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Clinical Sonography & Telecytology
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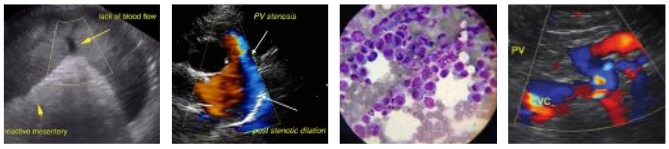

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Nacho Libre Ellison

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

15 years

WEIGHT

7.4

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

16513

DATE

4/5/23

PRESENTING CLINICAL SIGNS

p presented for senior wellness with hx of chronic vomiting with recent increase in frequency (daily). P also seems deaf, and is very VOCAL. On exam, P is thin/ mod muscle wasting with mild-mod thickened intestines, 2/6 parasternal heart murmur, lots of vocalization throughout exam- not necessarily unhappy or painful but talkative, getting a BP seemed impossible. Senior labs show normal CBC, IRIS stage 2 renal dysfunction with normal phosphorus/potassium, normal thyroid. I suspect increase in vomiting is due to primary GI rather than slight progress in renal disease as we are still solidly in stage 2. Have discussed IBD vs lymphoma as my top two differentials w/o.

Abnormal PE/Chem/CBC/UA Results: -CBC WNL -chem- azotemia (SDMA 16, creat 2.6, BUN 33) -T4 WNL (2.2) -u/a- new near-hyposthenuria (USG 1.015) with quiet stick/sediment- 2-5 WBC/HPF, did not culture starting RC hydrolyzed + renal diet 10) Medications/ Dosages: starting cobalequin chews (o's want to try this first before trying B12)

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 was 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 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. The left kidney measured 3.0 cm in length. The right kidney measured 3.0 cm in length.

Adrenal Glands

The area of the left adrenal gland was free of overt pathology The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.29 cm width.

Spleen

The spleen exhibited mild generalized enlargement with subtle areas of minor capsule asymmetry. Mild splenic parenchyma heterogeneity exhibiting subjective mild decreased splenic parenchyma echogenicity was present. The spleen measured 1.2 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 thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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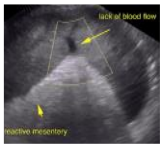

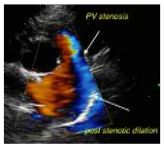

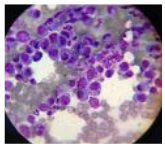
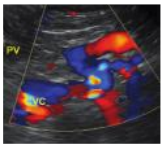

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with minor luminal gas. The ventral gastric body wall width measured 0.27 cm.

The generalized small intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. The duodenum wall measured 0.31 cm width. The jejunum wall measured 0.30 cm width. The ileocolic wall measured 0.45 cm width.

Sonographically unremarkable visible colon wall layers were present with generalized soft to non-formed fecal matter and subjective mild segmental colonic distention.

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

Intermittent mild mesenteric lymphadenopathy was noted. No omental masses or evidence of peritoneal effusion were noted.

ULTRASONOGRAPHIC FINDINGS

- Infiltrative enteropathy pattern
- Intermittent mild mesenteric lymphadenopathy
- Mild colon distention containing soft to non-formed fecal matter
- Sonographically unremarkable empty stomach
- Mild splenomegaly
- Moderate bilateral chronic renal changes

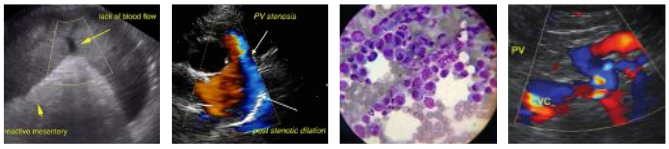
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine was consistent with infiltrative enteropathy with inflammatory (IBD / eosinophilic enteritis) or neoplastic (IBD, mast cell neoplasia, or other) enteropathy possible. Granulomatous intestinal disease i.e., Dry Form FIP is considered a less likely differential diagnosis.

Full-thickness intestinal biopsies would be required for a definitive diagnosis. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. If intestinal biopsies are not elected or possible, empirical IBD protocol with as-needed gastrointestinal support would be reasonable.

