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Clinical Sonography & Telecytology
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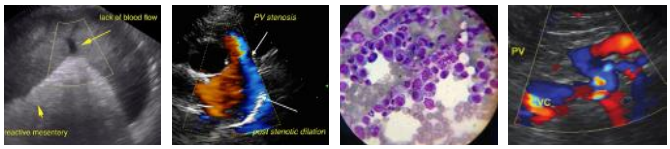

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Smokey Salajin

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
10 years

WEIGHT
11 pounds

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

IMAGING PERFORMED BY
Trae Cutchin

HOSPITAL NAME
Friendship Springs Veterinary Care

REFERRING VET
Trae Cutchin

INVOICE
10573ag

DATE
05/11/2022

PRESENTING CLINICAL SIGNS

History: Intermittent vomiting over the last 8 months, now inappetant and somewhat lethargic

Abnormal PE/Chem/CBC/UA Results: CBC pending. Chems and T4 are unremarkable. UA is wnl. Radiographs yesterday are unremarkable. UA was collected by US-guided cystocentesis. While doing this, colon came into view and appeared abnormal on US.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild nondependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal renal size with asymmetrical margination was 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 4.2 cm in length. The right kidney measured 4.3 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.39 cm. The right adrenal gland was 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 thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained a moderate amount of retained anechoic fluid without evidence of mechanical pyloric outflow obstruction. The gastric body wall measured 0.23 cm in width.

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 0.23 cm in width. The jejunum wall measured 0.22 cm in width. The ileocolic wall measured 0.30 cm in width.

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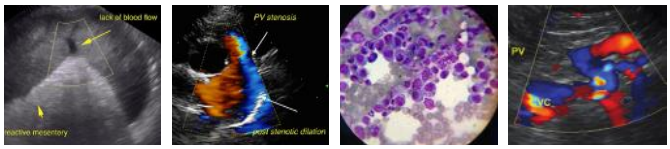

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The proximal colon exhibited sonographically unremarkable wall layering containing formed to semi formed feces. The transverse and descending colon exhibited moderate mural hypertrophy with decreased mural echogenicity extending caudally to the level of the colorectum dorsal to the urinary bladder. The descending colon wall measured 0.56 cm in width. Nonformed to liquid feces present in the descending colon.

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 was evident.

Free Abdomen

Regional peri colic reactive mesentery and intermittent mildly prominent to hypoechoic colic lymph nodes were present. No peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Hypomotile stomach
- Regionally thickened intact yet indistinct transverse and descending colon wall layering
- Associated regional peri colic reactive mesentery
- Intermittent nonspecific yet mild colic lymphadenopathy
- Overtly normal small bowel
- Nonspecific chronic renal changes and mild urinary bladder sediment

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The transverse to descending colon wall thickening was nonspecific with potential etiologies including inflammatory disease, infiltrative colonic neoplasia or less likely granulomatous disease (FIP). The associated colic lymphadenopathy was not overly suggestive of neoplastic criteria with concurrent lymphoid hyperplasia or minor reactive lymphadenitis suspected. Given the hypomotile stomach as well as history of chronic intermittent vomiting, generalized gastroenterocolic disease without evidence of GI mural changes cannot be excluded. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

Gastroenterocolic biopsies would be ideal for definitive diagnosis.

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

Empirically continued as needed GI support, monitoring for diarrhea +/- diarrhea PCR panel, hydrolyzed diet trial, high colony count probiotic and empirical cobalamin supplementation could be considered.

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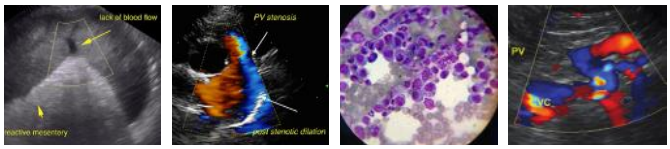

