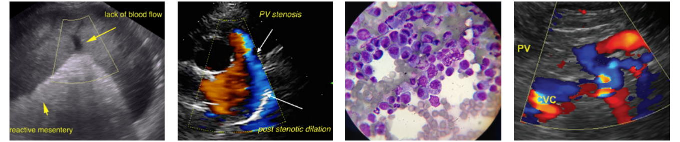
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Otis Gilman

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

8 Years

WEIGHT

14.48 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Saum Hadi

HOSPITAL NAME

Bethany Family PC

REFERRING VET

Dr. Saum Hadi

INVOICE

36772

DATE

4/10/22

PRESENTING CLINICAL SIGNS

P presents for increasing frequency of vomiting in the last month. First presented in mid March. Minor abnormalities seen then on labs (see below) that were suggestive of stage 2/4 CKD. Symptoms have acutely worsened significantly in last few days. Now, P exhibiting frequent diarrhea with hematochezia, lethargy, and yowling around the house. Significant weight loss (17.16->14.48 in last 6 months). Repeat labs pending. P is an indoor/outdoor cat.
Abnormal PE/Chem/CBC/UA Results: Chem 27/CBC/UA/T4/fecal OP performed on 3/17: USG: 1.024, BUN: 40 mg/dL, Creatinine 2.3 mg/dL, SDMA 13 ug/dL. Rest WNL (T4: 1.4 ug/dL)

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 non-dependent particulate sediment 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 left kidney was subnormal in size with moderate to marked loss of corticomedullary border demarcation, asymmetrical margination, and suspect lateral cortical infarct. Increased medullary echogenicity noted. The left kidney measured 2.6 cm.

The right kidney was mildly enlarged, measuring 5.0 cm. Moderate loss of corticomedullary border demarcation noted. 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 not definitively visualized.

Spleen

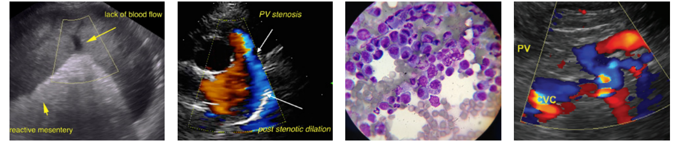
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute 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 mild, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

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. Gastric body wall measured 0.28 cm.



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The small intestine exhibited primarily intact wall layering with variable muscularis/mucosa hypertrophy owing to segmental propensity for mildly prominent muscularis layer. A solitary intestinal mural mass exhibiting moderate mural hypertrophy, decreased to variable mural echogenicity and loss of discernable wall layering in the subjective mid to potential caudal abdomen was present. The intestinal mural mass measured approximately 3.0 cm in diameter with wall width up to 1.5 cm.

The descending colon walls were mildly prominent, exhibiting subjective intact wall layering. Nonformed to liquid fecal matter was present in the colon lumen with lumen dilation.

Pancreas

The left pancreatic limb exhibited mild prominent size with areas of mild capsule asymmetry and subtle hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

A solitary, mildly prominent to enlarged iliac node was present, exhibiting non-homogeneous parenchyma, measuring 2.2 cm x 0.66 cm. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

Focally enlarged mesenteric lymph nodes were present, primarily around the intestinal mural mass and adjacent intestinal segments. Example measured 1.6 cm x 0.8 cm. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Associated perilymphatic and peri intestinal reactive mesentery noted. No free fluid.

ULTRASONOGRAPHIC FINDINGS

- Minor urinary bladder sediment
- Left kidney subnormal size with chronic degenerative changes
- Right kidney mild renomegaly with moderate chronic changes and non-specific medullary rim sign
- Enterocolonopathy with segmental intestinal mural mass
- Associated mesenteric and focal medial iliac lymphadenopathy
- Possible low-grade pancreatitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

Compensatory right kidney hypertrophy suspected owing to subnormal left kidney size. Potential for non-specific nephritis without overt evidence of neoplastic criteria.

Primary finding of segmental mild intestinal mural changes as well as intestinal mural mass may indicate inflammatory, neoplastic, or granulomatous (dry form FIP) etiologies. The definitive location of the intestinal mural mass was not obviously determinable with potential small and large bowel location possible.

Assuming normal clotting status, ultrasound guided FNA of the intestinal mural mass +/- lymph node for cytology and staging as well as 3-view chest radiographs would be reasonable. Laparotomy with gross inspection of the gastrointestinal tract, potential resection and anastomosis of the intestinal mural mass, as well as concurrent full thickness intestinal and lymphatic biopsies could also be considered.

