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Clinical Sonography & Telecytology
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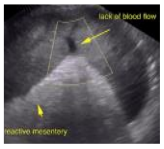
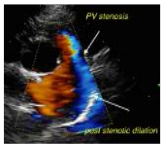
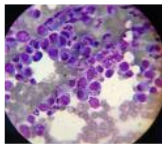
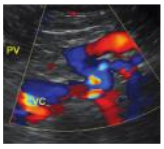




SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Faith Furry Friends Network

SPECIES
Feline

BREED
DSH

SEX
F/S

AGE
8 months

WEIGHT
5.8 lbs

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

IMAGING PERFORMED BY
Dr. Jennifer Todd

HOSPITAL NAME
Lambs Gap Animal Hospital

REFERRING VET
Dr. Jennifer Todd

INVOICE
16037

DATE
2/1/23

PRESENTING CLINICAL SIGNS

Faith is an eight month old, FS, DSH who was rescued as a very young kitten and is under the care of Furry Friends Network Rescue. She has had chronic liquid diarrhea since being rescued. Multiple comprehensive parasite screens and diarrhea PCR for tritrichomonas, giardia, crypto, salmonella, toxo, panleuk, campy, coronavirus have been performed. Summary of timeline and treatments below: Summary: Faith diarrhea since July 2022, failure to thrive July Fecal Isospora, treated with albon and metronidazole increased ALT, increased GGT, anemia, monocytosis August fecal Neg Sept fecal Neg October diarrhea, decreased albumin, increased globulin, marked increased WBC, anemia treated with panacure, proviable, amoxi improved slightly October 30th diarrhea PCR=campylobacter, c. perf. alpha=43 treated with tylan November severely increased WBCs, FUO PCR wnl treated with clindamycin for possible Toxo December diarrhea PCR c. per alpha=2565 treated with azithromycin and metronidazole January diarrhea PCR c. per alpha=5447 Suggestions by internal medicine consult: * bland highly digestible canned diet exclusively such as I/D or EN or Biome *continue proviable *need repeat CBC and chemistry asap *consider tylan for 1-2 weeks post resolution of symptoms *consider B12 injections weekly *consider fecal transplantation *consider novel protein diet *consider imaging Internist sees kittens with diarrhea and poor start to take up to first year of life before GI gets stabilized with chronic GI disease, c.perf. alphatoxin is overgrowth, secondary, not primary but even though is secondary, at this level is likely contributing factor Repeat CBC, chemistry panel is attached as a pdf for your information (1/30/23) Idexx flagged for internal path review of CBC also included on report. Additional consult with internal medicine advised: Increased Globulin and Age make FIP high on rule out list -other rule outs could be fungal, toxo, neoplasia, chronic GI abscess from GI perforation Next diagnostic steps should be 12 hour fasted abdominal ultrasound and GI panel (GI panel will not give you cause, but will tell us if she needs supplementation) -if free fluid in abdomen, collect and submit for FIP PCR -could consider abdominal exploratory with full GI biopsies, toxo titers, histoplasmosis on urine Abdominal US and TLI/PLI/Cobalamin/Folate submitted today.

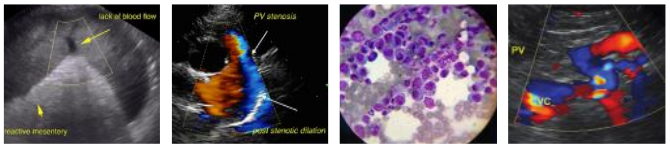
ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild to moderate, non-dependent, particulate sediment, which may indicate cellular debris / protein, crystalline debris, lipid or mucus, was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were 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. A subtle to indistinct hyperechoic corticomedullary band, consistent with a subtle to indistinct 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,



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lymphoma, and FIP. However, it is a nonspecific finding. The left kidney measured 3.7 cm in length. The right kidney measured 3.8 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 0.23 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.22 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.

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.

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 0.24 cm.

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. The duodenum wall measured 0.28 cm width. The jejunum wall measured 0.22 cm width. The ileocolic wall measured 0.29 cm width.

Normal visible colon wall layers were present with generalized semi to non-formed fecal matter consistent with patient history.

Pancreas

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

Several to multiple midabdominal to peri-intestinal 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 minor perilymphatic hyperechoic omentum was present. An intermittent scant pocket of peritoneal free fluid was noted in the caudal abdomen and adjacent to the small intestine. An example of a mesenteric lymph node measured 1.5 cm length x 0.61 cm width at the caudal pole.