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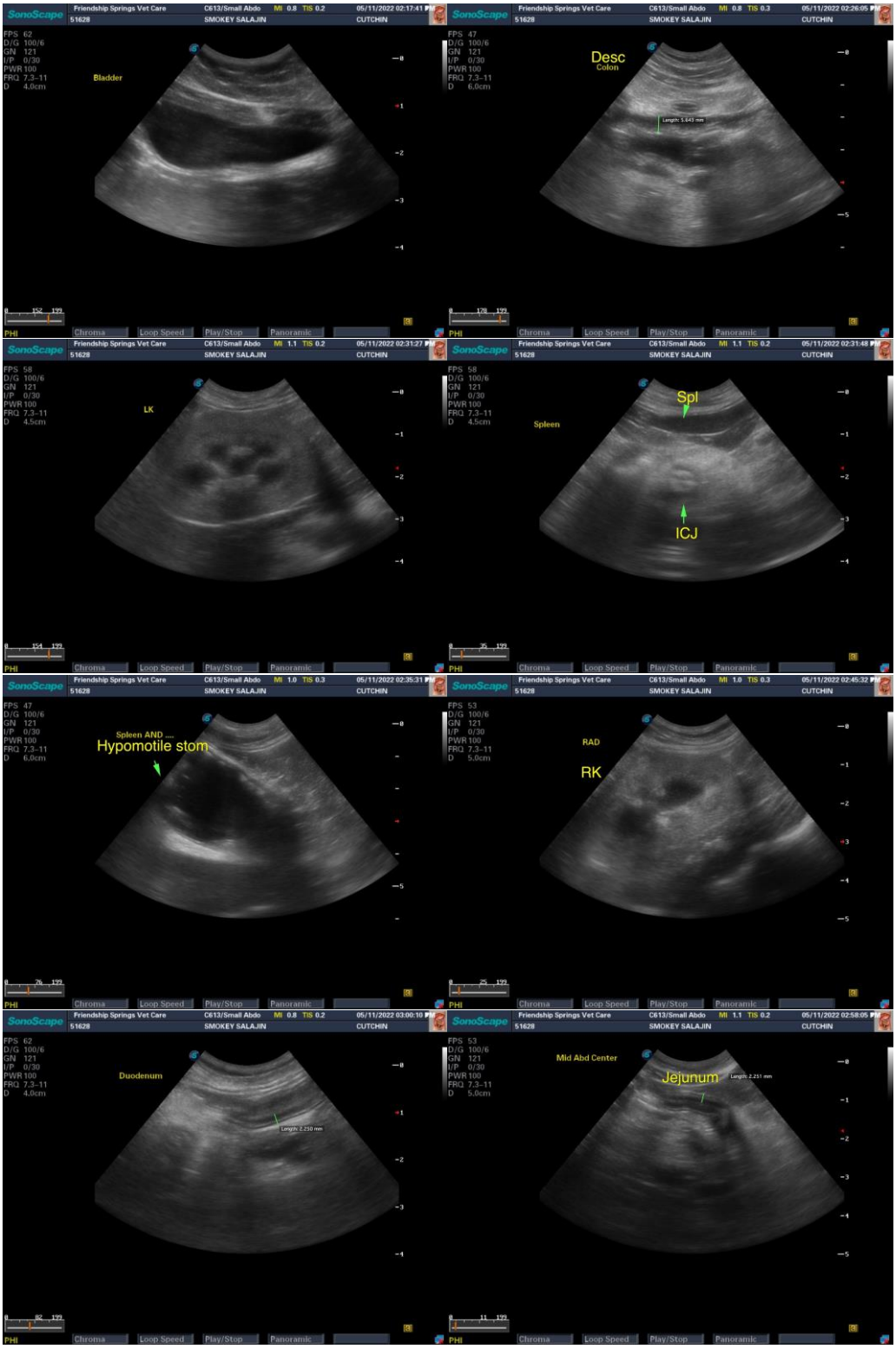

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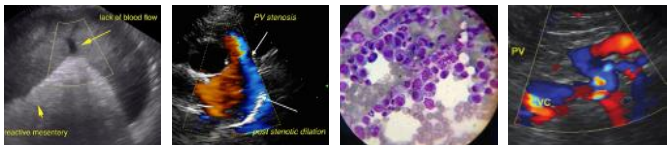

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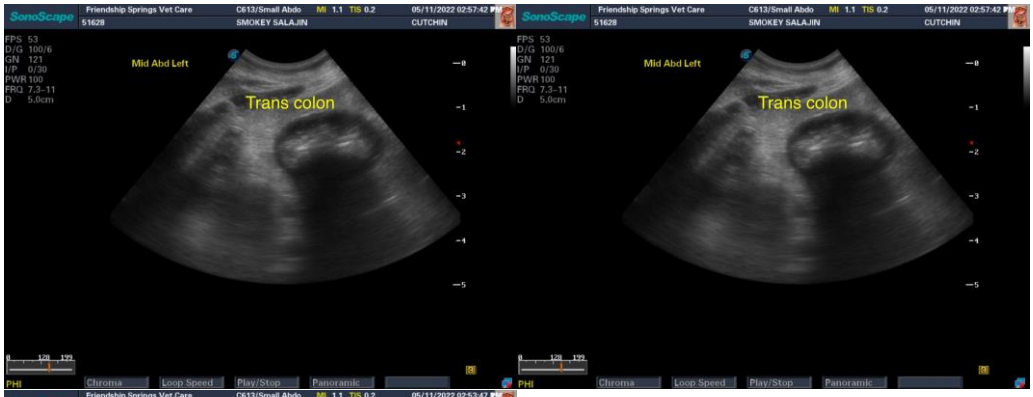

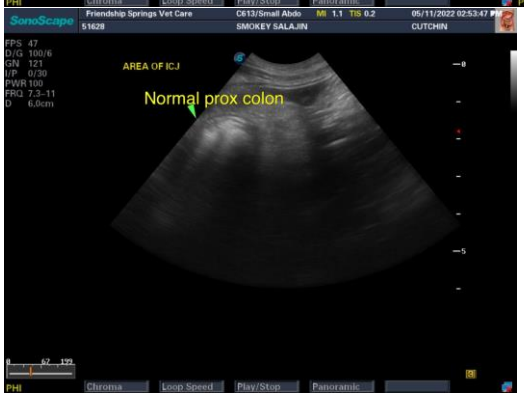

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com