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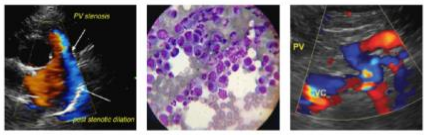
SVS Mobile Imaging CT 262 - 366 - 5970
fredgromalak@gmail.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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PATIENT

Boo LaCroix 51387A

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Intact Female

AGE

16 Weeks

WEIGHT

1.3 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison VS-Dr. Calhoun

INVOICE

16071

DATE

6/14/22

PRESENTING CLINICAL SIGNS

History: Boo presents to MVS today with possible intussusception. She was a transfer from primary care DVM. On Wednesday she was restless and seemed uncomfortable. Primary care performed xrays and determined she was constipated, advised to administer 1mL of mineral oil PO TID. Starting Friday Boo developed diarrhea, and primary care advised to stop the mineral oil, and start administering immodium PO. Saturday morning she was presented to a local ER for constipation and general decline, where they administered SQ fluids and a dewormer. She has not eaten since Sunday morning, is still drinking but is decreased lately. She has not defecated since Sunday morning and has had decreased urination.

Abnormal PE/Chem/CBC/UA Results: Abdominal radiographs: Poor detail (probably age related), dilated SI and radiodense structure in the caudal abdomen. No thoracic cavity lesions noted

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 were noted.

Aortic trifurcation was normal.

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 no evidence of pelvic dilation. A hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. The right kidney measured 3.4 cm. The left kidney measured 3.2 cm.

Adrenal Glands

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

Spleen

The spleen was subnormal in size, consistent with volume contraction. Normal splenic parenchyma and maintained symmetrical capsule contour were 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 exhibited intact and sonographically normal wall layering. The stomach exhibited moderate to marked distention with retained anechoic fluid and nonshadowing chyme.

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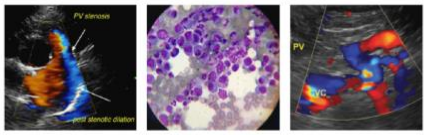

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The small intestine exhibited segmental obstructive pattern, exhibited by moderate to marked segmental small intestinal dilation with similar appeared retained anechoic fluid and nonshadowing chyme to the level of a intussusception with secondary inflammatory mural changes in the subjective mid to caudal abdomen, indicating likely jejunal location. Concurrent segments of empty small intestine, exhibiting intact wall layering and maintained 1:3 muscularis to mucosa ratio and likely distal to the intussusception were noted. No overt pathology in the area of the ileocolic junction.

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

Pancreas

The pancreas was normal in size and contour with subtle hypoechoic parenchyma, compared to adjacent hyperechoic peripancreatic omentum.

Free Abdomen

Multiple enlarged mid abdominal mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 1.6 cm x 0.45 cm.

Periintestinal hyperechoic mesentery was present. Small pockets of scant peritoneal free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Intussusception, likely jejunal in location with concurrent obstructive gastrointestinal pattern, likely proximal, empty small intestine, likely distal.
- Associated regional to generalized periintestinal to peritoneal hyperechoic mesentery and mesenteric lymphadenopathy
- Mildly hypoechoic yet normal size pancreas- normal variant or reactive pancreatic changes. Potential for low-grade concurrent inflammation possible.
- Mild peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Exploratory laparotomy with reduction or resection anastomosis of the intussusception recommended. The definitive length of the intestine involved in the intussusception was difficult to ascertain. No overt evidence of associated foreign material, i.e., linear foreign body, yet this potential cannot be definitively excluded.

The hyperechoic periintestinal mesentery and associated lymphadenopathy are suggestive of reactive omental changes and lymphadenopathy. Potential for emerging peritonitis is possible.

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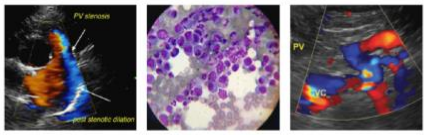

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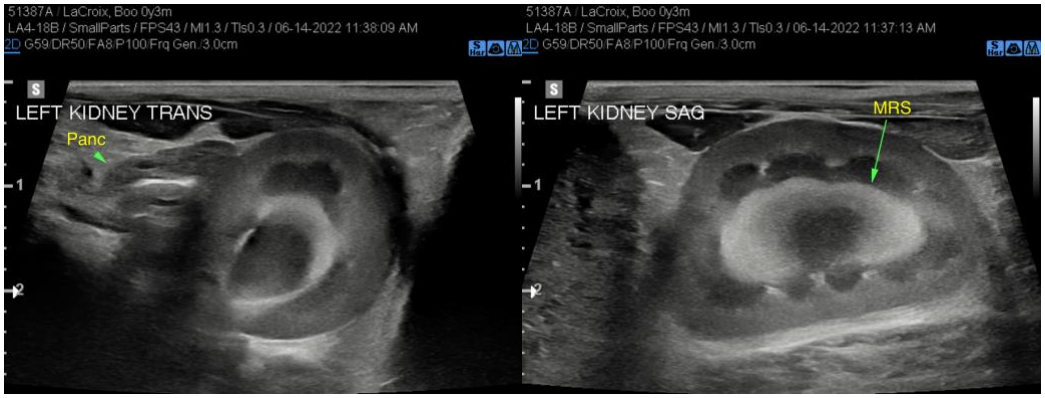

