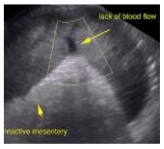
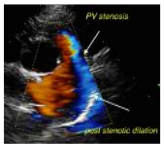
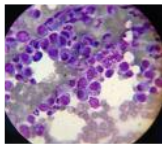
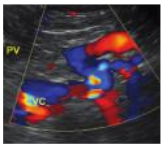
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™





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

PATIENT

Echo Starling

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

3 years

WEIGHT

11.78 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Brita Kiffney

HOSPITAL NAME

Northshore VH

REFERRING VET

Dr. Brita Kiffney

INVOICE

16713

DATE

4/27/23

PRESENTING CLINICAL SIGNS

chronic vomiting kitty with unremarkable labwork. P has been an intermittent vomiter her whole life, frequency has increased to daily vomiting. Often in am, but does occur at all time points. Vomitus is variable- bile, partially digested food, undigested food. P has good appetite and energy, no other concerning clinical signs at home. PE is unremarkable- slightly overweight, no palpable abdominal masses or SI thickening. O's prefer imaging rather than starting with food trial.

Abnormal PE/Chem/CBC/UA Results: BC: mild neutropenia (2.3K) with decreased platelet count, clumping, and moderate decreased estimate on film chem: WNL T4: WNL (2.1) u/a: USG 1.041, borderline proteinuria (0.2) fecal pending

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 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 mild bilateral pyelectasia. The left kidney measured 4.2 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

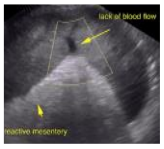
No overt pathology was noted in the area of the left or right adrenal glands.

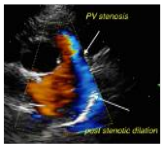
Spleen

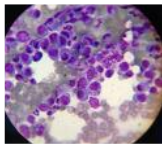
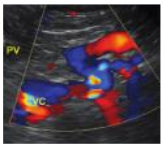
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen exhibited borderline to mild enlargement measuring 1.1 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 normal gallbladder walls containing anechoic content with a mild amount of nonorganized echogenic gallbladder debris primarily in the cranial lumen. No evidence of inflammatory criteria was noted. The cystic and common bile ducts were normal.





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Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach contained a mild amount of retained anechoic fluid extending into the pyloric outflow. No evidence of mechanical pyloric outflow obstruction was noted. The pylorus wall width measured 0.20 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 0.26 cm width. The jejunum wall measured 0.21 cm width. The ileocolic wall measured 0.33 cm width.

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

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

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

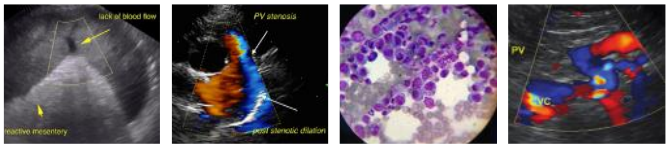
- Gastritis pattern with mild gastric hypomotility
- Sonographically unremarkable small bowel / pancreas
- Nonspecific borderline / mild splenomegaly
- MInor bilateral pyelectasia
- Mild gallbladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may indicate cellular debris / protein, crystalline debris, or mucus. The bilateral pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.

Sonographically, the appearance of the stomach is consistent with gastritis and mild secondary gastric hypomotility criteria without overt small intestinal inflammatory or infiltrative neoplastic pattern. Dietary intolerance / food hypersensitivity, suspected gastritis, occult parasitism, structurally insignificant concurrent inflammatory enteropathy or low-grade pancreatitis, which may present as sonographically normal, all potentials.

If evidence of weight loss, a GI panel to include PLI/TLI/Cobalamin/Folate +/- screening splenic FNA cytology using a 25-gauge needle, is recommended.



