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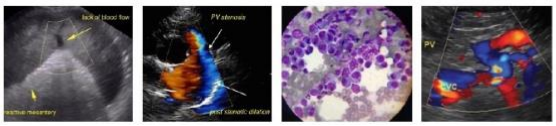

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Boris Weston

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6 Years

WEIGHT

5.00 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Chippawa AH

REFERRING VET

Dr. Dowell

INVOICE

13930

DATE

2/14/22

PRESENTING CLINICAL SIGNS

History: Weight loss, syringe feeding, itchy skin and lethargic. FIV positive. Has been on Cerenia, Restoralax, Viralys, Doxycycline and now Prednisolone. Has been seen eating cat litter. Was favouring left front leg recently also. Has also been on Hypoallergenic food but does not love it.

Abnormal PE/Chem/CBC/UA Results: Hematocrit decreased and worsening. Worsening Auto - agglutination. Anemia Real PCR negative. FIV positive.

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.

Normal size and margination was 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 4.3 cm in length. The right kidney measured 4.3 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 0.32 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.48 cm.

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

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. Mild retained ingesta, exhibiting subtle progressive to dirty distal acoustic shadowing was present. The gastric body wall measured 0.25 cm.

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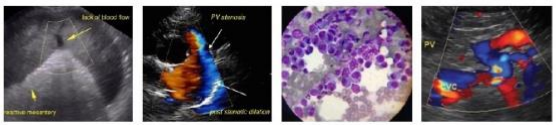

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The small intestine presented intact wall layering with subjective propensity for segmental to generalized mildly prominent muscularis layer to the level of the ileocecocolic junction. The duodenum wall measured 0.28 cm. The ileocolic wall measured 0.33 cm.

The proximal colon walls exhibited prominent to mildly thickened indistinct wall layering. The proximal colon wall measured 0.5 cm in wall width. Non-formed feces present in the proximal to transverse colon with subjective formed feces present in the descending to distal colon.

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 was evident.

Free Abdomen

No overt lymphadenopathy noted.

ULTRASONOGRAPHIC FINDINGS

- Suspect mild chronic inflammatory enteropathy.
- Prominent to mildly thickened proximal colon, exhibiting indistinct wall layering, non-formed feces present in the proximal to potential transverse colon.
- Overtly normal stomach, containing mild potentially retained progressively shadowing ingesta.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine exhibited subtle to mild mural changes which are suggestive of chronic, likely inflammatory enteropathy. Concurrent colitis suspected. The current use of prednisolone, however, may potentially be suppressing gastroenterocolic mural changes. Potential for nonobstructive hairball density in the stomach, if clinical history of hairballs is possible, although potential retained ingesta or (if documented NPO) mild gastric stasis could be present. Potential for low grade neoplastic enteropathy or potential emerging infiltrative proximal colonopathy cannot be excluded.

Further assessment may include GI panel, to include PLI, TLI, cobalamin and folate as well as three view chest radiographs to rule out occult thoracic pathology as a contributing factor to the patients weight loss and anemia. Enterocolic biopsies are likely required for a definitive diagnosis.

Empirically, continued gastrointestinal support +/- IBD protocol, pending GI panel, would be reasonable. Empirical cobalamin supplementation suggested, if GI panel is not elected. CBC pathology review may be considered given the worsening anemia. Conservatively, sonographic monitoring of the small intestine and colon for progressive mural changes, pending clinical response to therapy, is recommended.

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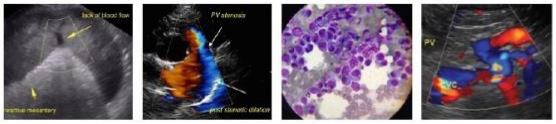

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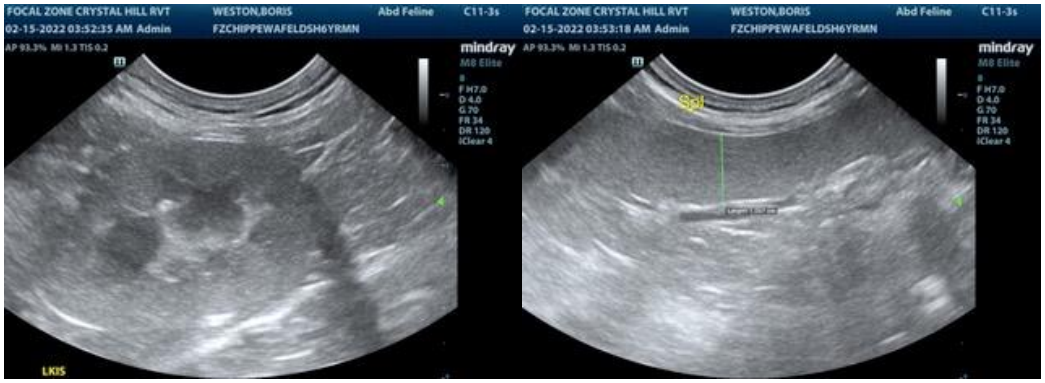

