SonoPath
Clinical Sonography & Telecytology
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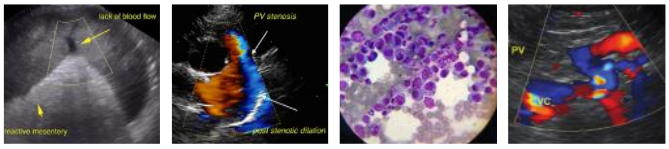

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Finn Marchensky

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

7 years

WEIGHT

6.16 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sarah Barthelemy

HOSPITAL NAME

Cranston VH

REFERRING VET

Dr. Nielsen

INVOICE

15355

DATE

11/3/22

PRESENTING CLINICAL SIGNS

Started vomiting in June and elevated spec fpl at that time. Normalized and now vomiting has returned, 2-3x/day . Normal bowel movements. No weight loss. Diet change occurred after initial vomiting episodes and that improved it for period of time but has now relapsed. Current diet RC GI moderate calorie.

Abnormal PE/Chem/CBC/UA Results: Elevated spec fpl in June at 4.9. Creat in June 139, sdma 14. Spec fpl repeated in July and normalized to 3. Labs to be repeated today.

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 4.4 cm in length.

Adrenal Glands

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

Spleen

The spleen exhibited borderline to mild enlargement with 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 1.2 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 proximal common bile duct was dilated and tortuous without overt post hepatic obstruction. The common bile duct measured 0.25 cm diameter. The mildly dilated to tortuous proximal common bile duct did not appear to extend caudally to the level of the duodenal papilla.

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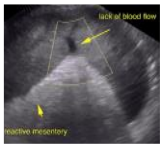

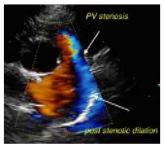

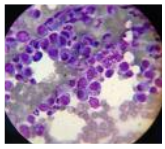
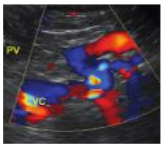

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Gastrointestinal

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 0.30 cm.

The small intestine presented intact wall layering and primarily maintained a 1:3 muscularis/mucosa ratio with segmental propensity for subtle to mildly prominent muscularis layer. No evidence of intestinal masses or loss of intestinal wall layering. The duodenum wall measured 0.26 cm width. The jejunum wall measured 0.27 cm width. The ileocolic wall measured 0.32 cm width.

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

Pancreas

The pancreas was normal in size and contour with subtle hypoechoic parenchyma compared to adjacent omentum with mild subjective peripancreatic hyperechoic mesentery.

Free Abdomen

A solitary gastric or pancreaticoduodenal was present in the right cranial abdomen adjacent to the stomach and pancreas base. The lymph node was homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. The lymph node size was 1.0 cm in diameter. Concurrent, intermittent, minor mesenteric lymph nodes were noted. No omental masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

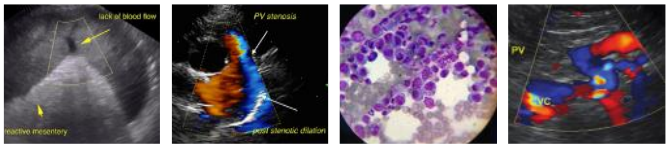
- Intact to segmental mildly prominent small intestinal walls
- Possible low-grade pancreatitis
- Mild nonobstructive common bile duct dilation
- Focal nonspecific yet likely benign gastric / pancreaticoduodenal lymphadenopathy
- Borderline to mild splenomegaly - nonspecific, subjectively benign, likely indicative of incidental hyperplasia, hematopoiesis, splenitis, possible mild splenomegaly owing to sedation if clinically applicable, no evidence of neoplastic criteria

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This proximal common bile duct dilation 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.

Screening splenic FNA could be considered primarily to ensure only benign changes are present, assuming normal clotting status and using a 25-gauge needle if evidence of weight loss.

Although potential for a normal patient variant, the small intestine exhibited subtle segmental mural changes which may suggest underlying inflammatory enteropathy. Dietary intolerance / food hypersensitivity or occult parasitism as contributing factors are possible. Correlation with pending