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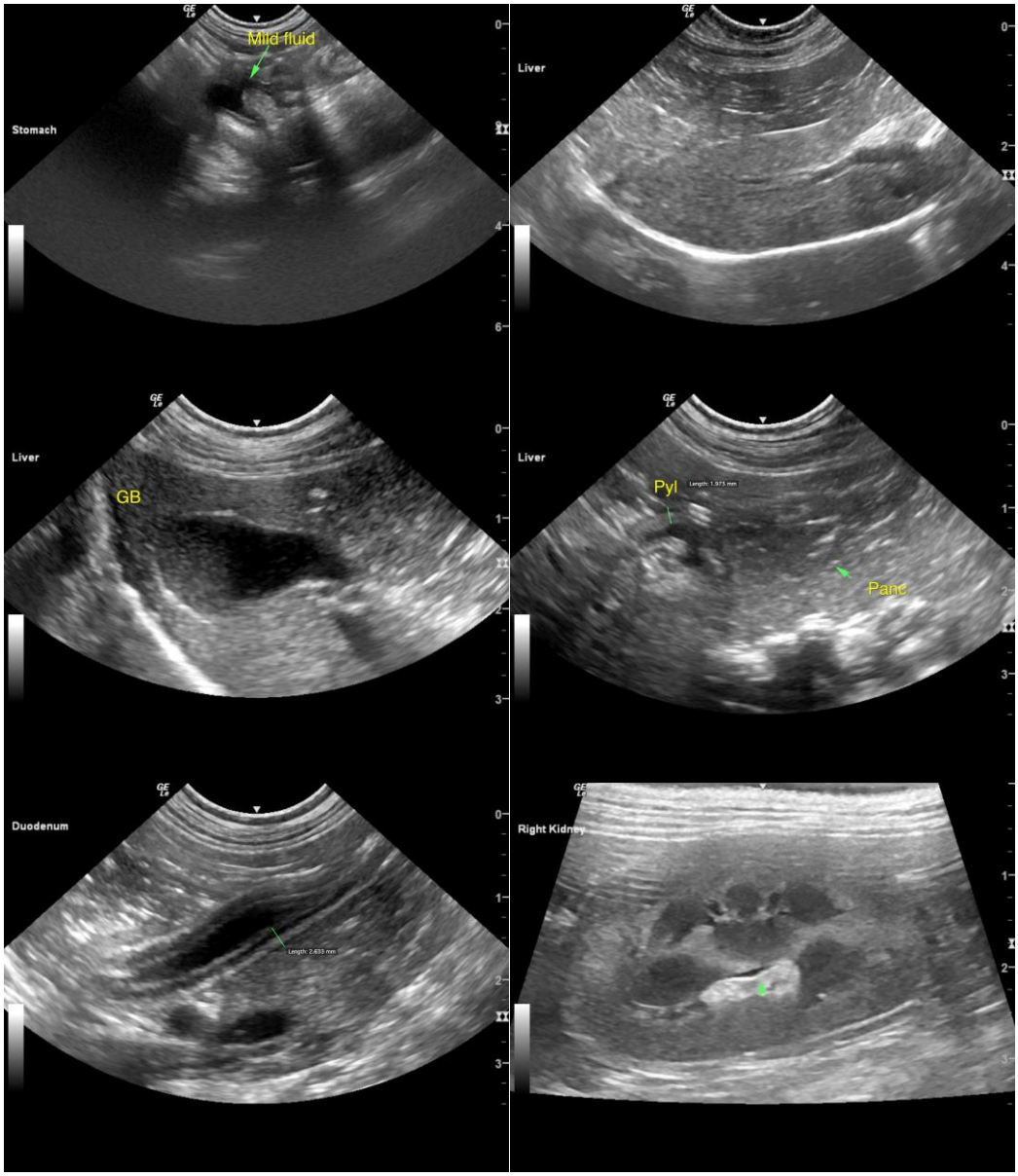
Empirically, canned novel protein or hydrolyzed diet with as-needed gastroprotectants +/- coverage for helicobacter may prove beneficial. Three-view chest radiographs are suggested to rule out occult thoracic or esophageal pathology, if not done.



