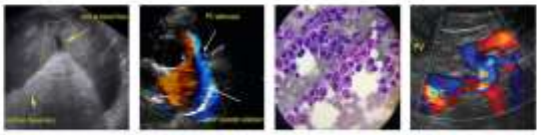


PATIENT

Nacho Meyer

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

14 years

WEIGHT

15 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME

Stanglein VC

REFERRING VET

Dr. Green

INVOICE

12618

DATE

11.15.2021

PRESENTING CLINICAL SIGNS

History: 3 week duration decreased appetite, ~2# weight loss

T4 0.5, otherwise unremarkable CBC/Chemistry Panel

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.0 cm in length. The right kidney measured 4.4 cm in length.

Adrenal Glands

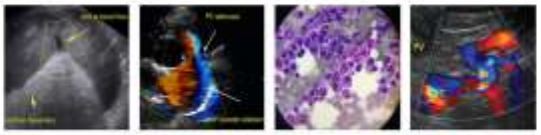
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.36 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.44 cm width.

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 0.93 cm width.

Liver/ Gallbladder

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. A solitary, nonspecific, non-expansive, mildly hypoechoic nodule was noted In the mid-dorsal parenchyma adjacent to the gallbladder, measuring 1.1 cm in diameter The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with mild, echogenic, nonmineralized biliary sludge. The proximal common bile duct was dilated and tortuous without overt post-hepatic obstruction. The common bile duct measured 0.24 cm diameter.



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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 0.25 cm.

The small intestine exhibited segmental mild yet hypoechoic mural hypertrophy with associated segmental metabolic to paralytic ileus, along with a mild amount of retained, nonspecific to shadowing ingesta with potential for hairball density. Loss of distinct wall layering was noted within the segmentally thickened intestine. This segment of the intestine measured potentially 4.0-5.0 cm in length with wall width measuring 0.44 cm. By comparison, normal-appearing jejunum measured 0.20 cm wall width.

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

Pancreas

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

Free Abdomen

Associated regional peri intestinal reactive mesentery and likely mesenteric lymphadenopathy were present. No overt evidence of peritoneal effusion was noted.

Probable subcutaneous fat or lipoma noted ventral to the urinary bladder, yet not overtly within the abdominal cavity was present.

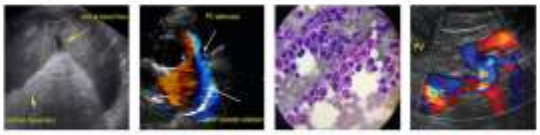
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Segmentally thickened small bowel with associated mild metabolic to paralytic ileus and minor retained nonspecific ingesta, potential for luminal hairball density or similar
- Associated regional mild peri intestinal reactive mesentery and likely minor lymphadenopathy
- Suspect low-grade chronic active pancreatitis
- Nonspecific hepatic parenchymal nodule
- Mild gallbladder debris with nonobstructive proximal common bile duct dilation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder debris may be secondary to fasting or indicate nonclinical cholestasis. The proximal common bile duct finding 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.



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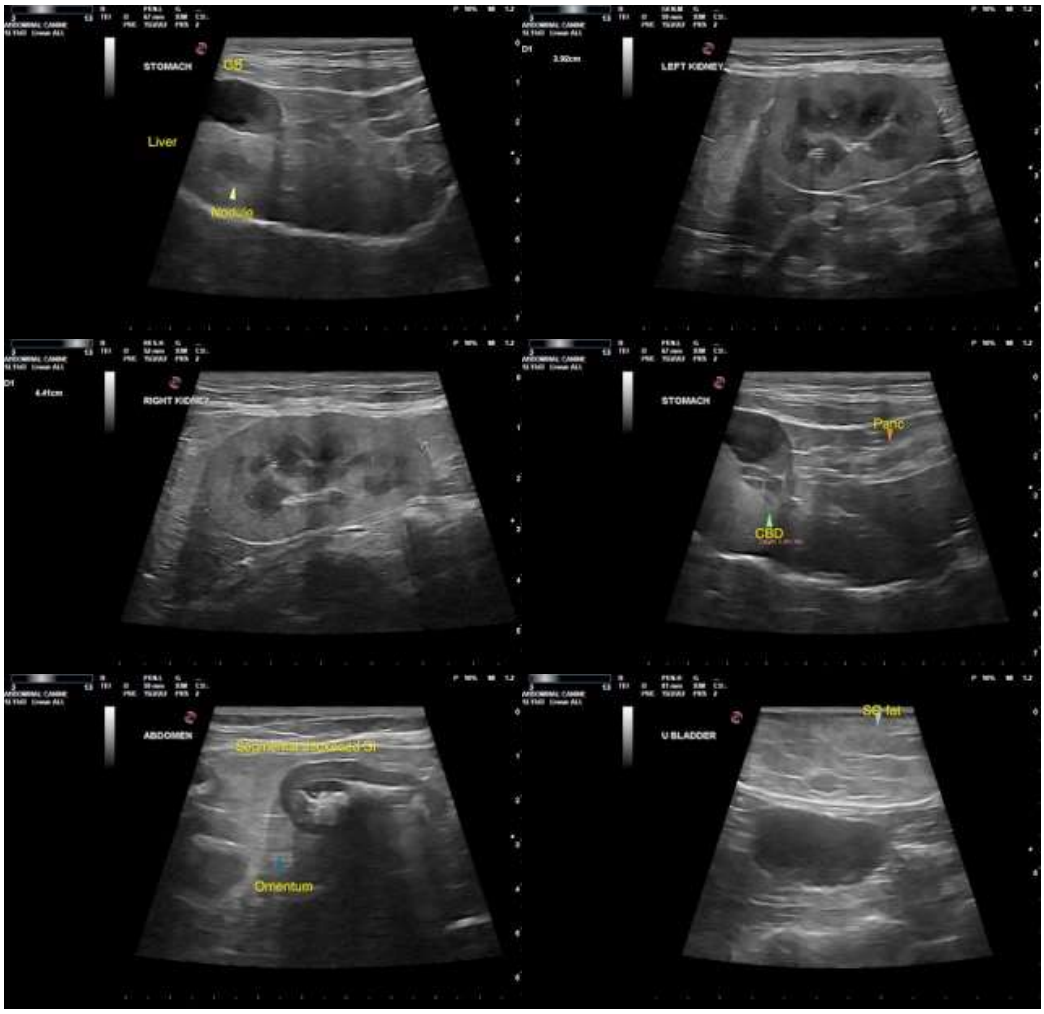
The nonspecific hepatic nodule may indicate benign processes such as hematopoiesis, nodular hyperplasia, or similar. The possibility of potential primary, neoplastic, or metastatic nodule cannot be definitively excluded. If accessible, ultrasound-guided FNA of this nodule, prior to surgical considerations, could be considered vs. sonographic monitoring.

