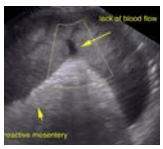
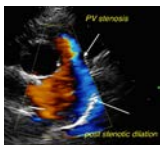
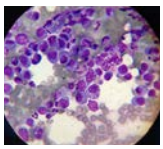
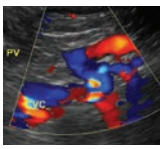

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1-800-838-4268 info@sonopath.com

PATIENT

Salem Faubion

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

17 Years

WEIGHT

3.75 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Callihan

HOSPITAL NAME

Animal Emergency Care

REFERRING VET

Dr. Baker

INVOICE

42881

DATE

11/20/22

PRESENTING CLINICAL SIGNS

Intermittent inappetence for ~2 weeks. Ate a small amount last night but nothing this morning. Owner also reports weight loss. Started Clavamox 11/17 for a UTI that was diagnosed at Fairhaven. Current meds: Clavamox, Methimazole, Lactulose and Cerenia. Finished Elura. Not giving Miralax currently. Seen at AEC on 11/12 for inappetence and constipation - treated with SQ fluids, enema, Cerenia and Mirtazapine.

Abnormal PE/Chem/CBC/UA Results: -small mass effect palpated distal colon -On 10/27/22 - bw done then and was reported to be WNL; normal concentrated urine -check lytes/gluc/BUN/Cr today normal

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 were noted.

The right kidney was normal in size at 3.6 cm. The left kidney was mildly subnormal in size at 2.7 cm. 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. A hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is likely an idiopathic finding.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.30 cm. The right adrenal gland measured 0.38 cm.

Spleen

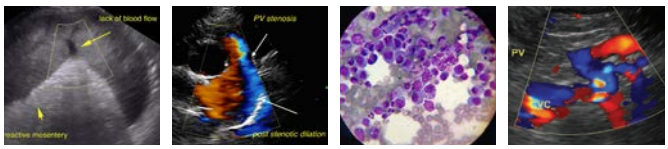
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The spleen measured 0.79 cm in width at the level of the hilus. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

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 was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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.



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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. Duodenum wall measured 0.26 cm. Jejunum wall measured 0.26 cm. Ileocolic wall measured 0.34 cm.

The colon exhibited overtly normal size with primarily intact, sonographically unremarkable wall layering. A focal discrete area of ventral descending colon mural hypertrophy was subjectively present, exhibiting subjective intact to mildly indistinct wall layering, measuring approximately 0.60 cm x 0.40 cm. By comparison, normal appearing descending colon wall measured 0.12 cm. Formed, strongly shadowing fecal matter present in the distal descending colon and area of colorectum with nonformed fecal matter in the subjective proximal and transverse colon.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. Likely consistent with age related pancreatic changes, and incidental.

Free Abdomen

Minor isoechoic colic lymphadenopathy noted adjacent to the ileocolic junction. These discreet colonic lymph nodes were not consistent with inflammatory or neoplastic criteria.

No evidence of peritoneal free fluid or omental masses.

ULTRASONOGRAPHIC FINDINGS

- Bilateral mild nonspecific medullary rim sign
- Variably formed feces in colon with formed to shadowing feces distal colon / colorectum
- Subjective focal mild to discrete thickened ventral descending colon - no obvious desc colon / colorectal mass
- Sonographically unremarkable GI / pancreas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, primarily geriatric to nonspecific abdomen without evidence of overt or significant visceral pathology. Nonstructural GI disease or low-grade pancreatitis, which may present sonographically normal, dietary intolerance, nonobstructive constipation possible. A GI panel to include PLI/TLI/Cobalamin/Folate as well as three view chest radiographs and neurological / musculoskeletal examination are recommended to assess for or rule out occult disease which may cause weight loss. The focal mild thickened ventral descending colon is not obstructive and not obviously suggestive of emerging neoplasia yet sonographic monitoring of this area is recommended especially if progressive signs of constipation.

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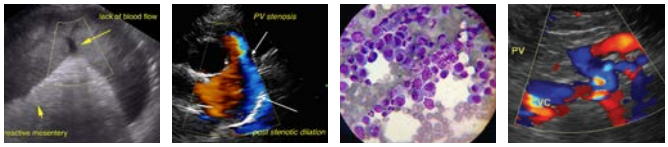