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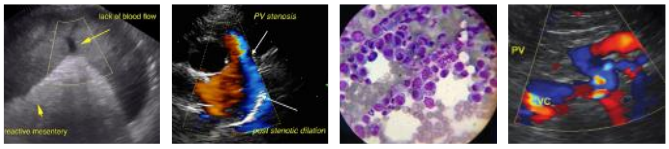

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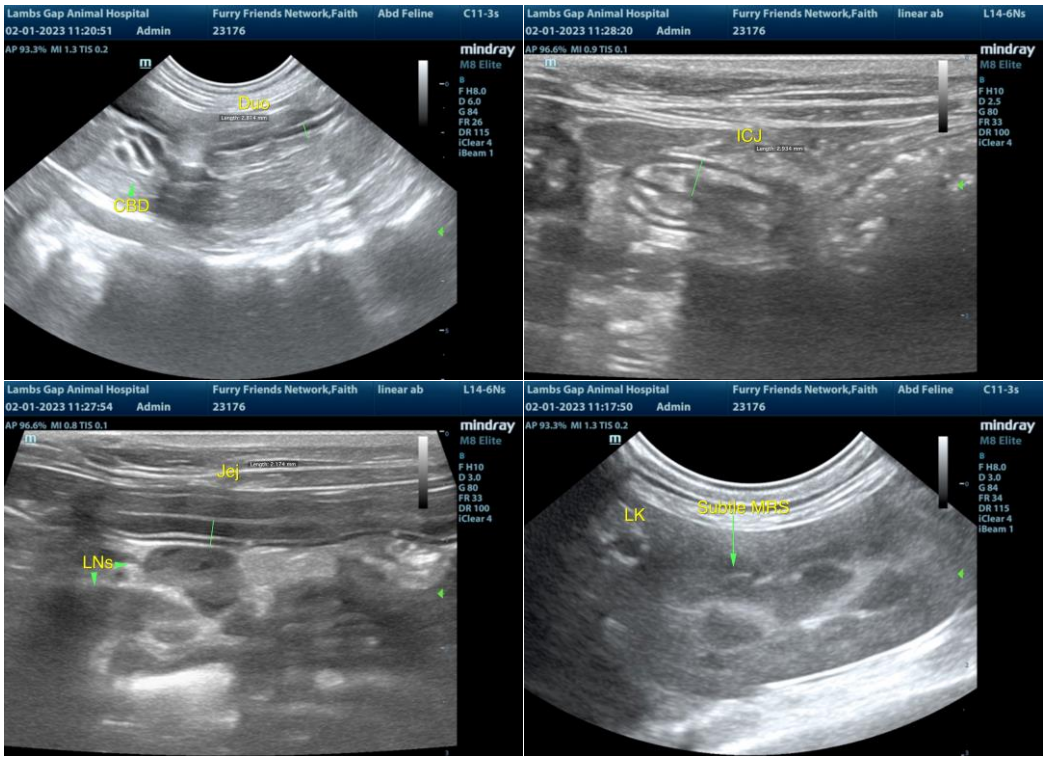
ULTRASONOGRAPHIC FINDINGS

- Structurally unremarkable gastrointestinal tract / colon with semi to non-formed fecal matter
- Intermittent nonspecific mesenteric lymphadenopathy, intermittent small pocket of scant caudal abdominal to peri intestinal free fluid
- Bilateral subtle nonspecific medullary rim sign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically, no evidence of significant gastrointestinal mural pathology, intussusception, intestinal masses, or significantly altered wall layer ratio. Likewise, no evidence of significant peritoneal free fluid, sufficient enough for free fluid analysis +/- additional diagnostics. The lymph nodes may indicate primary or secondary lymphoid hyperplasia, reactive lymphadenitis owing to underlying intestinal disease, emerging granulomatous or possible neoplastic lymphadenopathy, or immunologic immaturity. Possible ultrasound-guided FNA of a mesenteric lymph node, if accessible and of adequate size could be considered for further assessment. Full-thickness intestinal +/- lymphatic biopsies are likely required for a definitive diagnosis. Pending additional diagnostics, a hydrolyzed or possible lower carbohydrate diet (< 7% carbs) +/- non-flavored fiber supplementation could prove beneficial.



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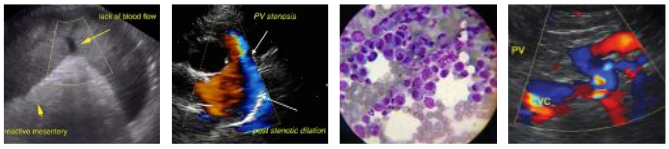

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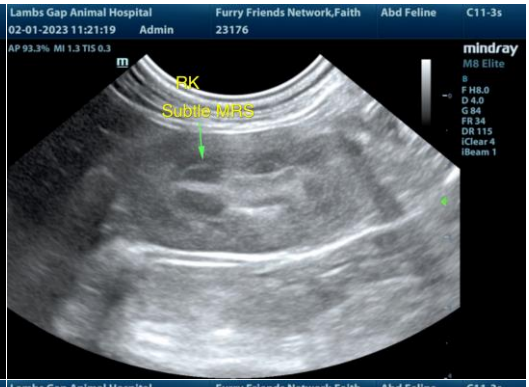

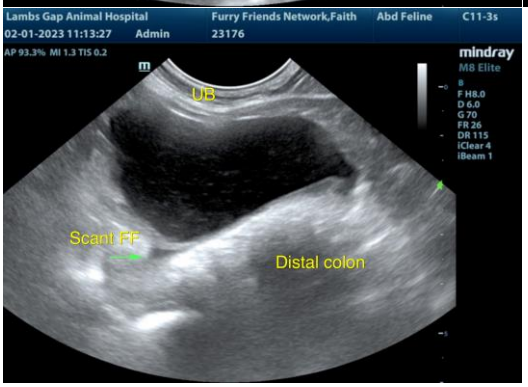

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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