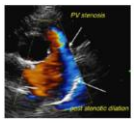
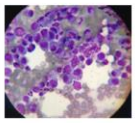
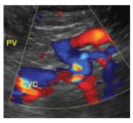

PATIENT

Oliver O'Brien

SPECIES

Feline

BREED

DSH

SEX

NM

AGE

7 years

WEIGHT

8 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Hartman

INVOICE

15317

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11-1-22

PRESENTING CLINICAL SIGNS

Today owner reports drinking more, has not eaten anything since yesterday morning. Diarrhea for just over a week, No vomiting, poor appetite, weight loss. Was treated with SQ fluids, cerenia, convenia, metronidazole. No improvement.

Abnormal PE/Chem/CBC/UA Results: elevated neutrophils, Chem 17, lytes, T4 all normal fPL - abnormal, Spec fPl - normal (1.5) UA - normal except blood (suspect this is due to cystocentesis)

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 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. The left kidney measured 4.0 cm in length. The right kidney measured 4.5 cm in length.

Adrenal Glands

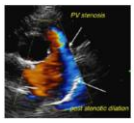
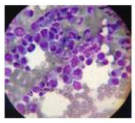
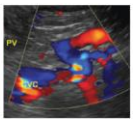
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.42 cm width. No overt pathology was noted in the area of the right adrenal gland.

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. Potential for mild medial folding of the cranial spleen, which is not indicative of underlying splenic pathology and likely a patient variant, was present. The spleen measured 0.7 cm width at the level of the hilus.

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 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.

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Gastrointestinal

The stomach presented intact and sonographically unremarkable wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate, likely retained, nonshadowing ingesta / chyme without overt evidence of mechanical pyloric outflow obstruction. The stomach was otherwise normal. The gastric body wall width measured 0.23 cm.

The small intestine exhibited intact wall layering with subjective maintained 1:3 muscularis/mucosa ratio. Generalized nonshadowing variably echogenic ingesta / chyme, along with segmental retained anechoic fluid, suggestive of segmental to generalized ileus or inefficient peristalsis pattern, were present. No overt evidence of mechanical obstruction secondary to obstructive mural pathology or foreign material to the level of the ileocolic junction. Small intestinal wall width measured 0.22 cm. No evidence of pathology at the level of the ileocolic junction. The ileocolic junction wall width measured 0.25 cm.

The colon exhibited overtly normal wall layering containing semi-formed to soft fecal matter consistent with patient history.

Pancreas

The left pancreatic limb was normal in size with minor capsule asymmetry. Subtle nonhomogeneous to hypoechoic parenchyma compared to adjacent omentum was present.

Free Abdomen

Intermittent, small pocket of scant peritoneal free fluid was present. Intermittent to multiple mid-ventral abdominal mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 2.6 cm x 1.2 cm.

ULTRASONOGRAPHIC FINDINGS

- Subjective low-grade to chronic pancreatitis pattern
- Intact gastrointestinal wall layering with primarily generalized gastrointestinal ingesta / chyme and suspect segmental to generalized ileus / inefficient peristalsis pattern
- Intermittent to multiple prominent to mildly hypoechoic mesenteric lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given that the patient is reported documented NPO or inappetent, the presence of gastrointestinal ingesta / chyme may suggest some degree of generalized gastrointestinal ileus or inefficient peristalsis pattern. At times, this may be seen with both underlying chronic inflammatory or neoplastic infiltrative enteropathy.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. No overt evidence of mechanical obstruction i.e., foreign material, intestinal mass, etc.

Screening FNA cytology of an enlarged mesenteric lymph node is warranted for further assessment. Definitive diagnosis would likely require full-thickness intestinal +/- lymphatic biopsies for