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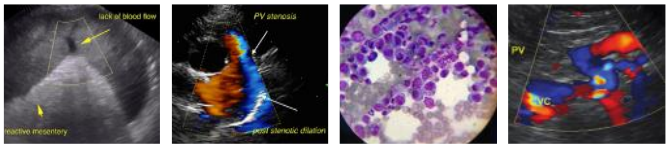

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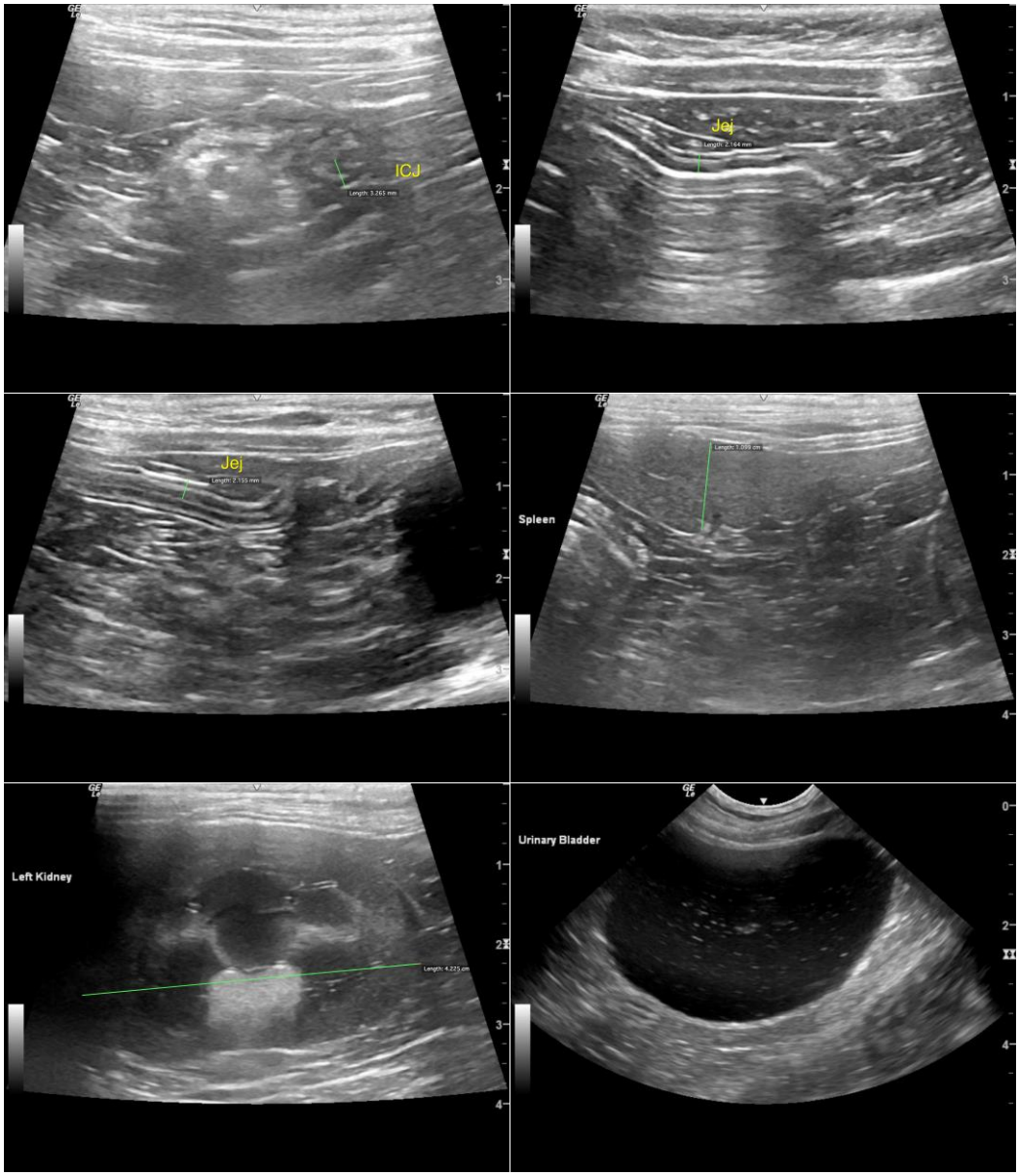

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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