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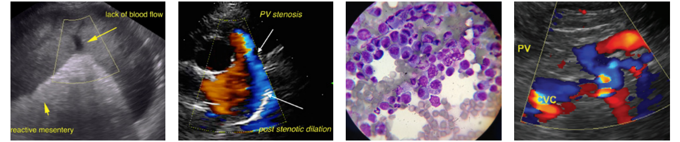

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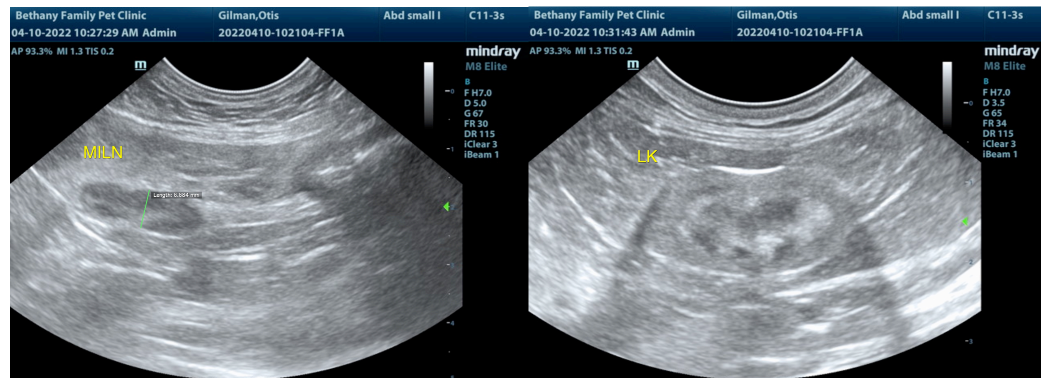

