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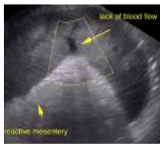
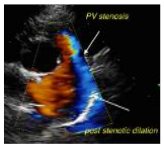
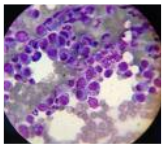
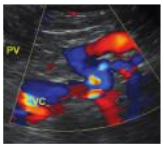
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Bentley Tashijian

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 Years

WEIGHT

9 Pounds 6 Ounces

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Miller

HOSPITAL NAME

ACC Flanders

REFERRING VET

Dr. Hallihan

INVOICE

14606

DATE

4/5/22

PRESENTING CLINICAL SIGNS

History: On and off vomiting and diarrhea, weight loss, stage 2 iris CKD. Current meds: Famotidine 10 mg/ml - 0.25ml SID

Abnormal PE/Chem/CBC/UA Results: Na/K ratio 31, Neut 92%, Lymph 5%, Abs. Neuts 9660, Abs. Lymphs 525 UA: RBC 11-20 HPF, Blood 3+ SG: 1.040

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 ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted. Aortic trifurcation was normal.

The left kidney was normal in size, measuring 3.8 cm. The right kidney was mildly subnormal in size, measuring 2.5 cm. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Areas of indistinct hyperechoic cortex echogenicity, consistent with cortical infarcts, were present in both kidneys.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.38 cm.

No overt pathology 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.

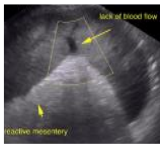
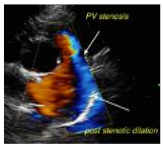
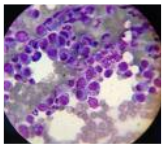
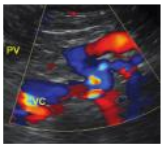
Liver

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 normal in size yet partially divided into two compartments. Anechoic content was present. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Minor retained non-shadowing ingesta/chyme was present in the pylorus lumen. The gastric body wall measured 0.25 cm.

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The small intestine exhibited generalized prominent to thickened wall layering with generalized to variable muscularis hypertrophy. The altered to hypertrophied wall layering appeared to be most prominent in the subjective distal small intestine in the area of the ileum to the level of the ileocolic junction. The ileocolic junction measured 0.40 cm with potential ileum wall width approaching 0.60 cm. The jejunum wall measured 0.35 cm wall width. The duodenum wall measured 0.31 cm.

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

Pancreas

The left limb of the pancreas was normal in size and contour with heterogeneous parenchyma compared to adjacent omentum. The right limb was normal in size and contour with heterogeneous to mildly hyperechoic parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Multiple, enlarged jejunocolic lymph nodes were present. These lymph nodes exhibited nonhomogeneous parenchyma. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic and periintestinal reactive mesentery was present. No overt free fluid was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mild urinary bladder sediment- minor cellular or crystalline debris likely
- Bilateral chronic degenerative renal changes with cortical infarcts, subnormal right kidney size
- Diffuse enteropathy, exhibiting moderate to marked mural hypertrophy and altered wall layer ratio
- Non-homogeneous jejunocolic lymphadenopathy
- Associated perilymphatic and periintestinal reactive mesentery
- Possible concurrent chronic pancreatitis

Secondary Findings

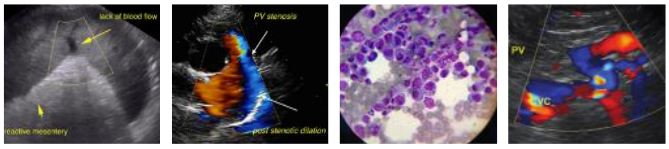
- Bilobed gallbladder-normal variant in a cat

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestinal presentation is consistent with infiltrative enteropathy. Considerations may include inflammatory infiltrative enteropathy (i.e., IBD/eosinophilic enteritis) or neoplastic infiltrative enteropathy with round cells, such as lymphoma, mast cell neoplasia or other. Dry form FIP is also a potential yet considered less likely. Associated lymphadenopathy may indicate lymphatic hyperplasia, lymphadenitis or early neoplastic lymphadenopathy.

Assuming normal clotting status, ultrasound guided FNA of an enlarged jejunocolic lymph node +/- thickened small intestinal wall, if accessible, could be considered. Gold standard full thickness intestinal and lymphatic biopsies are likely required for a definitive diagnosis.