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

Incidental splenic hyperplasia, hematopoiesis, and splenitis assuming no evidence of sedation, are possible. Potential for early splenic infiltrative round cell neoplasia, given the intestinal presentation,



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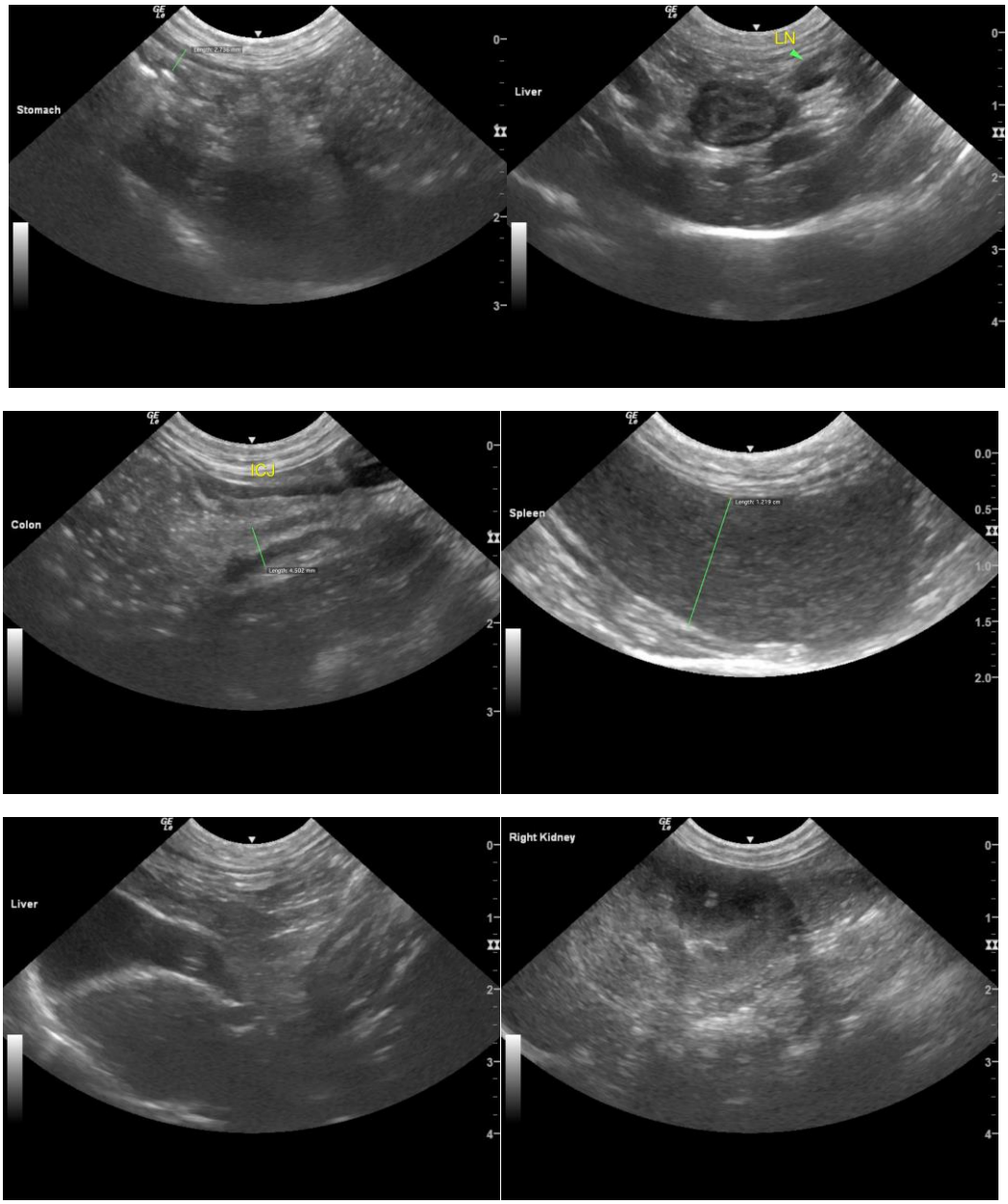
cannot be excluded. Assuming normal clotting status and using a 25-gauge needle, screening splenic FNA cytology is recommended.



