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Clinical Sonography & Telecytology
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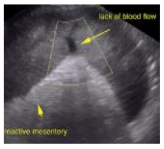
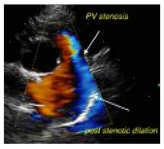
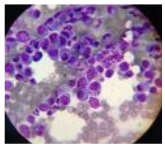
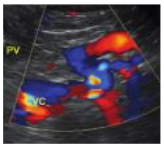

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Chloe George

SPECIES

Feline

BREED

DSH

SEX

F/S

AGE

14

WEIGHT

6.2

INTERPRETED BY

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

IMAGING PERFORMED BY

Ashley Douglass, DVM

HOSPITAL NAME

Mt. Yonah Animal Hospital

REFERRING VET

Ashley Douglass, DVM

INVOICE

17215

DATE

6/29/23

PRESENTING CLINICAL SIGNS

Early renal disease, weight loss, vomiting, supsect IBD
Abnormal PE/Chem/CBC/UA Results: Elevated SDMA (18), BUN (45), Total Protein (9.4)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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.

No evidence of pathology in the area of the aortic trifurcation.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. No pyelectasia was noted.

Adrenal Glands

The left and right adrenal glands were 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/ Gallbladder

The liver was enlarged in size with areas of mild capsule asymmetry and nonhomogeneous parenchyma. Intermittent subtly hypoechoic nondisruptive intraparenchymal nodules were noted. Normal hepatic vascular volume was present. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction.

Gastrointestinal

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 intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of mildly thickened muscularis layer. No overtly visualized loss of intestinal wall layering or intestinal masses.

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

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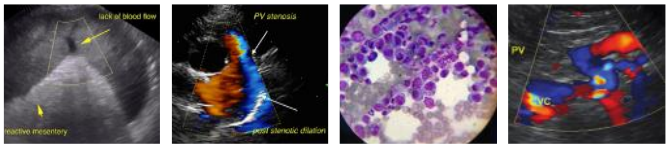

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Pancreas

The pancreas base and left pancreatic limb exhibited normal size with minor capsule asymmetry and nonhomogeneous hypoechoic pancreatic parenchyma with subtle pancreatic duct dilation.

Free Abdomen

No overtly visualized or significant omental lymphadenopathy, omental masses, or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Mild chronic renal changes
- Thickened yet intact small intestinal wall - consistent with infiltrative criteria, suspect IBD / eosinophilic enteritis, potential for neoplastic infiltrative enteropathy with round cells, i.e., lymphoma or similar
- Hepatomegaly exhibiting nonhomogeneous subtly nodular parenchyma
- Mild nonobstructive proximal common bile duct dilation - suspect cholangitis vs. age-related patient variant
- Probable low-grade to mild chronic active pancreatitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given intestinal wall changes in conjunction with probable mild chronic active pancreatitis, IBD or other inflammatory enteropathy and Triaditis are considered most probable. Infiltrative intestinal or hepatic neoplasia cannot be definitively excluded. Assuming normal clotting status and using a 25-gauge needed, screening hepatic FNA cytology is warranted for further clarification. Full-thickness intestinal biopsies, as well as hepato-pancreatic biopsies, are required for a definitive diagnosis.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Empirical IBD / Triaditis protocol would be reasonable if sampling is not possible.

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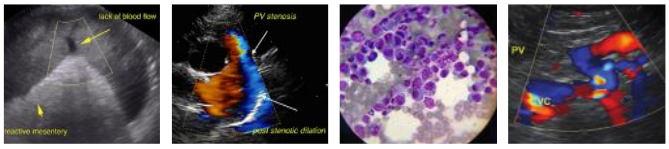

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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