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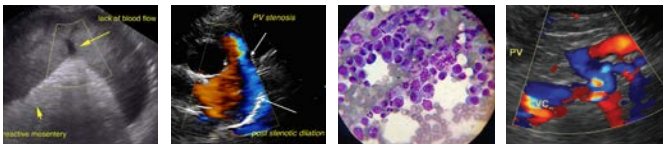

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1-800-838-4268 info@sonopath.com

PATIENT

Jeter O'Brien

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

15 Years

WEIGHT

7.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Loving Care VH

REFERRING VET

Dr. Steele

INVOICE

26076

DATE

10/6/21

PRESENTING CLINICAL SIGNS

Vomiting, not eating since Sunday. Weight loss (1lb since May). O changed to corn based clumping litter and saw Jeter grooming off fur. Chews up plastic bags (shoprite and from the dry cleaners) unsure if ingested as O sees it ripped up on floor. Current meds: Renabast
Abnormal PE/Chem/CBC/UA Results: Hct 27.9, Hgb 9.4, Lymph 9.22, monos 1.48, eos 0.08, Plt 99, Gluc 169, Chl 110, Alt 175

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – 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 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. Mild cortical hypertrophy present in both kidneys. The left kidney measured 3.9 cm. The right kidney measured 3.7 cm.

Adrenal Glands

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.39 cm. No overt pathology in the area of the left adrenal gland.

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 0.54 cm in width.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder and cystic biliary duct were mildly distended in size, containing anechoic content. The common bile duct was normal. This is likely owing to decreased food intake.

Gastrointestinal

The stomach presented mild wall thickening secondary to mild echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Minor retained anechoic fluid was present without evidence or Retained gastric ingesta or foreign material. No evidence of mechanical pyloric outflow obstruction.

The small intestine presented intact wall layering with generalized propensity for mildly prominent muscularis layer, yet without evidence of significant mural hypertrophy. Minor segmental small bowel ileus present without evidence of obstructive pattern as well as segmental to generalized luminal gas. Duodenum wall measured 0.27 cm. Jejunum wall measured 0.25 cm. Ileocolic wall measured 0.34 cm.

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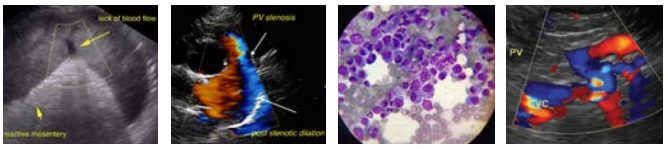

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The colon exhibited subjective mild generalized distention containing semiformed to potential nonformed feces. The colon walls were sonographically unremarkable.

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic inflammation. No overt evidence of neoplasia.

Free Abdomen

Intermittent, mildly prominent to enlarged mesenteric nodes were present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

Small pockets of very scant peritoneal free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Mild gastritis and gastric stasis
- Enteropathy with subjective mild prominent muscularis layer
- Associated intermittent mesenteric lymphadenopathy – probable mild hyperplasia or reactive lymphadenitis.
- Chronic active pancreatitis
- Low-grade hepatopathy – mild reactive or low-grade inflammatory hepatopathy possible

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt evidence of gastrointestinal obstructive pattern or obvious foreign material, although potential for small pieces of non-obstructive foreign material within the small intestine or colon (given the patient's history) cannot be definitively excluded. The appearance of the small intestine is suggestive of infiltrative enteropathy, IBD, or potential early neoplastic infiltrative enteropathy with round cells i.e., lymphoma, both of which may present in similar sonographic manner. IBD is favored given the intact wall layering and without evidence of concurrent significant lymphadenopathy.

Triad disease may be a consideration in this patient given the concurrent presence of probable chronic active pancreatitis and/or potential low-grade inflammatory hepatopathy. Full thickness intestinal biopsies +/- hepatopancreatic biopsies required for definitive diagnosis. Empirical therapy for IBD/Triaditis with as-needed gastrointestinal support would be reasonable. Dietary indiscretion, food intolerance, structurally insignificant inflammatory bowel or occult parasitism are all potentials.

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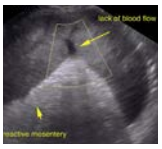
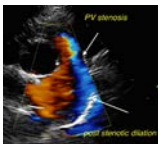
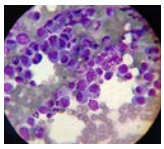
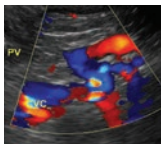

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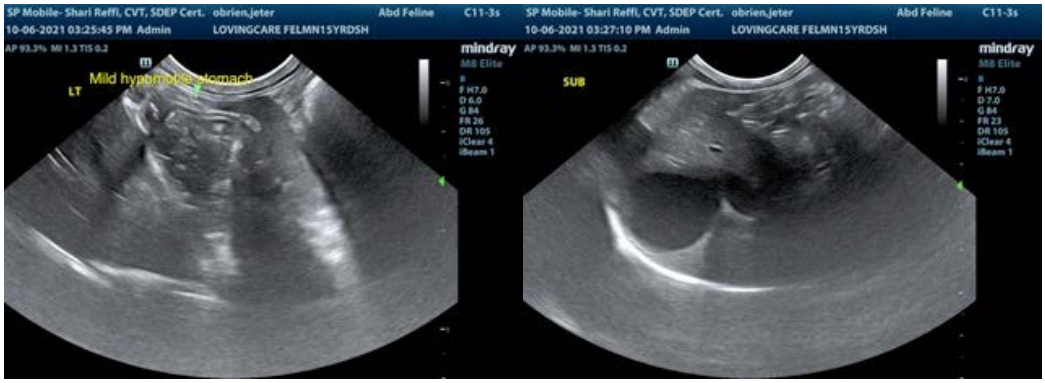

