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Clinical Sonography & Telecytology
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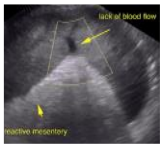
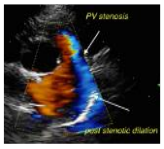
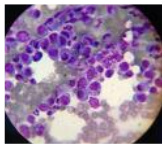
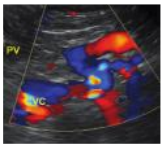

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Lucy Goldsworthy

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

13

WEIGHT

6.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Belan

HOSPITAL NAME

Bowmont AH

REFERRING VET

Dr. Asemadahun

INVOICE

15675

DATE

12/20/22

PRESENTING CLINICAL SIGNS

Lethargic vomiting enlarged ICCJ area on Ab x rays . Given 3 enemas on Saturday
Abnormal PE/Chem/CBC/UA Results: Non diagnostic

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 4.1 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 0.3 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.36 cm width.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. A solitary, non-expansive, hyperechoic nodule was present in the cranial to caudal parenchyma measuring 0.32 cm in diameter, consistent with probable benign myelolipoma. 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 or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas. The spleen was normal in size measuring 0.7cm width at the level of the hilus.

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. 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 mildly dilated and tortuous without overt post hepatic obstruction.

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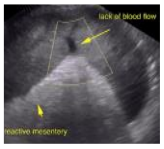

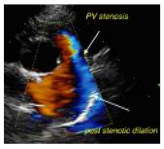

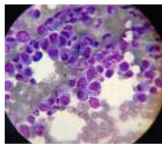
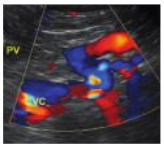

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Gastrointestinal

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 small intestine presented intact wall layering with generalized primarily maintained 1:3 muscularis/mucosa ratio. Subjective propensity for a mildly prominent muscularis layer was noted primarily in the subjective mid to distal small intestine extending to the level of the ileum. The small intestinal wall width measured 0.25 cm. The ileocolic junction exhibited mural thickening with indistinct to lost wall detail. The ileocolic wall width measured potentially up to 0.7 cm wall width.

Mildly thickened, hypoechoic wall layering was noted in the proximal colon extending to the transverse colon with subjective proximal to transverse colonic distention containing strongly shadowing formed fecal matter. The proximal colon wall width measured 0.28 cm.

Pancreas

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

Free Abdomen

Multiple, variably sized yet primarily mild, colic to jejunocolic lymph nodes were present primarily around the ileocolic junction. These lymph nodes were homogenous, mildly hypoechoic, and smoothly marginated. A normal width: length ratio was maintained (<0.5). Concurrent regional hyperechoic omentum around the ileocolic junction without evidence of overt peritoneal free fluid were noted.

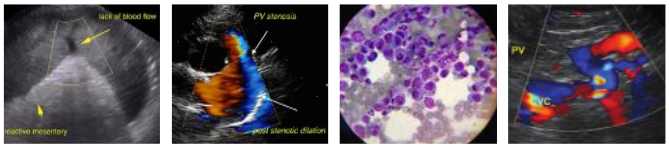
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Thickened ileocolic junction exhibiting indistinct wall layer detail
- Intact yet prominent adjacent to generalized ileum / small intestinal wall layering
- Mildly thickened proximal colon exhibiting subjective proximal to transverse colic distention containing strongly shadowing formed fecal matter
- Regional primarily peri-ileocolic hyperechoic mesentery and associated colic / jejunocolic lymphadenopathy

Secondary Findings

- Benign splenic nodule
- Mild chronic renal changes
- Nonobstructive proximal common bile duct dilation - likely age-related variant, potential for low-grade cholangitis if previous history of hepatic enzyme elevations



