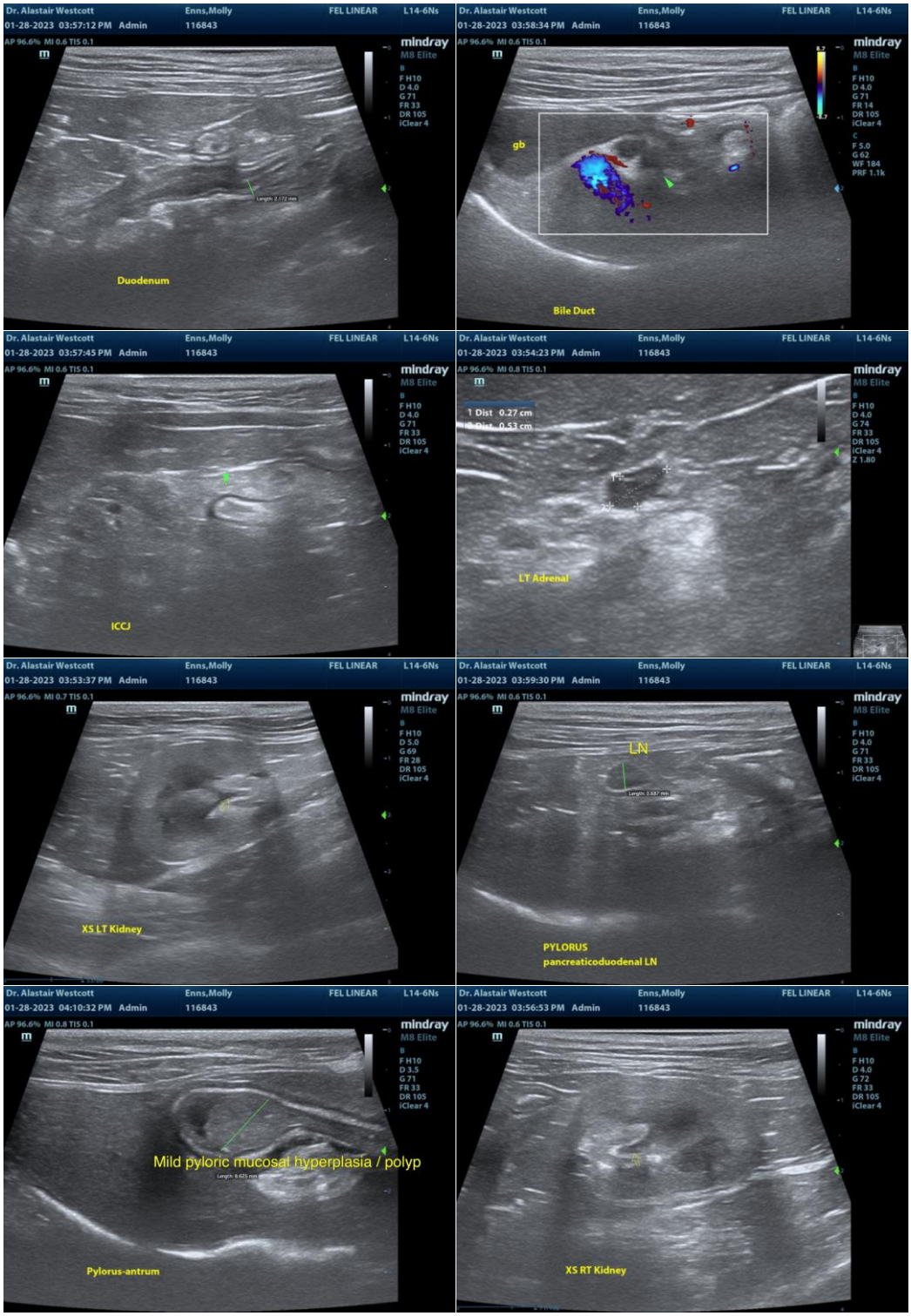

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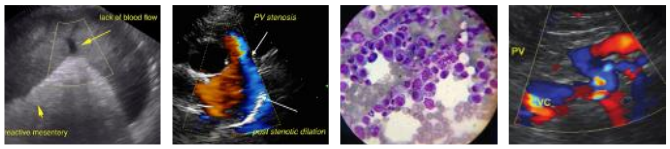

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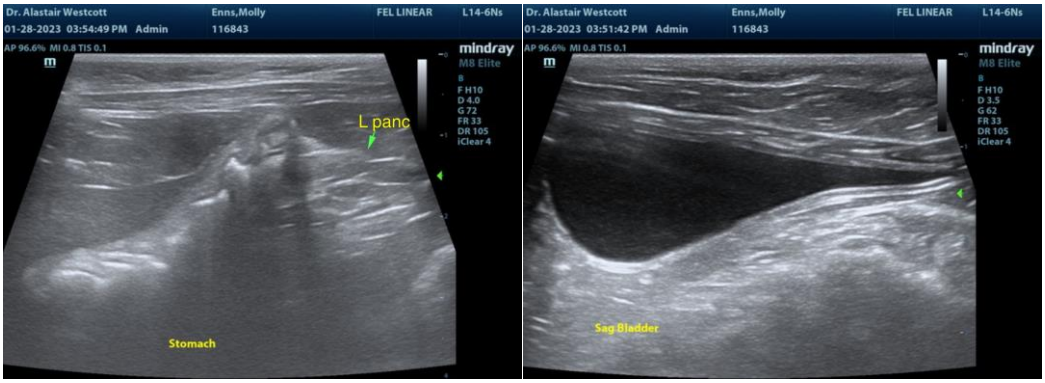

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
mac.daniel@sonopath.com