Empirically, IBD protocol, which may include novel protein or hydrolyzed diet, cobalamin supplementation, as needed gastrointestinal support and prednisolone (at lowest effective dose to



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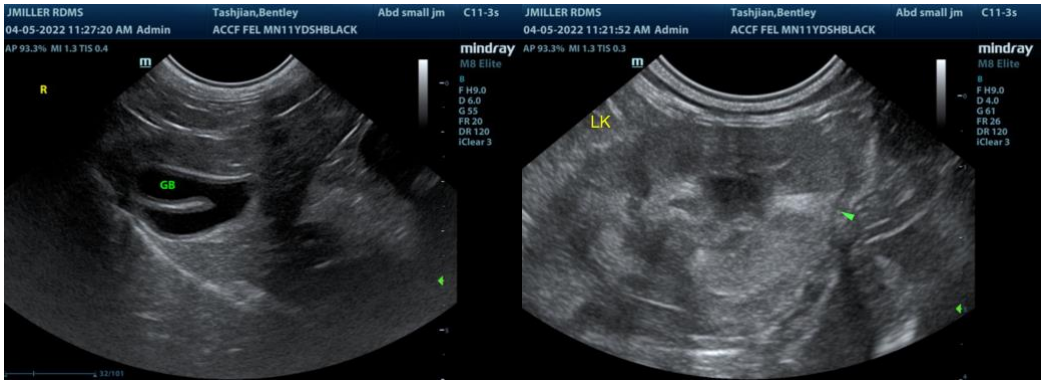
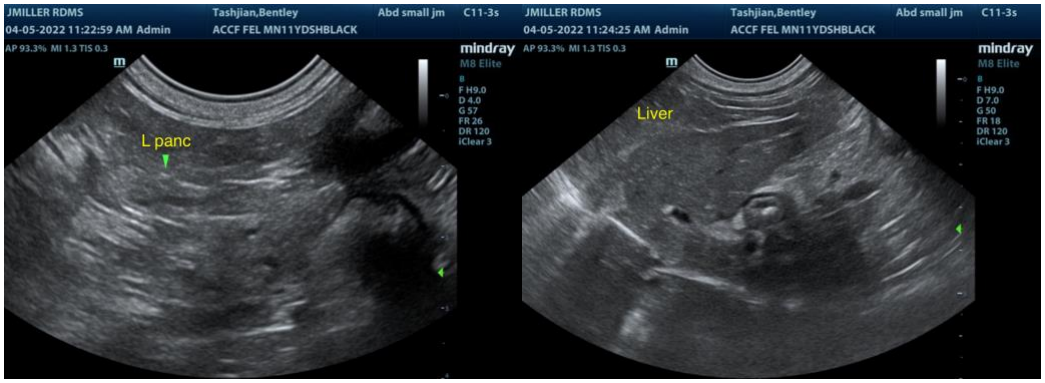
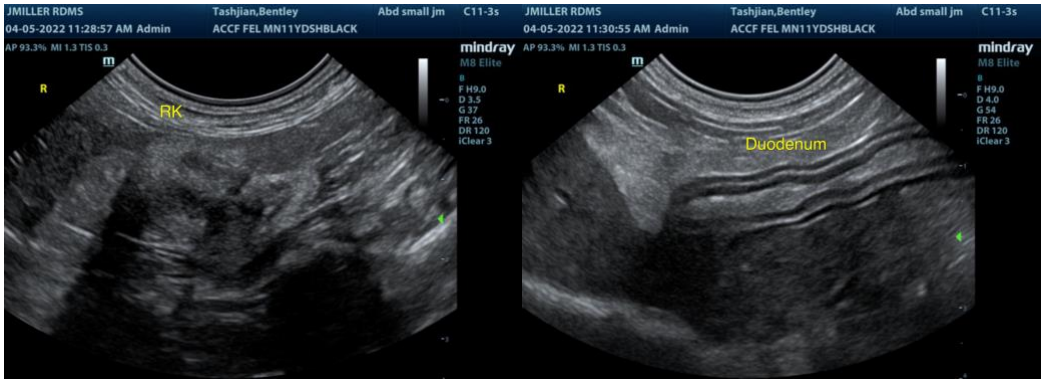
control clinical signs) with monitoring of clinical response as well as sonographic monitoring of the small intestine and lymph nodes would be reasonable.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.







