



PATIENT

Martha Davieau

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

11 years

WEIGHT

9 lbs.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Shari Reffi, CVT

HOSPITAL NAME

Branchville Country
Vet Clinic

REFERRING VET

Dr. Talbot-Velerio

INVOICE

14135

DATE

6/28/22

PRESENTING CLINICAL SIGNS

Inappetence, mucoid stool. Hx of Asthma. Current meds: Theophylline 25mg sid
Abnormal PE/Chem/CBC/UA Results: Amylase 1414 (1200 H); Glu 188 (170 H); Neuts 12,994 (8500 H); Lymphs 730 (1200 L)

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 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. The left kidney measured 3.5 cm in length. The right kidney measured 3.7cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.26 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.39 cm width.

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/ 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 mildly subnormal in size likely owing to the presence of gastric ingesta. Anechoic content was noted in the gallbladder. The cystic and common bile ducts were normal.

Gastrointestinal

The visualized gastric walls presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate nonshadowing ingesta / chyme most consistent with post prandial presentation without signs of ileus, obstruction or foreign material.



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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 width measured 0.23 cm. The jejunum wall width measured 0.24 cm. The ileocolic wall width measured 0.41 cm.

The colon exhibited generalized thickened yet primarily intact wall layering in the proximal and transverse colon extending into the proximal descending colon. The mid to distal descending colon to the approximate level of the urinary bladder exhibited moderate mural hypertrophy, decreased mural echogenicity, and loss of discernable wall layering. The proximal colon wall width measured 0.43 cm. By comparison, mid to distal descending colon wall width measured 0.57 cm. Semi-formed to non-formed feces was present in the colon, consistent with soft stool to diarrhea. Regional mild pericolic reactive mesentery was present.

Pancreas

The parenchyma of the right pancreatic limb of the pancreas was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. Focal hypoechoic left pancreatic parenchyma medial to the spleen was noted. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

Variably sized, anechoic to hypoechoic colic lymph nodes adjacent to the ileocolic junction were present. An example of a cystic-appearing colic lymph node measured 2.3 cm x 1.7 cm. Associated perilymphatic reactive mesentery was present. No evidence of peritoneal free fluid was noted.

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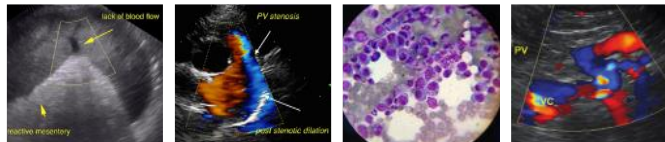
ULTRASONOGRAPHIC FINDINGS

- Generalized thickened colon more prominent in mid to distal descending colon with moderate chronic mural hypertrophy and loss of discernable wall layering
- Enlarged cystic-appearing colic lymph node with perilymphatic reactive mesentery
- Overtly normal small bowel, possible mild ileitis
- Gastric ingesta
- Suspect chronic to focal chronic active pancreatitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the colon may include chronic colitis and infiltrative neoplastic colonopathy specifically in the mid to distal descending colon. No overt evidence of concurrent gastrointestinal mural changes, although potential for structurally insignificant concurrent small bowel disease / ileitis is possible.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. Ultrasound-guided FNA of the thickened mid to distal descending colon wall, as well as colic lymph node for cytology +/- fluid analysis if cystic lymphadenopathy is confirmed, could be considered. Broad-spectrum deworming is warranted if the patient is indoor/outdoor. Colonic biopsies for histopathology are likely ideal if possible.



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Empirically, as-needed gastrointestinal support, hydrolyzed or possible higher fiber diet trial, Prednisolone, Metronidazole or Metronidazole / Sulfasalazine compounded combination at appropriate dose Initially BID x 14 days, then SID, may prove beneficial.

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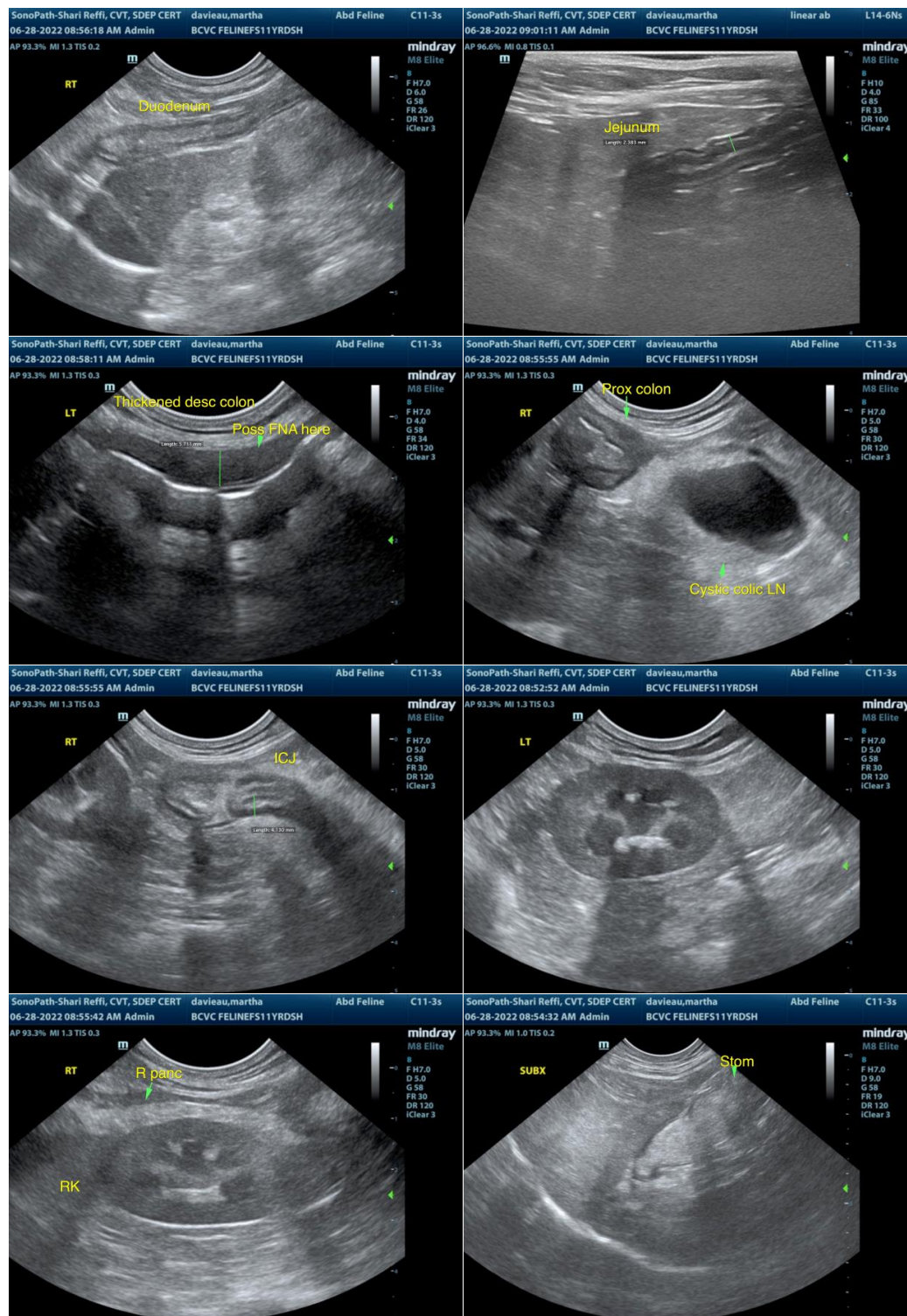
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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