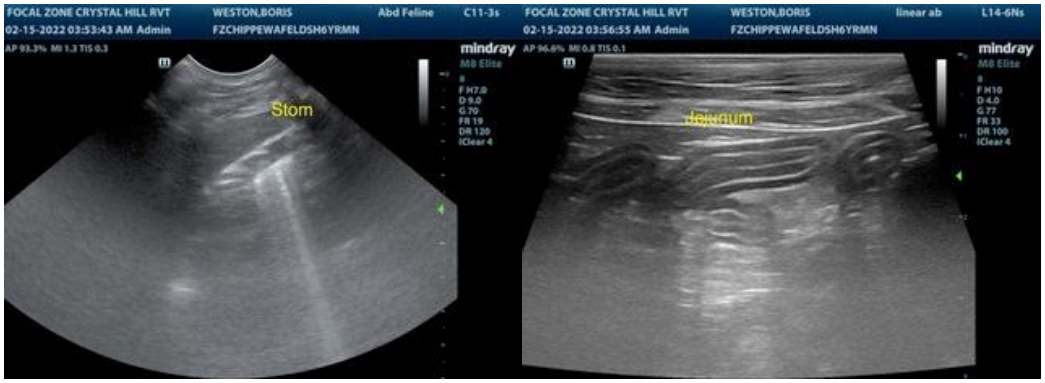

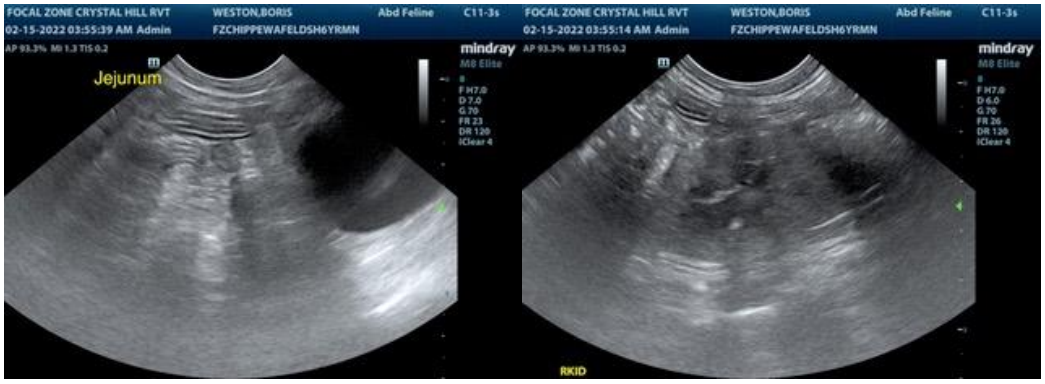

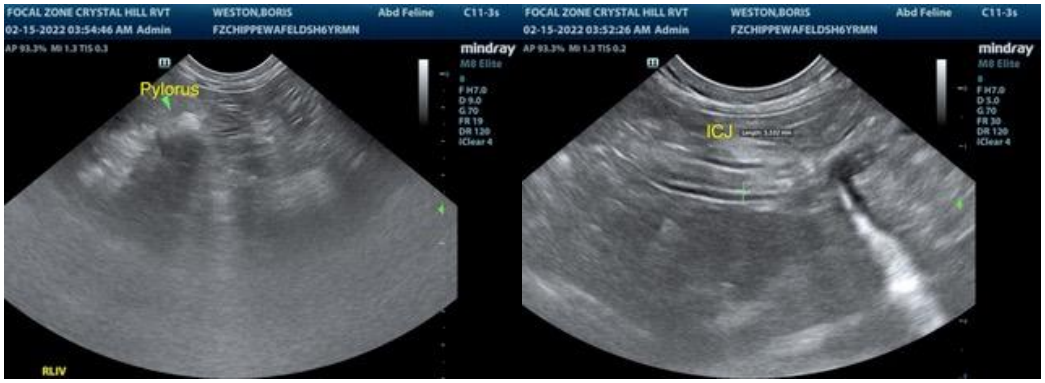

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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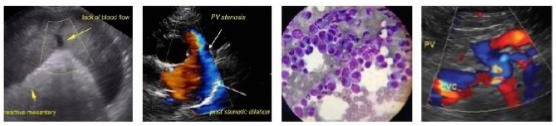

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com