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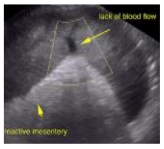
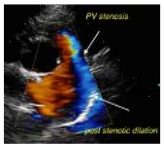
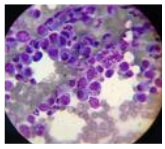
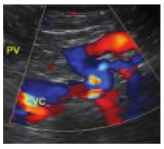
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™





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

PATIENT

Alex Bonfiglio

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

14 years

WEIGHT

9.4 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jasmine Palacios
SDEP Attendee

HOSPITAL NAME

Rivers Edge Pet Medical Center

REFERRING VET

Dr. Bridget Hayes

INVOICE

13612

DATE

4/5/22

PRESENTING CLINICAL SIGNS

Gradual loss of appetite, occasional loose stools. Mild weight loss. P is not currently on any medications.

CBC- WBC 13.9 with minor monocytosis

Chemistry Panel -SDMA 15, otherwise unremarkable

Urinalysis- Specific gravity 1.043, 1+Protein, 1+Blood

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, nondependent, particulate sediment was present without evidence of calculus formation. The sediment is likely consistent with cellular debris, given the urinalysis. 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 renal size with asymmetrical margination were present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. The left kidney measured 3.7 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

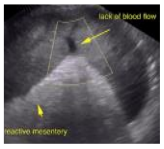
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.47 cm width. No overt pathology was noted in the area of the right adrenal gland.

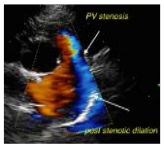
Spleen

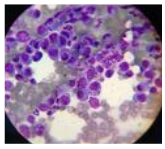
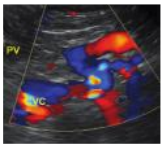
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.97 cm in width.

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 cystic and common bile ducts were normal.





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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Minor retained anechoic fluid was present in the antrum and pylorus.

The small intestine exhibited primarily Intact yet variably prominent to thickened wall layering with areas of subtle small intestinal corrugation. The duodenum wall width measured 0.24 cm. The jejunum wall width measured up to 0.33 cm in areas of mild mural hypertrophy to wall thickening. The ileocolic wall width measured 0.32 cm. The small Intestine also exhibited segmental Ileus exhibited by retained variable yet mild to moderate fluid, along with concurrent segments of empty small intestine.

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

Multiple, mild to moderately prominent, mildly hypoechoic jejunocolic lymph nodes were present. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic, as well as peri-intestinal reactive mesentery, was evident. An example of lymph node size was 2.2 cm x 0.6 cm. No overt free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Enteropathy exhibiting segmental intact yet variably thickened wall layering, segmental intestinal ileus to pseudo-obstructive pattern with concurrent empty small Intestine
- Associated jejunocolic lymphadenopathy
- Mild perilymphatic to peri-intestinal reactive mesentery

Secondary Findings

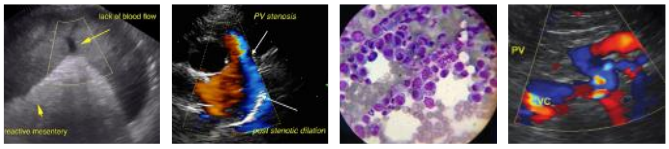
- Mild urinary bladder sediment
- Bilateral mild chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the gradual yet likely chronic gastrointestinal signs and weight loss in this patient, the small intestinal presentation may indicate either inflammatory or neoplastic infiltrative enteropathy, i.e., chronic IBD / eosinophilic enteritis vs. intestinal lymphoma or other neoplasia.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate, as well as three view chest radiographs to rule out concurrent thoracic pathology as a contributing factor to the patient's weight loss.

