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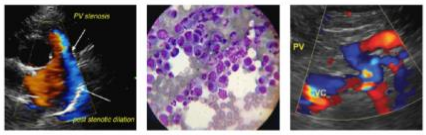

SonoPath
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**PATIENT**

Butterscotch Boeger

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Neutered Male

**AGE**

14 Years

**WEIGHT**

11.38 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Tom McNeill

**HOSPITAL NAME**

SVS Imaging CT

**REFERRING VET**

Dr. Allen- Badger VC

**INVOICE**

16406

**DATE**

6/29/22

## PRESENTING CLINICAL SIGNS

History: Diarrhea, weight loss (was recently 12.7 lb a couple of weeks ago). Also reported inappropriate urination.

Abnormal PE/Chem/CBC/UA Results: Exam NSF, Bloodwork and UA WNL, concentrated urine

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder presented mild uniformly thickened urinary bladder wall isoechoic to the adjacent normal urinary bladder wall. The luminal margin of the thickened urinary bladder wall was mildly asymmetrical in contour. The dorsal urinary bladder wall measured 0.26 cm. Mineralization or echogenic foci within the thickened areas of urinary bladder wall was not present. The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal 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.

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 3.1 cm in length. The right kidney measured 3.5 cm in length.

### *Adrenal Glands*

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.41 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.42 cm.

### *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. A solitary nondisruptive nonhomogeneous hyperechoic intraparenchymal nodule was present, measuring 1.2 cm in diameter. The nodule was not overtly consistent with neoplastic criteria and subjectively consistent with lipogranuloma or nodular/regenerative hyperplasia. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was normal in size with subjective partial division and two separate compartments. Anechoic content was present.

### *Gastrointestinal*

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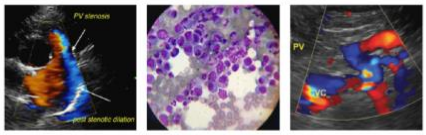

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.25 cm.

The majority of the small intestine exhibited intact wall layering and maintained 1:3 muscularis/mucosa ratio. No evidence of mechanical/metabolic intestinal ileus pattern to the level of the subjective ileum. A segment of suspected ileum exhibited distention with strongly shadowing ingesta to the level of the subjective ileocolic junction. The ileocolic junction exhibited subjective thickening with loss of discernable wall layer detail. The subjective ileocolic junction measured 0.65 cm in wall width. By comparison, normal appearing small intestine measured 0.21 cm in wall width. Mildly thickened small intestine, likely jejunum or ileum entering the segmentally distended bowel was confirmed.

The visualized segments of discernable colon appeared to be sonographically normal containing formed fecal matter.

### *Pancreas*

The pancreas was normal in size and contour with mildly hypoechoic to nonhomogeneous parenchyma with minor pancreatic duct dilation. The pancreas measured 0.65 cm in width in the left pancreatic limb.

### *Free Abdomen*

Focal to intermittent subtly prominent medial iliac lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation or neoplastic criteria and maintaining a normal width: length ratio (<0.5).

Intermittent, mildly prominent to enlarged colic lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of lymph node measured 0.8 cm x 0.4 cm.

Minor reactive mesentery was present in the area of the bowel distention and subjective ileocolic junction. No free fluid was present.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Suspect thickened ileum/ileocolic junction with concurrent bowel distention containing strongly shadowing, yet subjectively nonobstructive, possible impacted ingesta or fecal matter
- Mildly thickened small bowel, proximal to distended bowel.
- Associated probable colic lymphadenopathy
- Possible concurrent low grade chronic to chronic active pancreatitis
- Suspect mild cystitis

### Secondary Findings

- Bilateral chronic renal changes
- Nonspecific, yet likely benign hepatic nodule

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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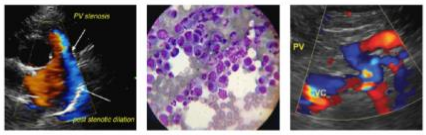

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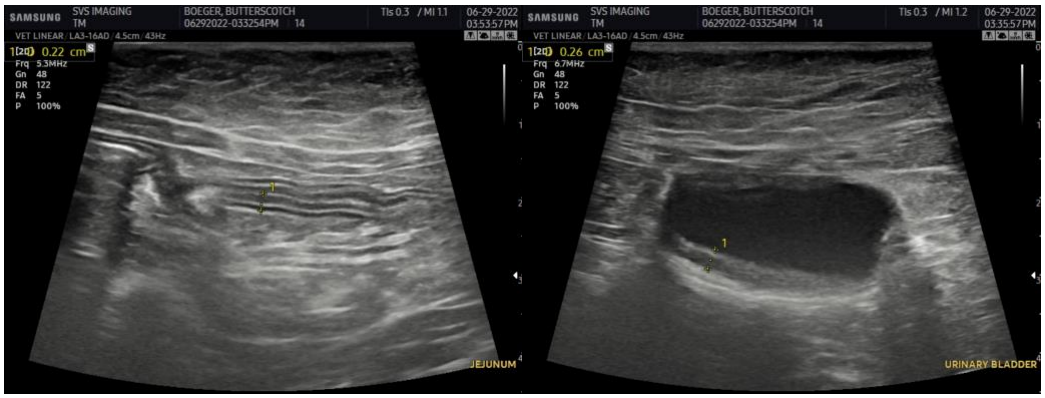
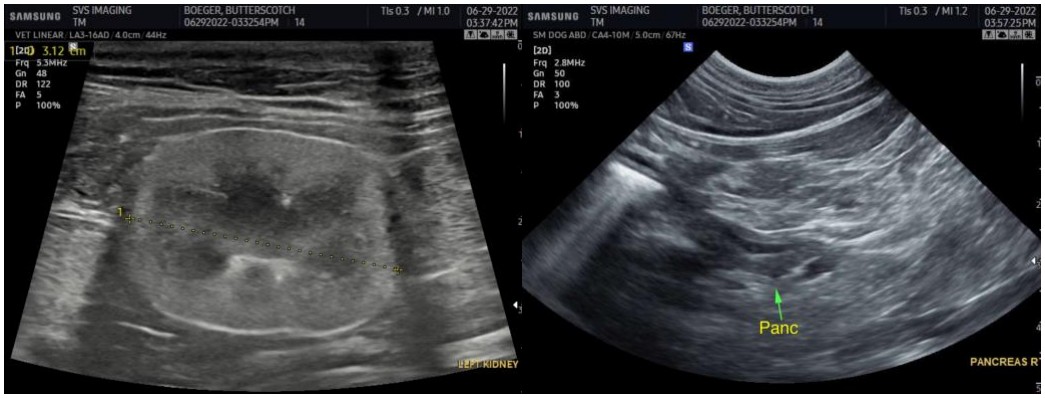
Potential considerations for the subjectively thickened ileum/ileocolic junction may include inflammatory disease, adenocarcinoma, lymphoma, dry form FIP, or potential fibroplasia. Three view chest radiographs +/- GI panel to include PLI, TLI, cobalamin and folate are warranted. Assuming no evidence of thoracic pathology, biopsies of the abnormal intestine with potential for resection anastomosis may be considered.

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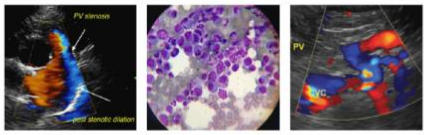

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**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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**