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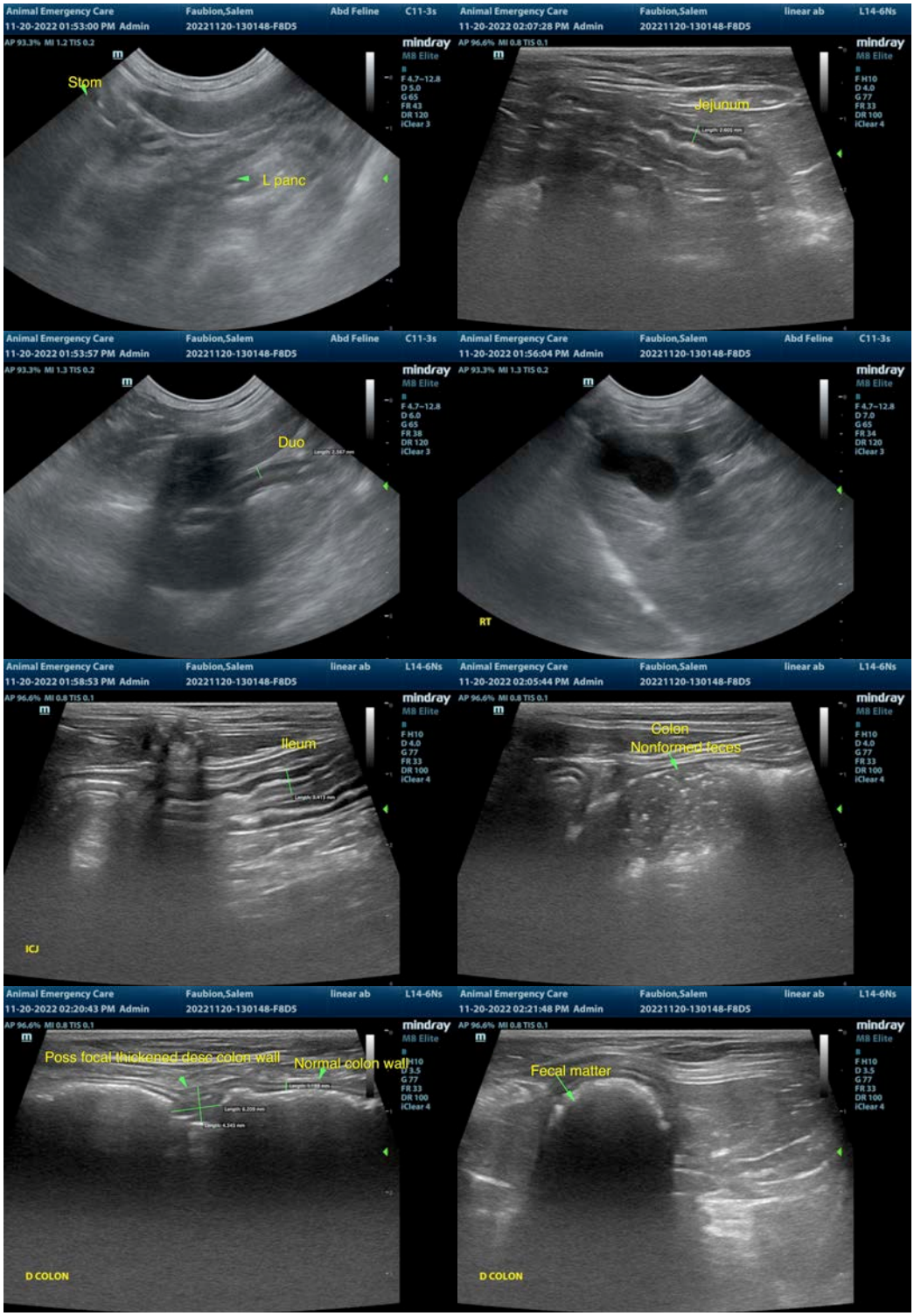

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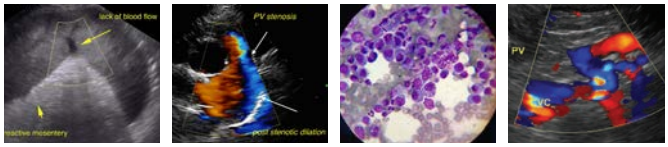

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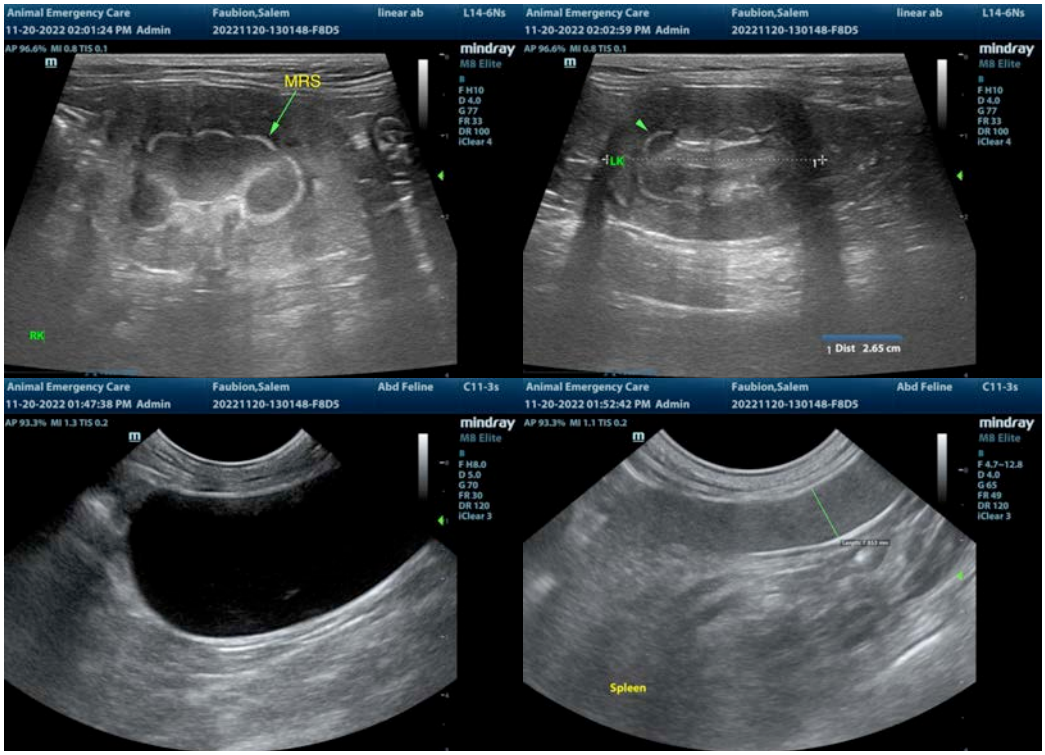

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com