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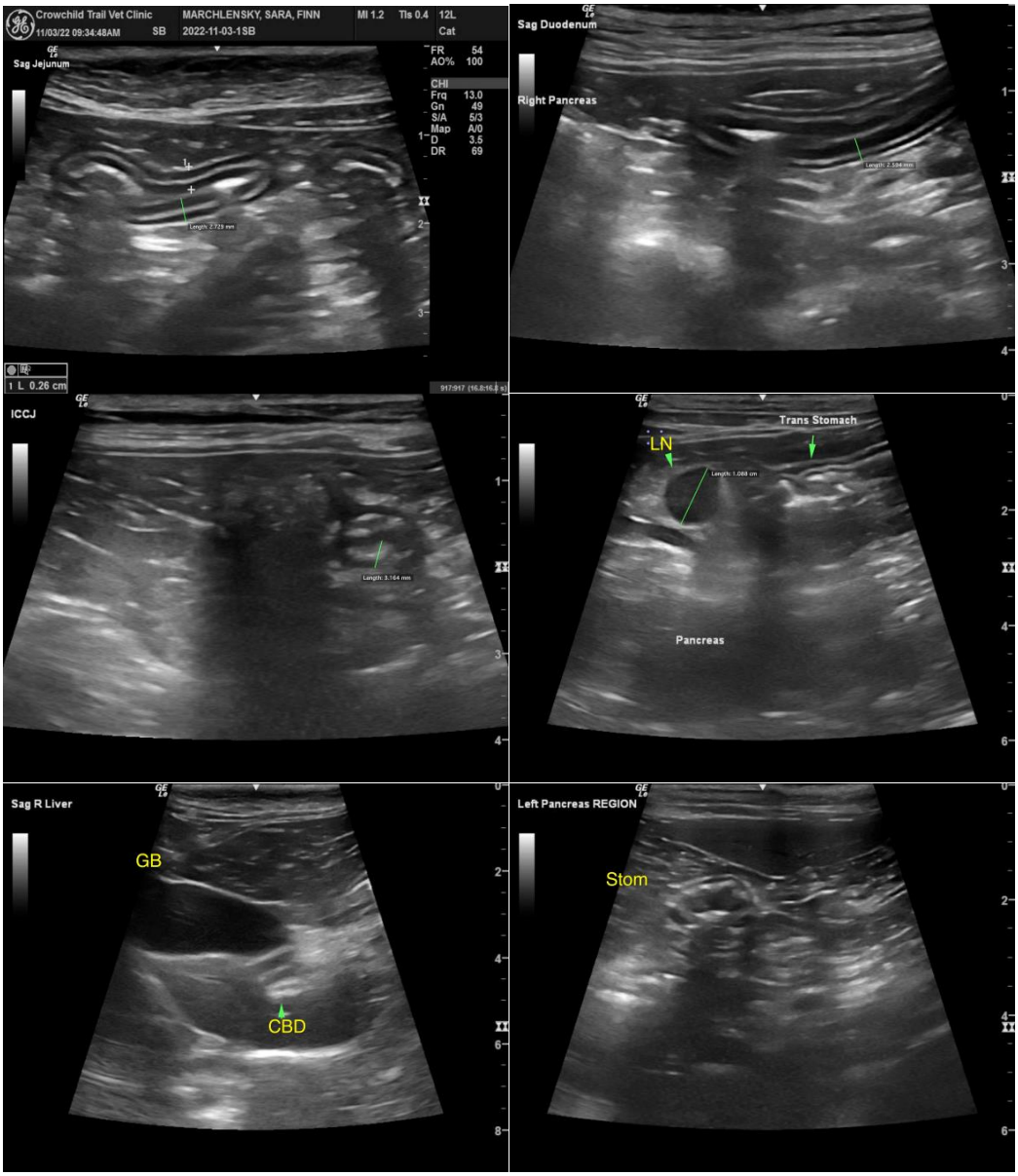
recheck lab work, possible recheck Spec fPL, or a full GI panel to include PLI/TLI/Cobalamin/Folate could be considered.

Conservatively, a hydrolyzed diet trial with as-needed GI support +/- broad spectrum deworming and assessment of clinical response would be reasonable.



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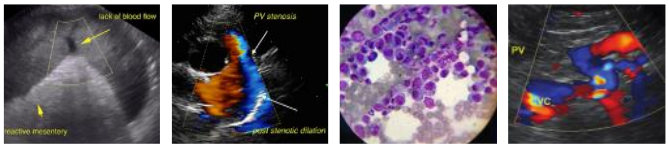

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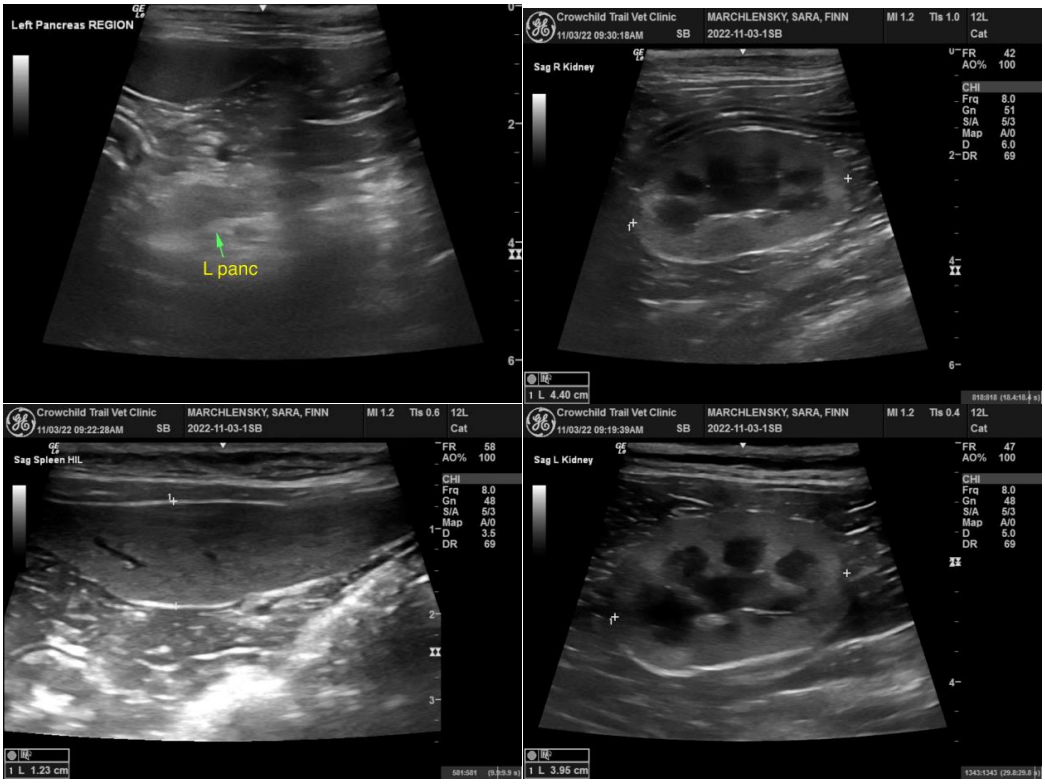

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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