



PATIENT

Lucy Ittenbach

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

13 years

WEIGHT

6 lbs. 13 oz.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ebersole

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Peyser/Dr.
Chadbourne

INVOICE

15302

DATE

10/28/22

PRESENTING CLINICAL SIGNS

Anorexia and weight loss. History of constipation and well controlled hyperthyroidism. Presented to emergency specialty clinic on 10/23 for labored shallow breathing and newly noted nasal discharge. Rads, BW, warm water/lube enema, SQ fluids and Cerenia inj. Had a large BM after enema, but isn't eating and is losing weight. Rx: Clavamox, Lactulose. Continued Methimazole 2.5mg BID and Miralax SID.

Abnormal PE/Chem/CBC/UA Results: PE: QAR, was brighter yesterday. Painful on light pressure of mid abdomen. CBC/Chem (10/23) BG 216, ALT 168, mild Monocytosis. RADS (10/23): chest clear; extremely distended descending colon (wider than pelvic inlet). RADS (10/27 at recheck at RDVM, attached): small amount of stool in distal colon, gas filled proximal colon and part of SI. Rest 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. 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 was 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 minor loss of corticomodullary symmetry and definition expected for the age of the patient. Subjective decreased outer cortex parenchyma echogenicity was noted. Pinpoint areas of medullary mineral were noted. No evidence of pelvic dilation was present. The left kidney measured 3.5 cm in length. The right kidney measured 3.7 cm in length.

Adrenal Glands

No overt pathology was noted in the area of the right and left adrenal glands.

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 exhibited borderline enlargement. The spleen measured 1.0 cm width at the level of the hilus. No splenic masses or nodules were noted.

Liver/ Gallbladder

The liver was borderline enlarged yet maintained symmetrical capsule contour with uniform parenchyma exhibiting subtle generalized increased parenchyma echogenicity compared to the spleen. The gallbladder was non-distended in size containing primarily anechoic content with mild nondependent, echogenic gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.



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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. The gastric body wall width measured 0.24 cm.

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 small intestinal wall width measured 0.21 cm. No overt pathology was noted in the area of the ileocolic junction.

The colon exhibited sonographically unremarkable wall layering. The colon exhibited generalized distention primarily noted in the transverse and descending colon containing non-formed fecal matter.

Pancreas

The left pancreatic limb exhibited mild prominent size with areas of minor capsule asymmetry and nonhomogeneous discretely nodular parenchyma. No evidence of regional peripancreatic reactive or hyperechoic mesentery.

Free Abdomen

No omental masses, overt lymphadenopathy, or evidence of peritoneal free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Mild chronic renal changes
- Borderline splenomegaly - nonspecific, yet suspect incidental, hyperplasia, hematopoiesis, or potential splenitis, early splenic neoplastic criteria given the patient's weight loss cannot be definitively excluded
- Low-grade hepatopathy - suspect low-grade inflammatory disease i.e., cholangitis / cholangiohepatitis, no overt hepatobiliary neoplastic criteria
- Mildly prominent nonhomogeneous to discretely nodular left pancreas - patient / age related variant, discrete pancreatic nodular hyperplasia, chronic to chronic active inflammation all potentials, no overt evidence of pancreatic neoplastic criteria
- Sonographically unremarkable gastrointestinal tract
- Segmental to generalized distended colon containing non-formed fecal matter - consistent with history of constipation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, a definitive cause of the patient's clinical signs and weight loss was not obvious, yet may potentially be secondary to chronic constipation. Screening hepatosplenic FNA cytology, assuming normal clotting status and using a 25-gauge needle, is warranted primarily to assess for or possibly identify inflammatory cell type in the liver, as well as ensure only benign minor splenic changes are present.

Potential for low-grade pancreatitis would be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation in the area of the pancreas. Correlation with ideally a GI panel to



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include PLI/TLI/Cobalamin/Folate, which would also assess for or rule out occult small intestinal disease as a contributing factor, is recommended.