An obvious area of mechanical obstruction in the Intestinal tract was not definitively evident, while the



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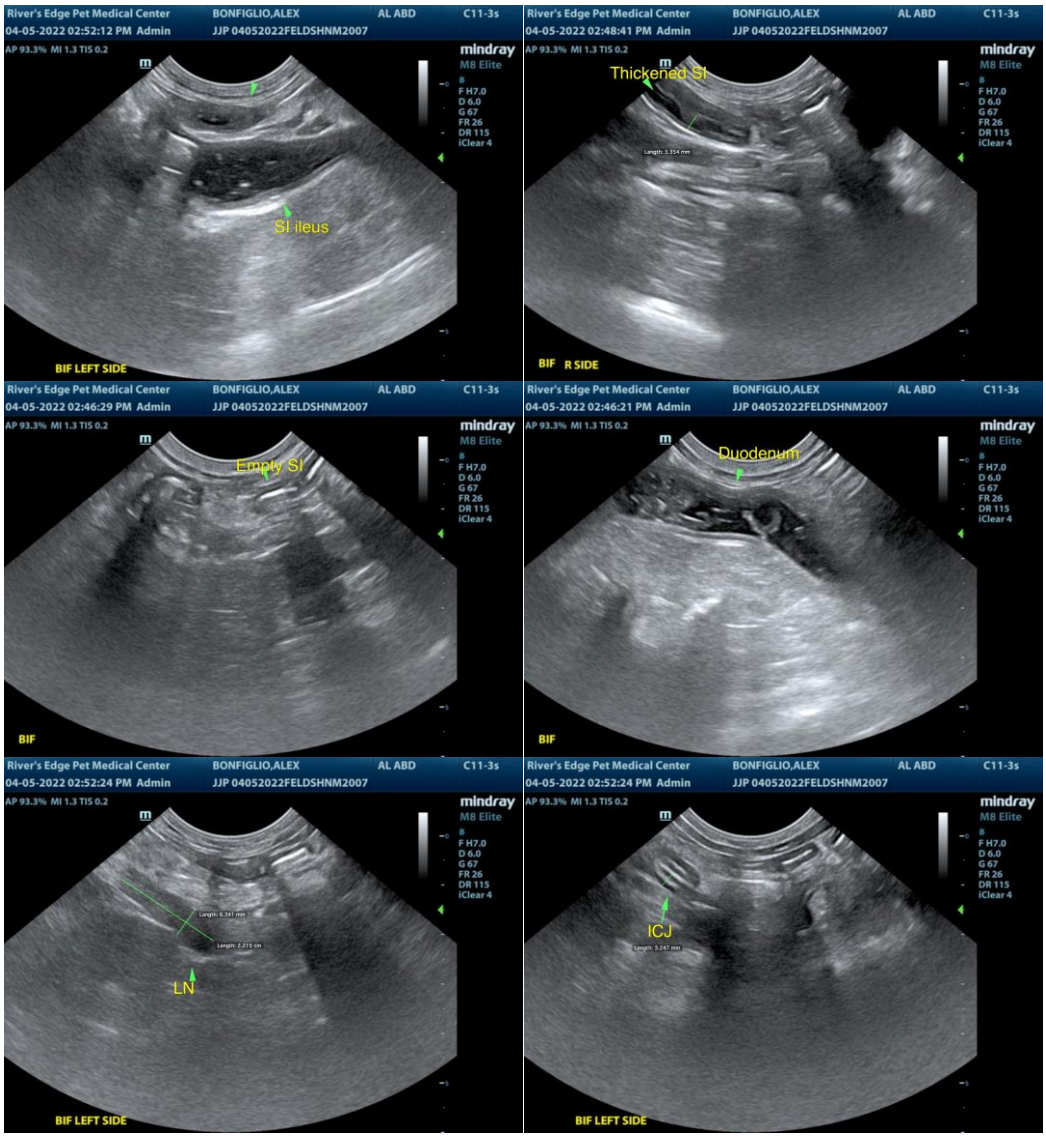
segmental ileus may indicate segmental inefficient peristalsis. However, the possibility of a non-visualized partial obstruction within the gastrointestinal tract, given the segmental ileus to pseudo-obstructive pattern cannot be excluded. Ideally, laparotomy with gross inspection of the intestinal tract and full-thickness intestinal biopsies, considered essential for a definitive diagnosis, is warranted.

The urinary bladder sediment is likely consistent with cellular debris, given the urinalysis. Urine culture and sensitivity on a sterile urine sample Is suggested if evidence of Inflammatory cells.

Empirically, IBD protocol Including cobalamin supplementation and as-needed gastrointestinal support with continued monitoring of clinical response and patient weight would be reasonable.