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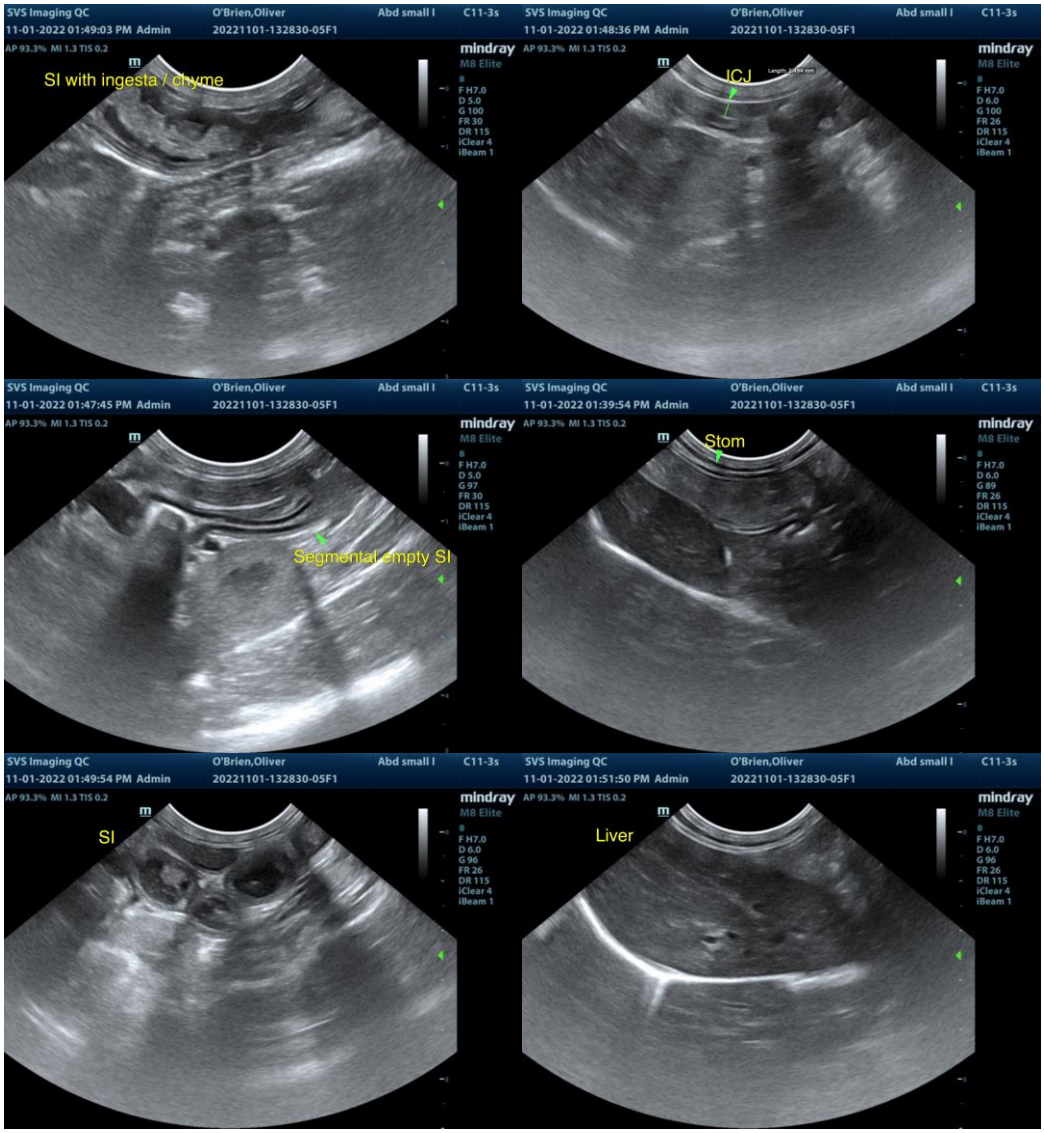
histopathology. Three-view chest radiographs are suggested to rule out occult thoracic pathology as a contributing factor to the patient's clinical signs and weight loss.

Empirically, as-needed gastrointestinal support with potential sonographic reassessment of the gastrointestinal tract following monitoring for persistent retained gastrointestinal ingesta may be considered.



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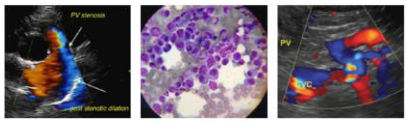

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Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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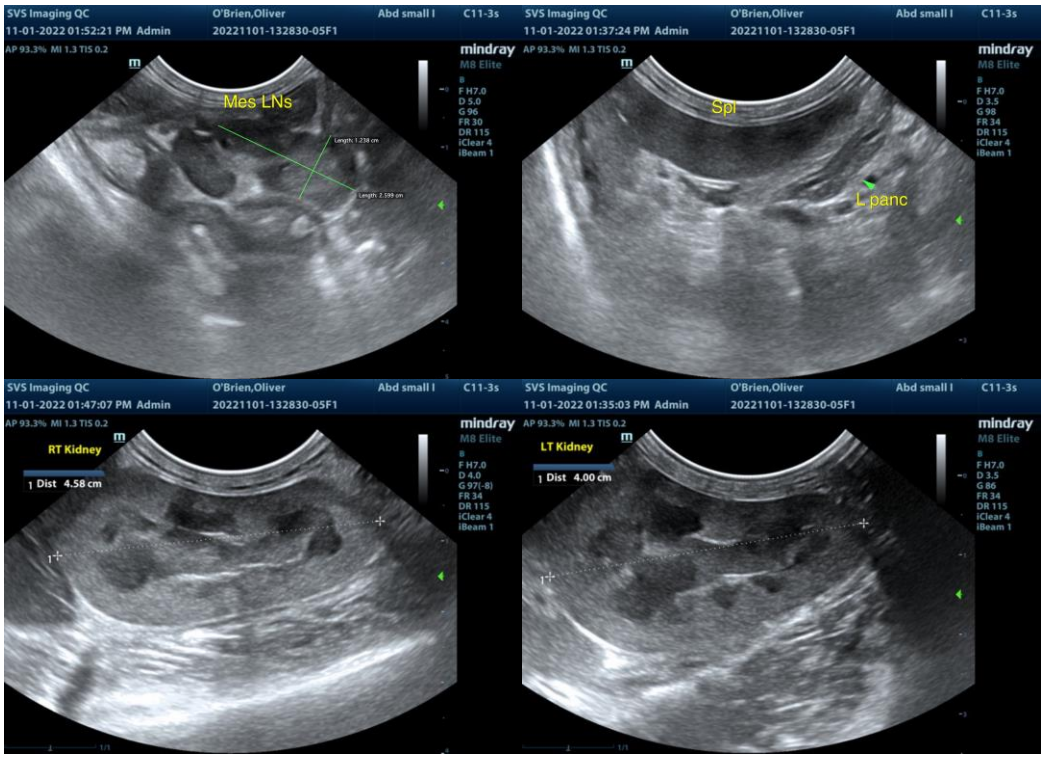

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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