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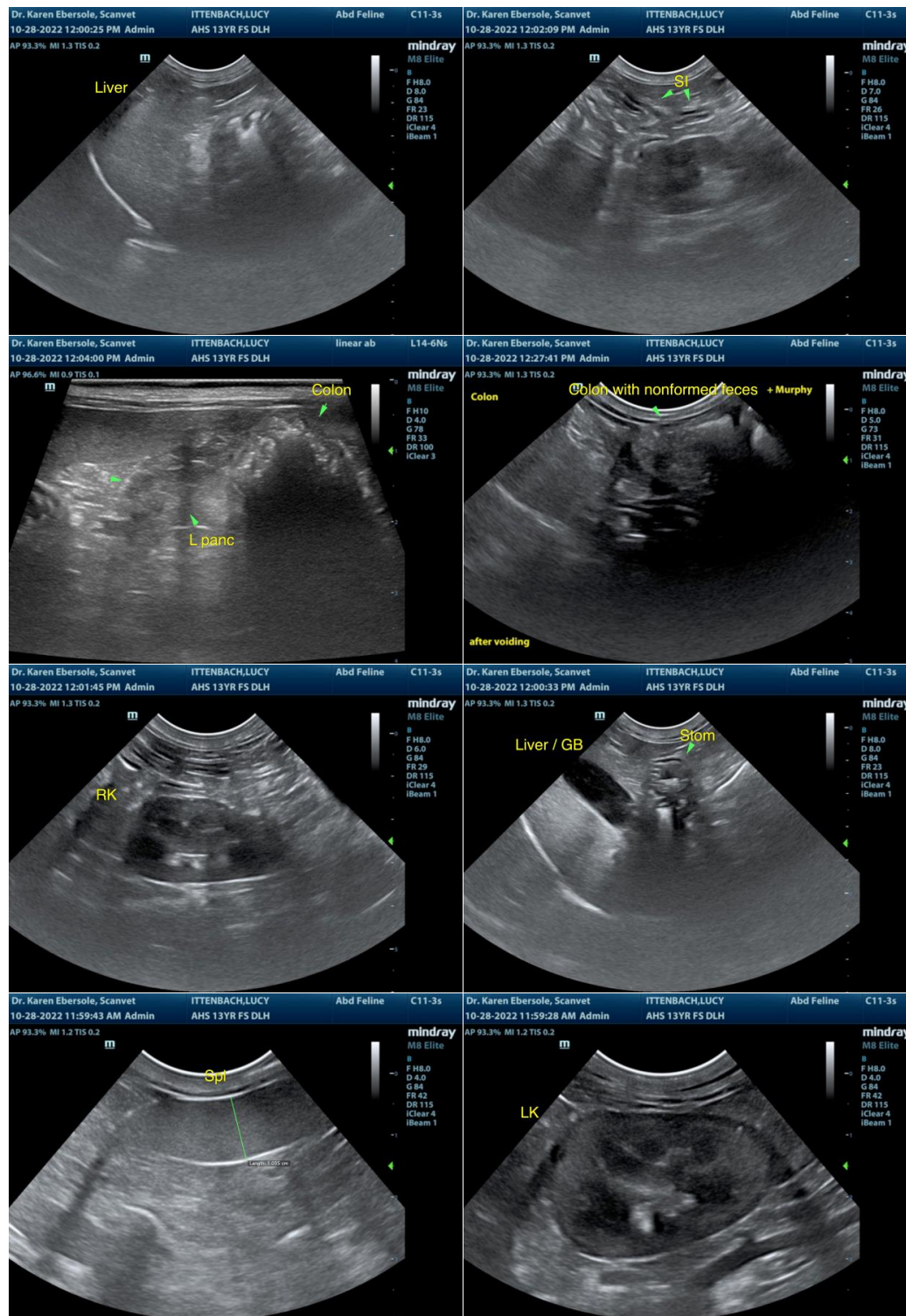
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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info@SonoPath.com

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