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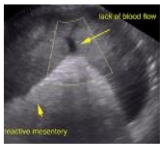
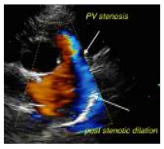
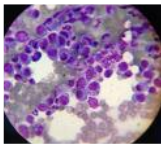
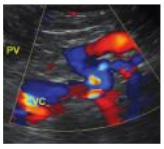

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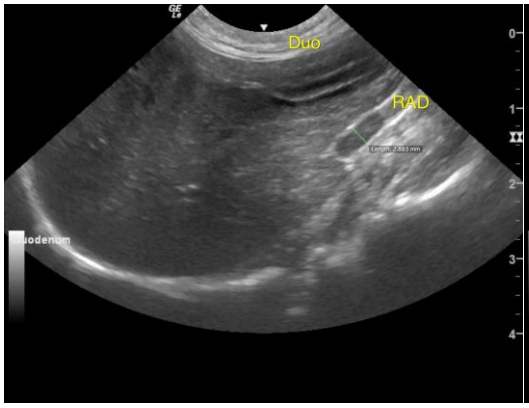

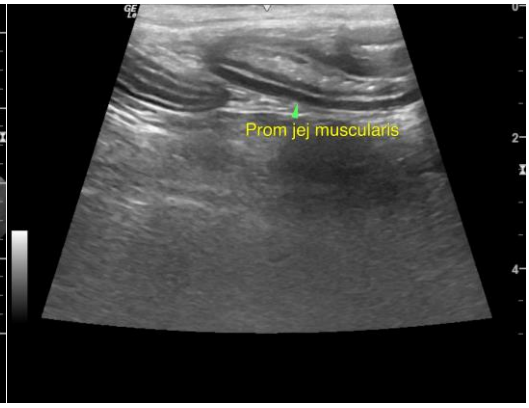

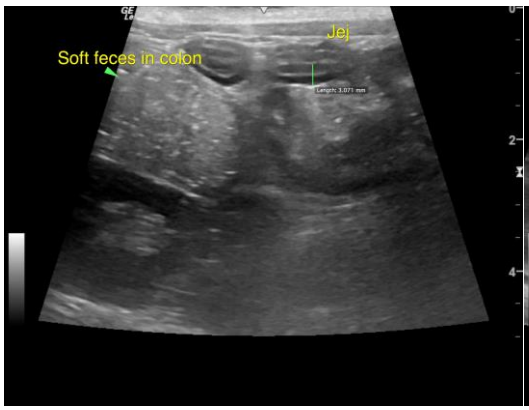

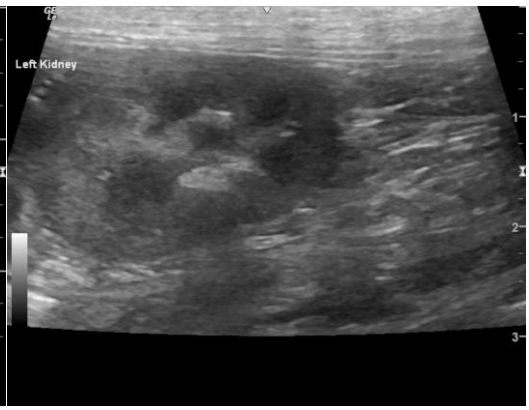

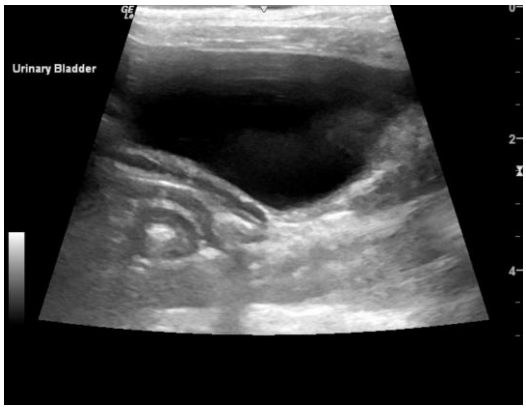

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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