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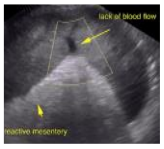
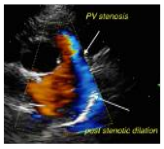
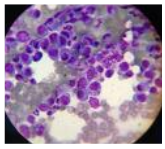
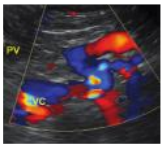
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Trini Ajodha

SPECIES
Feline

BREED
DSH

SEX
FS

AGE
11 years

WEIGHT
9.2 lbs.

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

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
New Bridge Veterinary

REFERRING VET
Dr. Glennon

INVOICE
14041

DATE
6/8/22

PRESENTING CLINICAL SIGNS

Weight loss and chronic vomiting, bloods WNL, T4 WNL, U/A WNL.

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 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. The left kidney measured 3.8 cm in length. The right kidney measured 3.6 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 0.28 cm width. No overt pathology was noted in the area of the right adrenal gland.

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. The spleen measured 0.75 cm width.

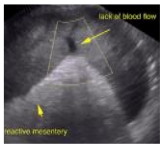
Liver/ Gallbladder

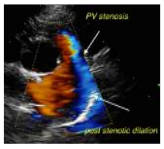
The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was mildly subnormal in size likely owing to the presence of gastric ingesta. The cystic and common bile ducts were normal.

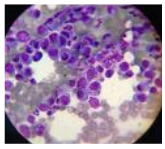
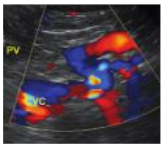
Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate ingesta exhibiting subtle progressive distal acoustic shadowing. The visualized gastric walls were sonographically normal. The pylorus wall width measured 0.26 cm.

The small intestine presented intact yet subjective mildly prominent wall layering owing to subjective propensity for subtly prominent generalized mucosa layer. No evidence of loss of intestinal wall layering or intestinal masses. Minor segmental concurrent small intestinal chyme was present. The duodenum





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wall width measured 0.29 cm. The jejunum wall width measured 0.28 cm. The ileocolic wall width measured 0.32 cm.

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

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 were evident.

Free Abdomen

Multiple jejunocolic 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 the lymph nodes measured 2.9 cm x 0.60 cm. No evidence of peritoneal free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- Overtly normal stomach containing moderate ingesta / chyme
- Suspect inflammatory enteropathy
- Associated subjectively benign / reactive jejunocolic lymphadenopathy
- Minor to early chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of gastric ingesta is nonspecific and likely indicates post-prandial presentation. Correlation with most recent meal ingestion is recommended. If documented NPO prior to the ultrasound, the presence of gastric ingesta may indicate some degree of gastric hypomotility or metabolic stasis. The sonographic presentation of the ingesta was most consistent with food, without evidence of foreign material.

The small intestine exhibited intact yet mildly prominent wall layering which, although patient variant is possible, may suggest underlying inflammatory enteropathy, given the patient's clinical history. However, given the lack of additional gastrointestinal signs such as diarrhea, this finding is nonspecific. Dietary intolerance / food hypersensitivity, occult parasitism if the patient is indoor/outdoor, essentially structurally insignificant suspected inflammatory enteropathy or low-grade pancreatitis may be contributing factors. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Three view chest radiographs are suggested if not done to rule out occult thoracic or esophageal pathology as a contributing factor to the patient's vomiting and weight loss. Pending GI panel results, hydrolyzed diet trial with potential long-term dietary therapy, prophylactic deworming, as-needed gastrointestinal support +/- prednisolone trial at lowest effective dose to control clinical signs may be considered with assessment of clinical response. Recheck sonogram to assess form progressive gastrointestinal or lymphatic changes if persistent / progressive clinical signs despite conservative therapy.

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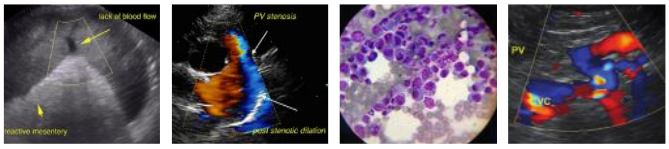