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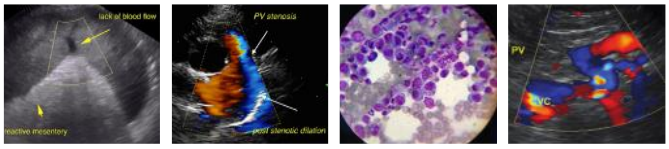

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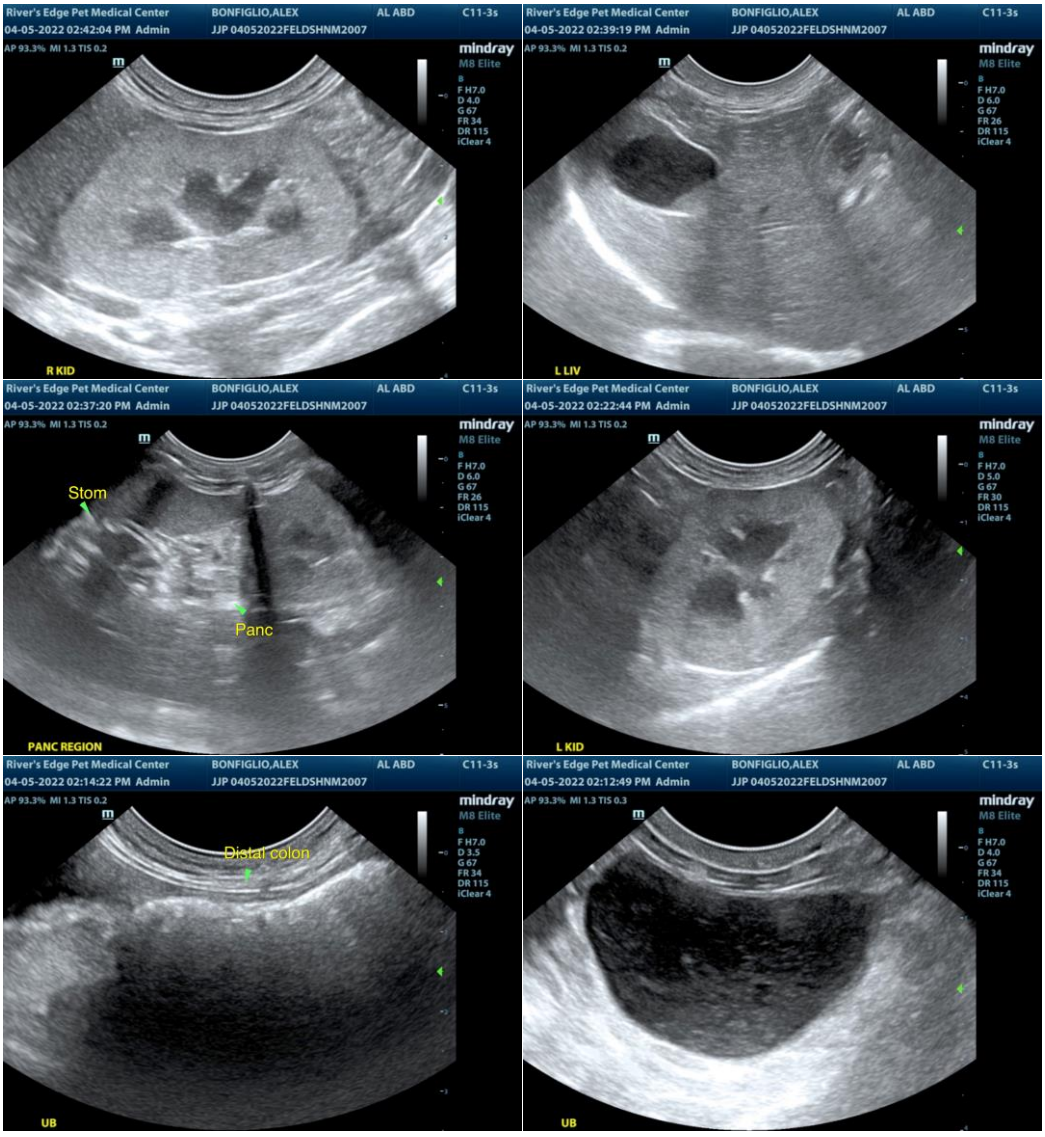

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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