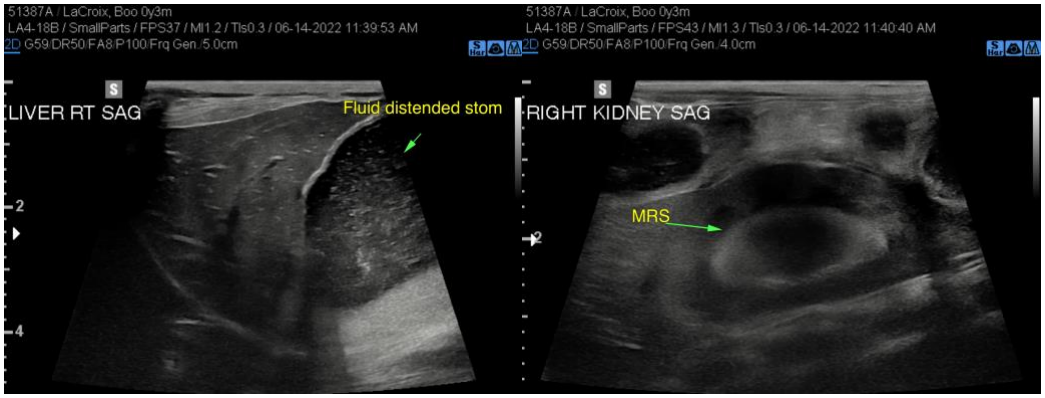

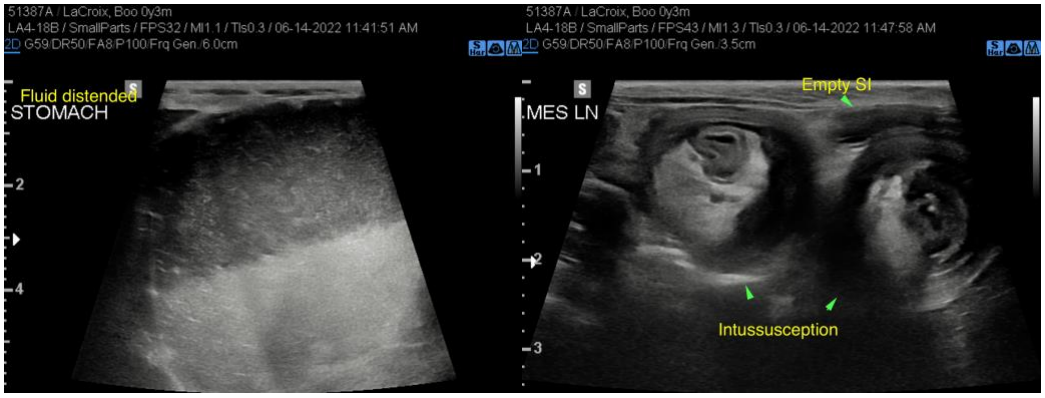

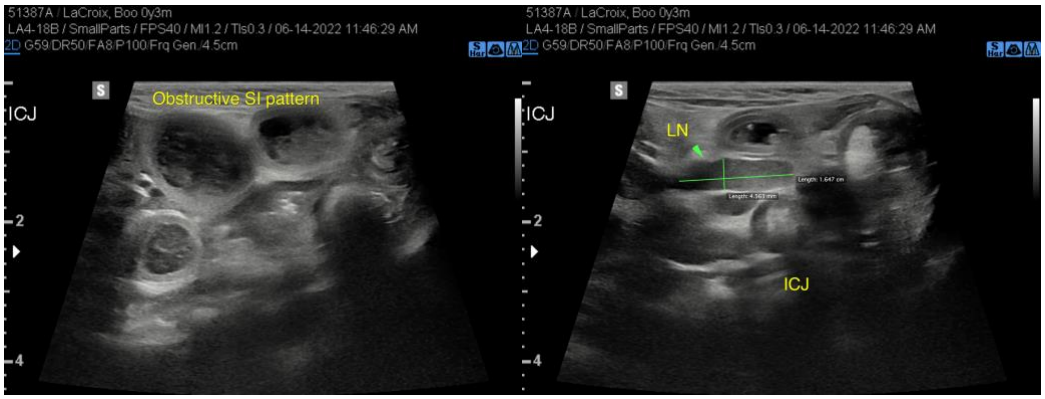

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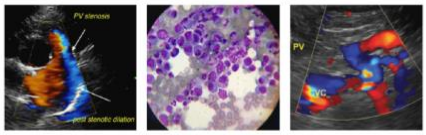

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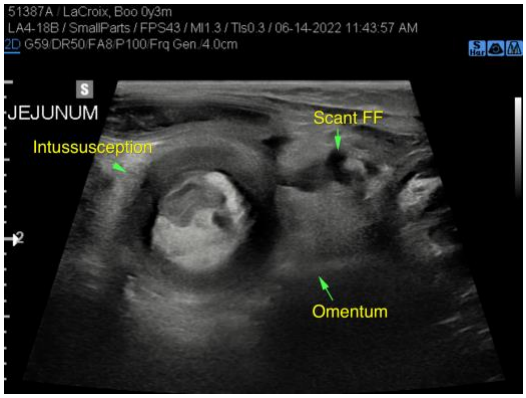

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
Eric.Lindquist@SonoPath.com