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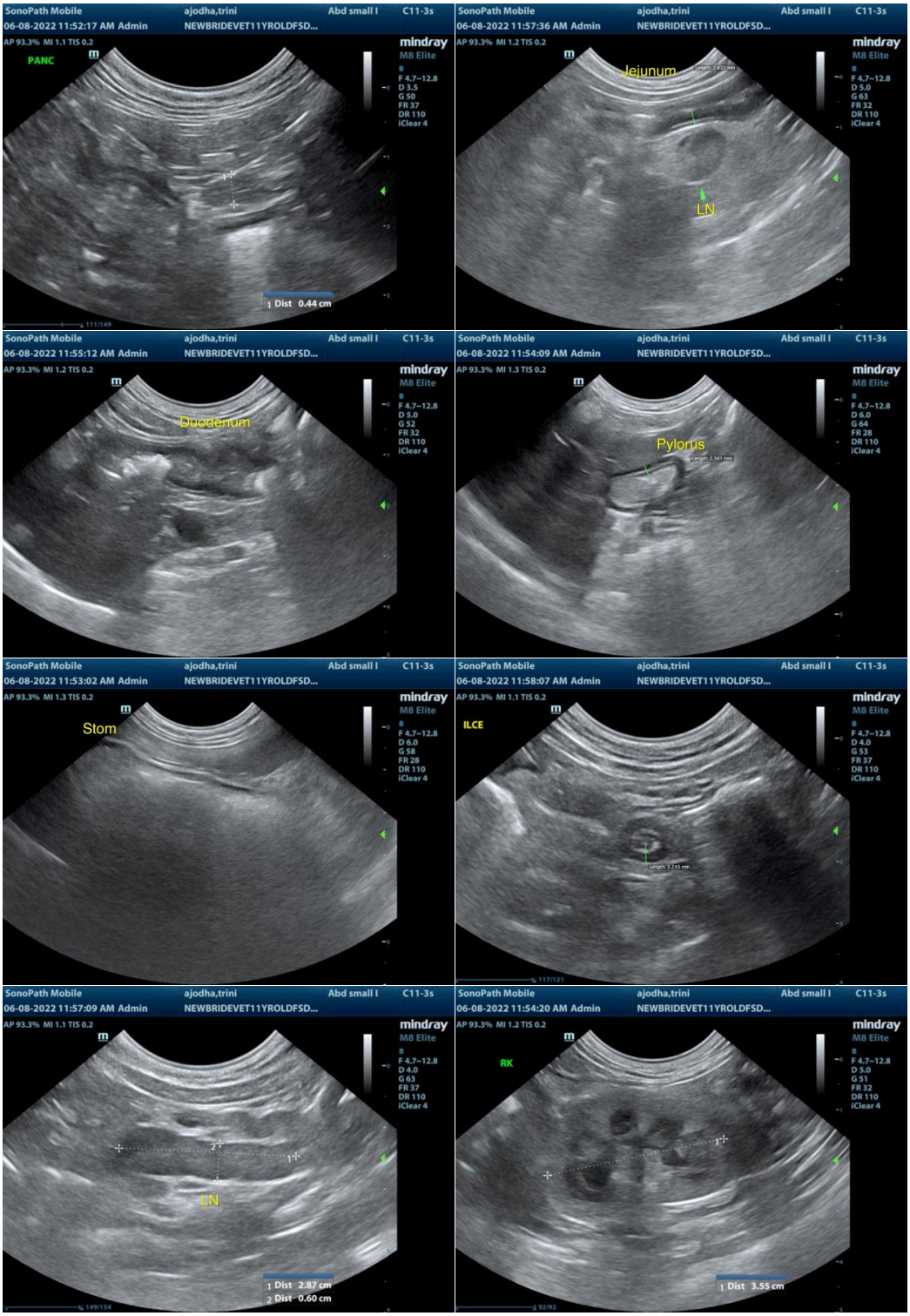

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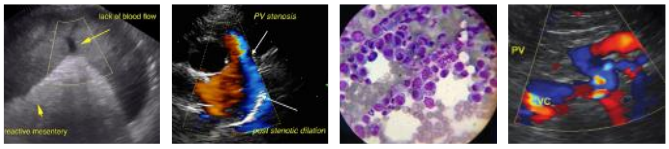

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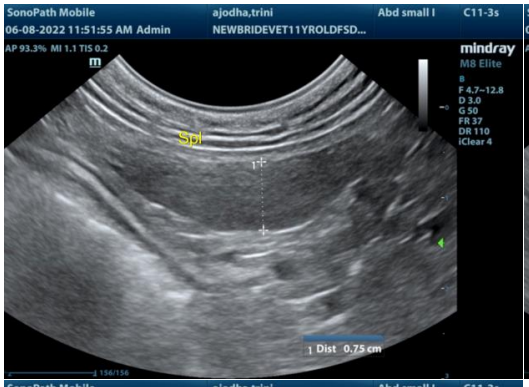

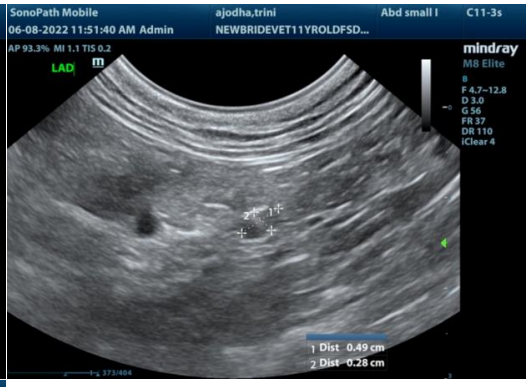

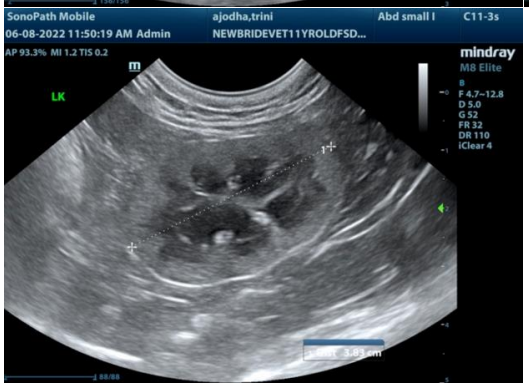

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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