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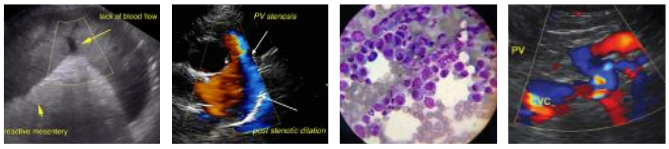

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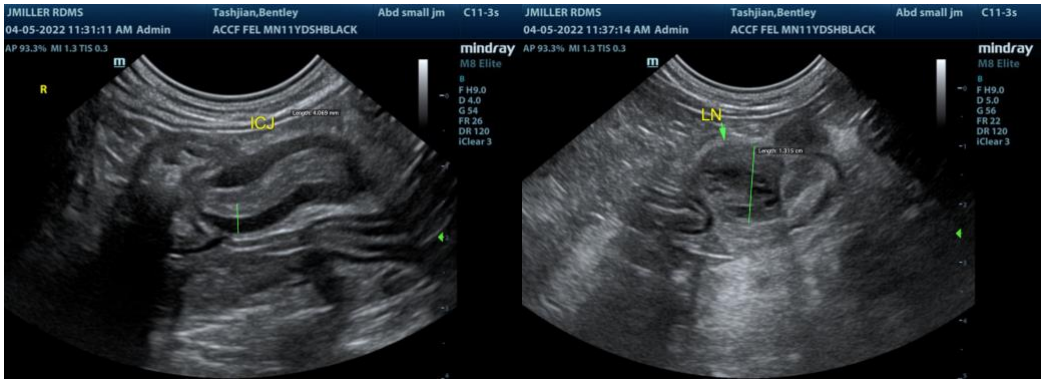

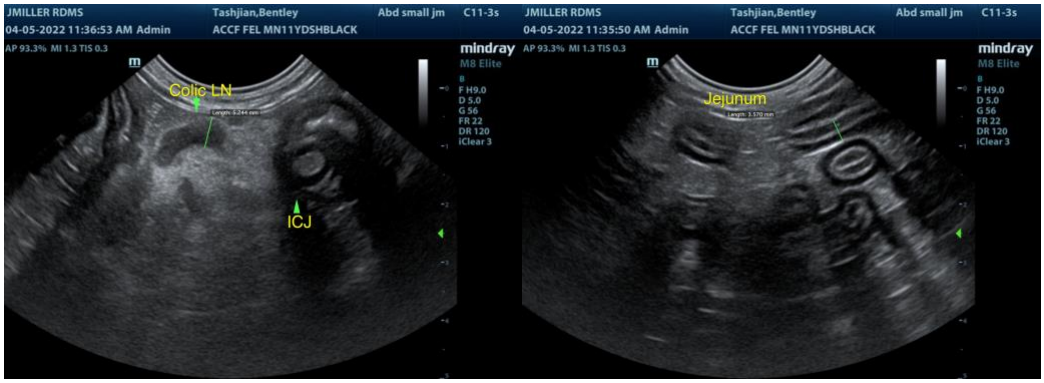

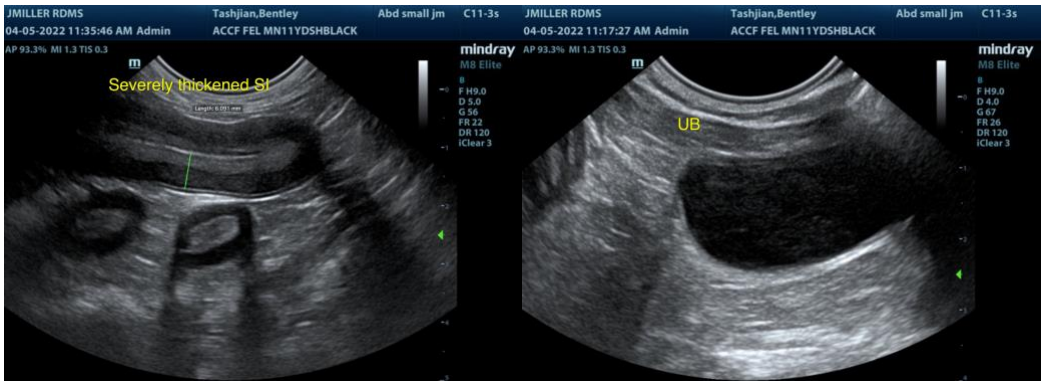

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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