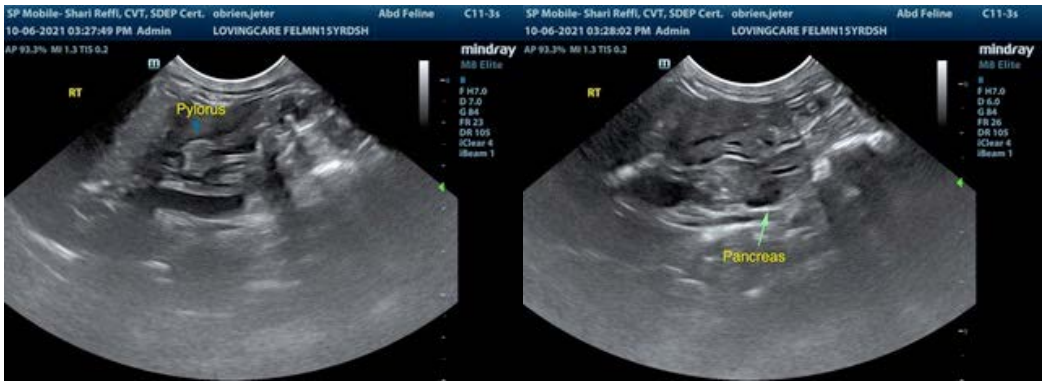

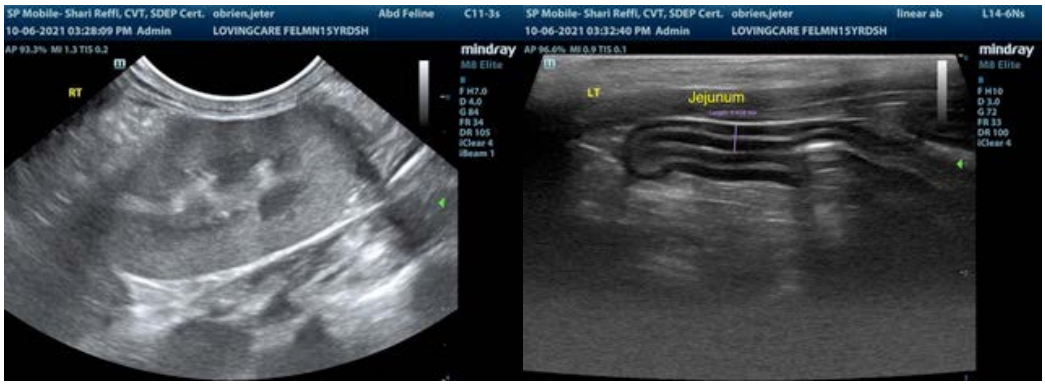

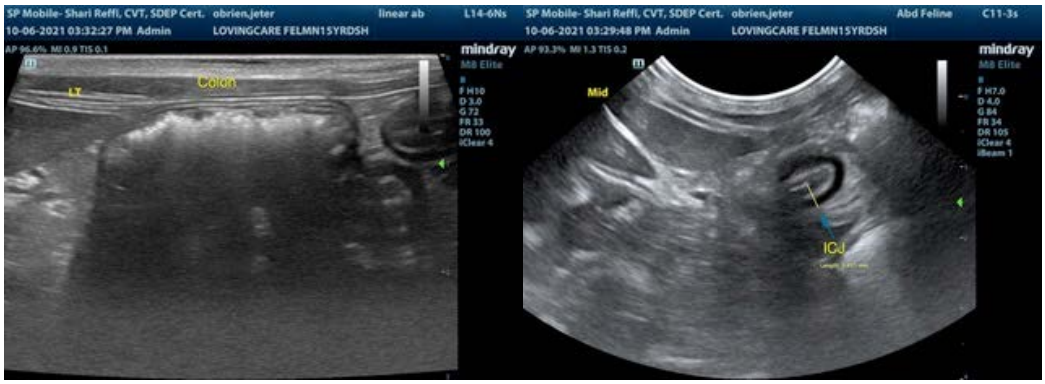

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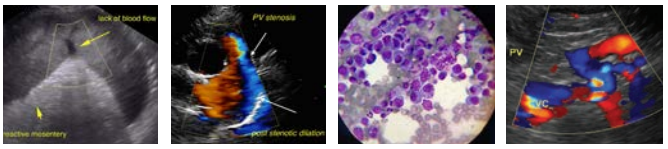

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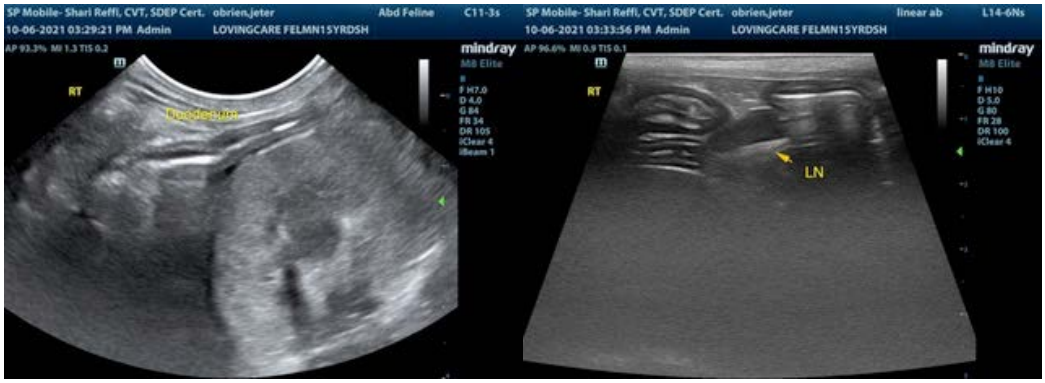

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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