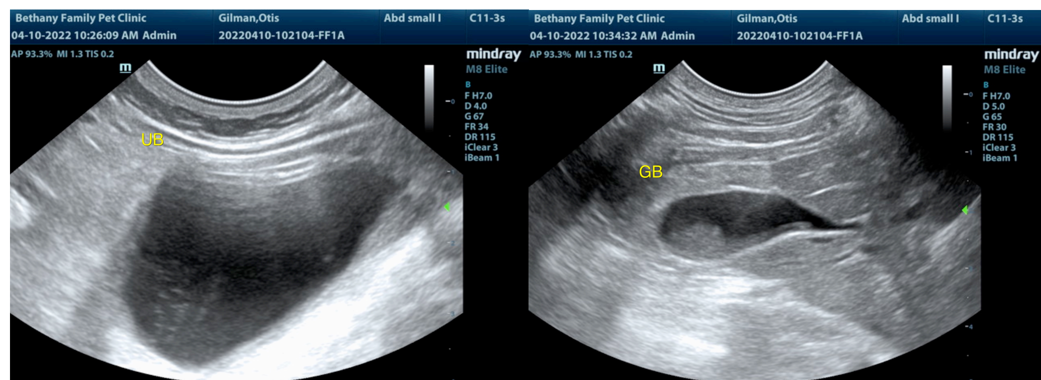

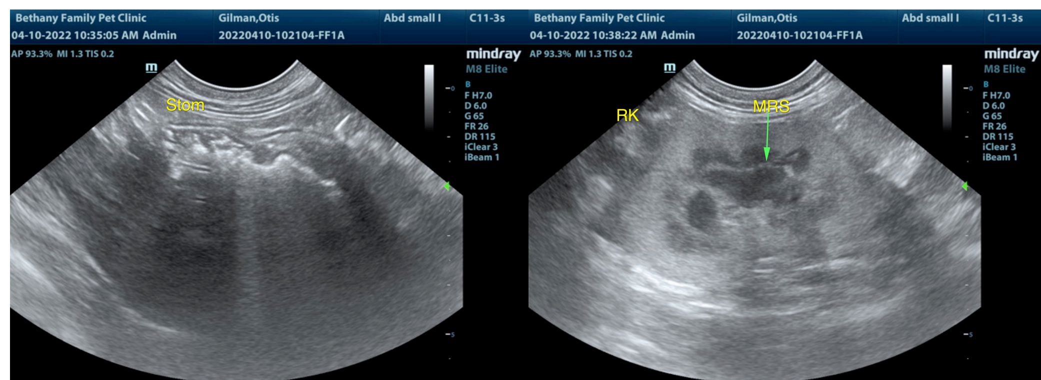

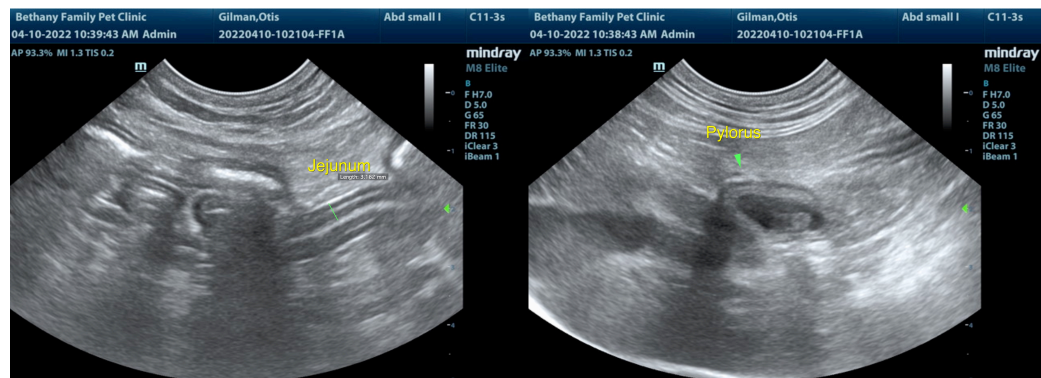

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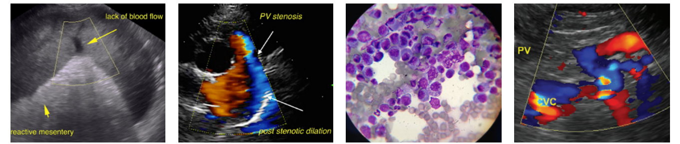

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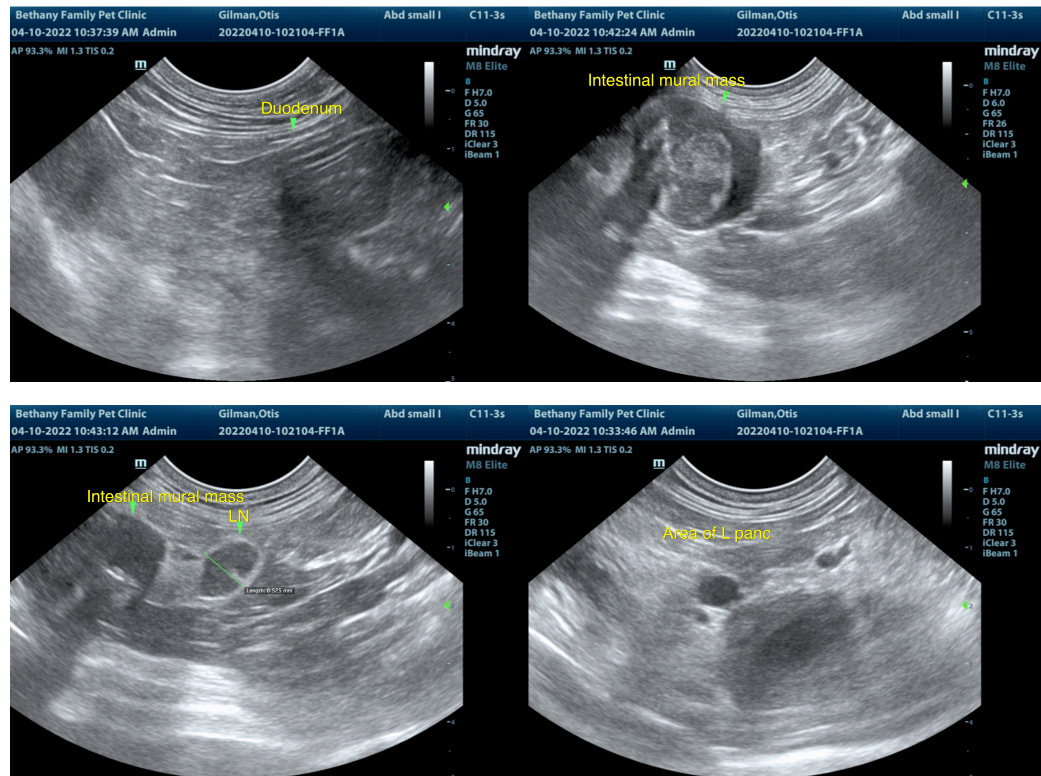

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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