The primary finding in this case is in regards to the segmental intestinal tract which may indicate segmental to potentially diffuse Inflammatory or neoplastic infiltrative enteropathy with round cells. Potential for nonobstructive foreign material i.e., hairball density is possible, although not definitive. Intestinal biopsies and/or resection anastomosis of the segmental thickened intestinal tract is required for a definitive diagnosis.

If surgery is not an option, appropriate IBD protocol with as-needed gastrointestinal support and sonographic monitoring of the intestinal tract could be considered. Three view chest radiographs are suggested to rule out occult thoracic pathology.



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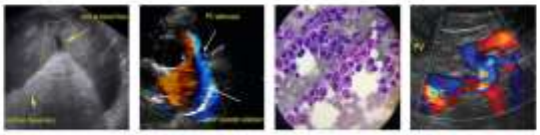

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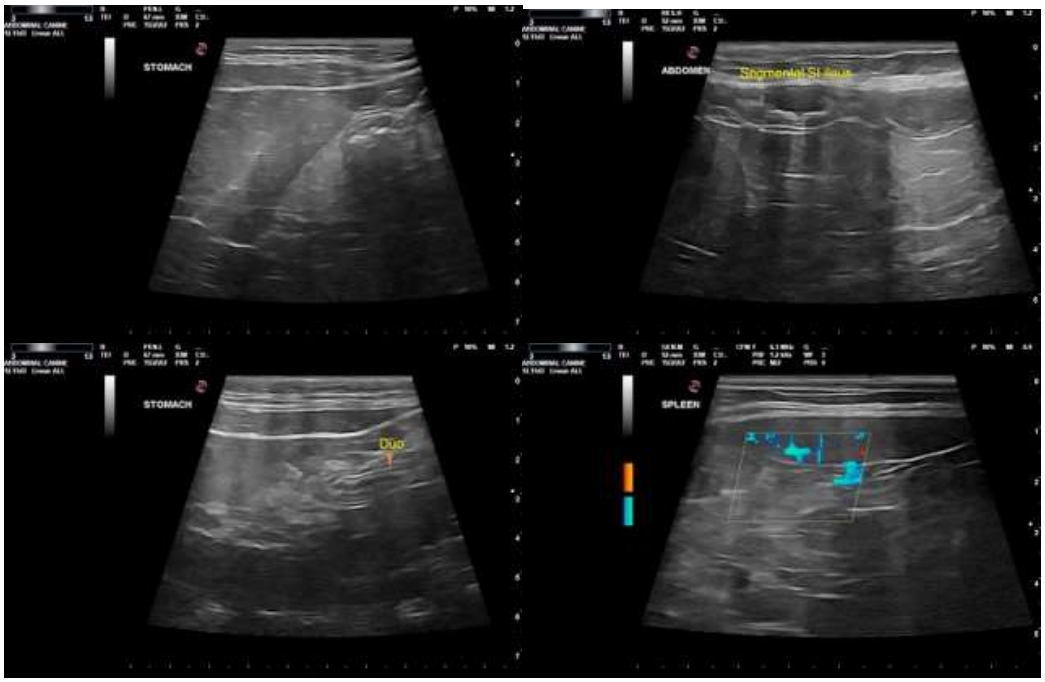

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com