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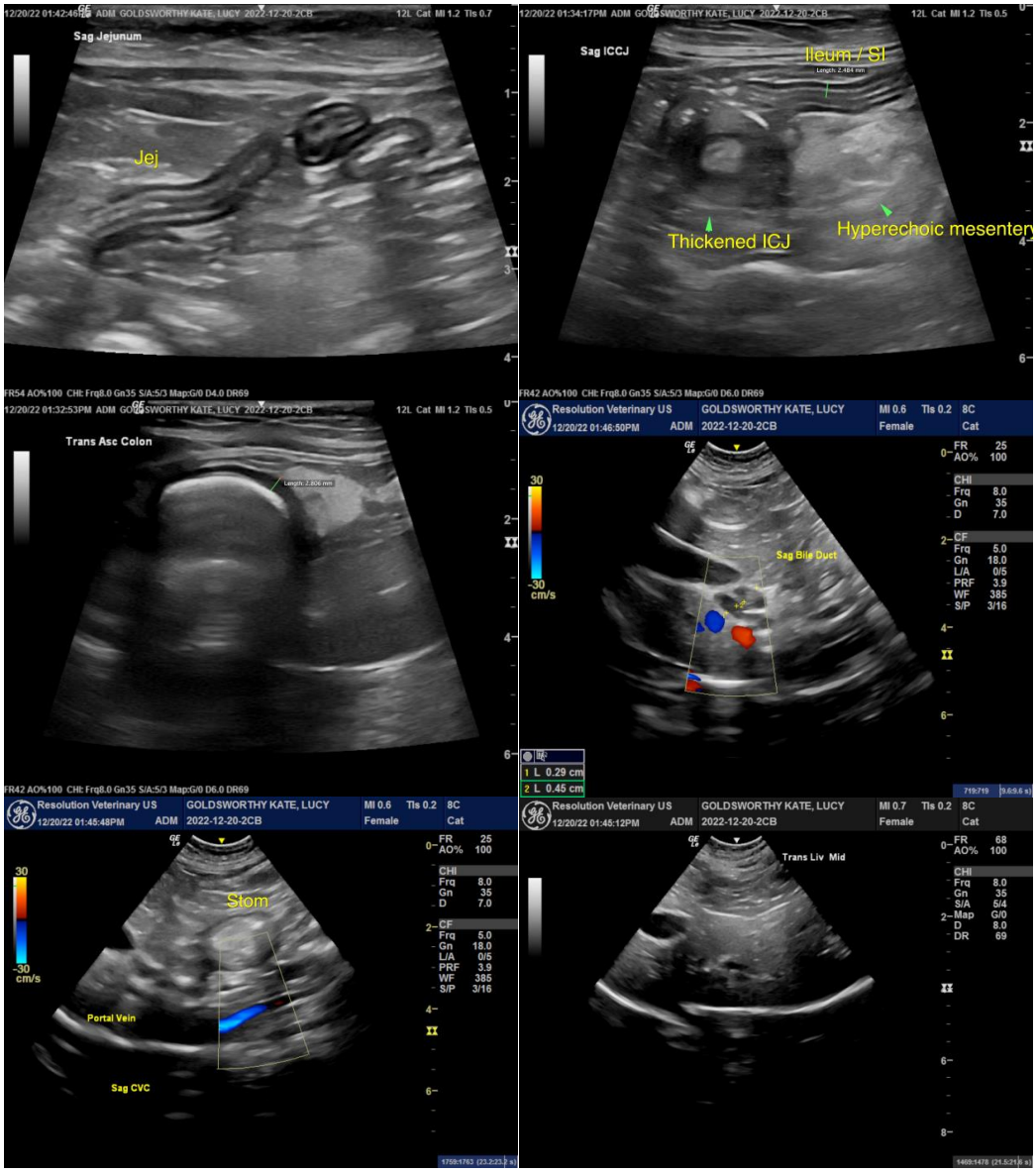
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ileocolic and small intestinal mural changes may indicate inflammatory vs. neoplastic infiltrative enterocolonopathy with associated regional lymphatic hyperplasia, reactive lymphadenitis, or possible early neoplastic lymphadenopathy. Intestinal biopsies are required for definitive diagnosis.

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Empirical IBD protocol with as-needed gastrointestinal support and assessment of clinical response +/- recheck sonogram to assess for progressive enterocolic mural changes would be reasonable.



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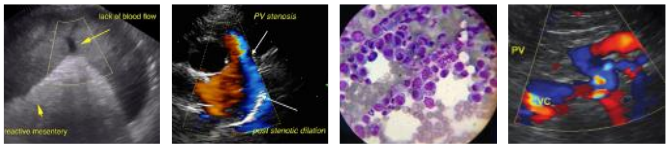

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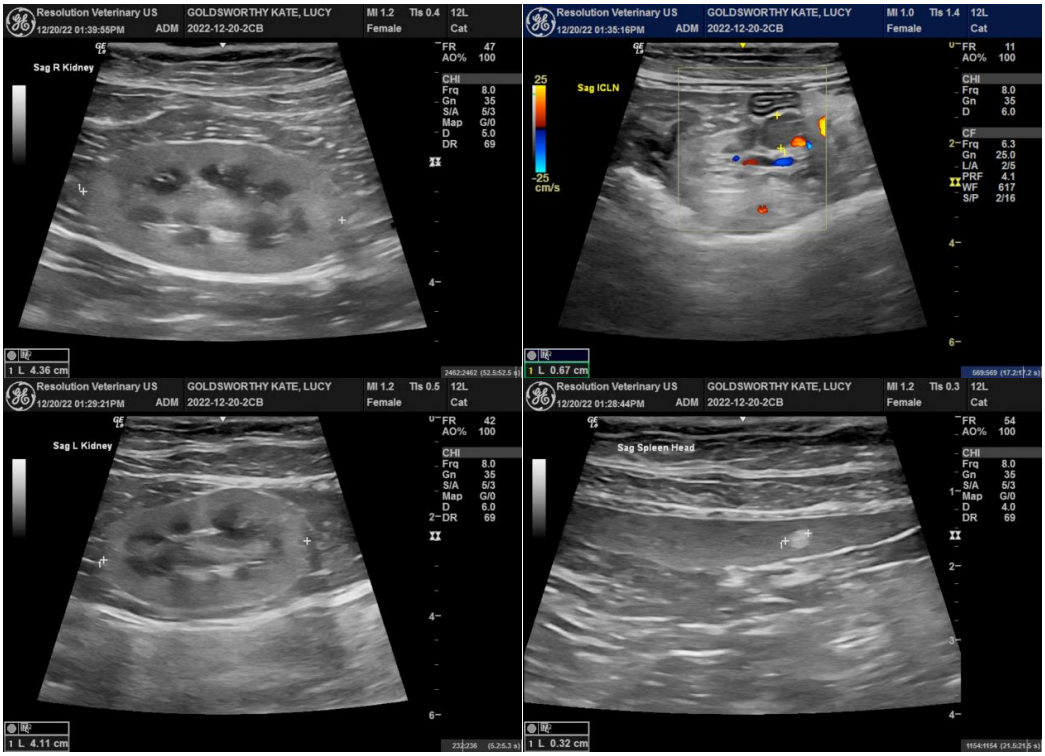

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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