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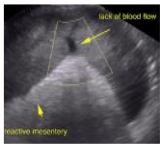

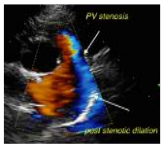

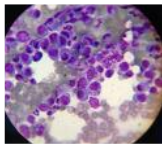
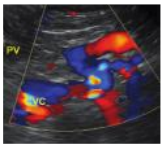


SonoPath.com
1-800-838-4268 info@sonopath.com

**PATIENT**

Winston Cortright

**SPECIES**

Feline

**BREED**

DSH

**SEX**

NM

**AGE**

13 years

**WEIGHT**

10.5

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Hope Brossman

**HOSPITAL NAME**

Animal Mansion VH

**REFERRING VET**

Shelley Parker DVM

**INVOICE**

17344

**DATE**

7/21/23

## PRESENTING CLINICAL SIGNS

Not eating, loose stools, mild vomiting. Mirtazapine Transdermal SID
Abnormal PE/Chem/CBC/UA Results: BW 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.

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. The left kidney measured 4.1 cm in length. The right kidney measured 4.3 cm in length.

### *Adrenal Glands*

The left and right adrenal glands were not definitively visualized.

### *Spleen*

The spleen was not definitively visualized, potentially owing to volume contraction.

### *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 non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

### *Gastrointestinal*

The stomach presented sonographically unremarkable intact wall layering. The lumen of the stomach was empty with no evidence of retained ingesta, fluid, or foreign material. The gastric body wall width measured 0.25 cm.

The small intestine presented intact prominent to mildly thickened wall layering exhibiting segmental nonobstructive ileus. Intestinal wall measured up to 0.3 cm wall width.

The colon exhibited generalized moderate distention with non-formed to liquid fecal matter. Overtly normal visualized colon wall was noted.

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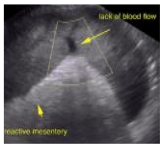

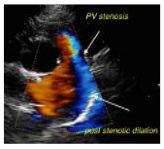

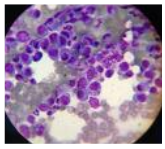
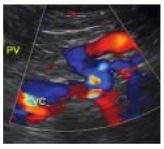


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### *Pancreas*

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*

Intermittent mesenteric lymph nodes were present. These lymph nodes were mildly prominent to enlarged, 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 0.8 cm diameter. There was no evidence of peritoneal effusion or omental masses.

## ULTRASONOGRAPHIC FINDINGS

### *Primary Findings*

- Enteropathy exhibiting segmental nonobstructive ileus
- Generalized moderate distended colon with non-formed fecal matter
- Intermittent mild mesenteric lymphadenopathy with mild perilymphatic hyperechoic omentum
- Sonographically normal empty stomach

### *Secondary Findings*

- Mild chronic renal changes

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine was not specific yet potentially suggestive of acute on chronic enteropathy with inflammatory neoplastic or granulomatous (Dry FIP) etiologies possible. No obvious evidence of mechanical intestinal obstruction or foreign material, which is thought less likely.

Associated mild reactive lymphoid hyperplasia, lymphadenitis, or early neoplastic lymphadenopathy is possible.

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Intestinal biopsies would be required for a definitive diagnosis. Empirically, gastrointestinal support, dietary therapy which may include novel protein or hydrolyzed diet trial with long term dietary therapy, high colony count probiotics such as Proviable, empirical deworming, cobalamin supplementation pending assessment of cobalamin levels, antibiotic therapy such as Metronidazole or Metronidazole / Zithromax combination, given the potential for mesenteric lymphadenitis +/- empirical IBD protocol, if intestinal biopsies are not possible, and assessment of clinical response may prove beneficial.

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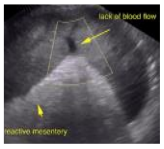
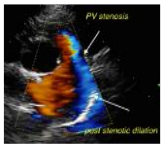
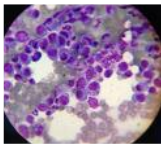
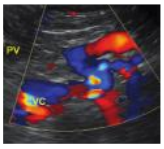

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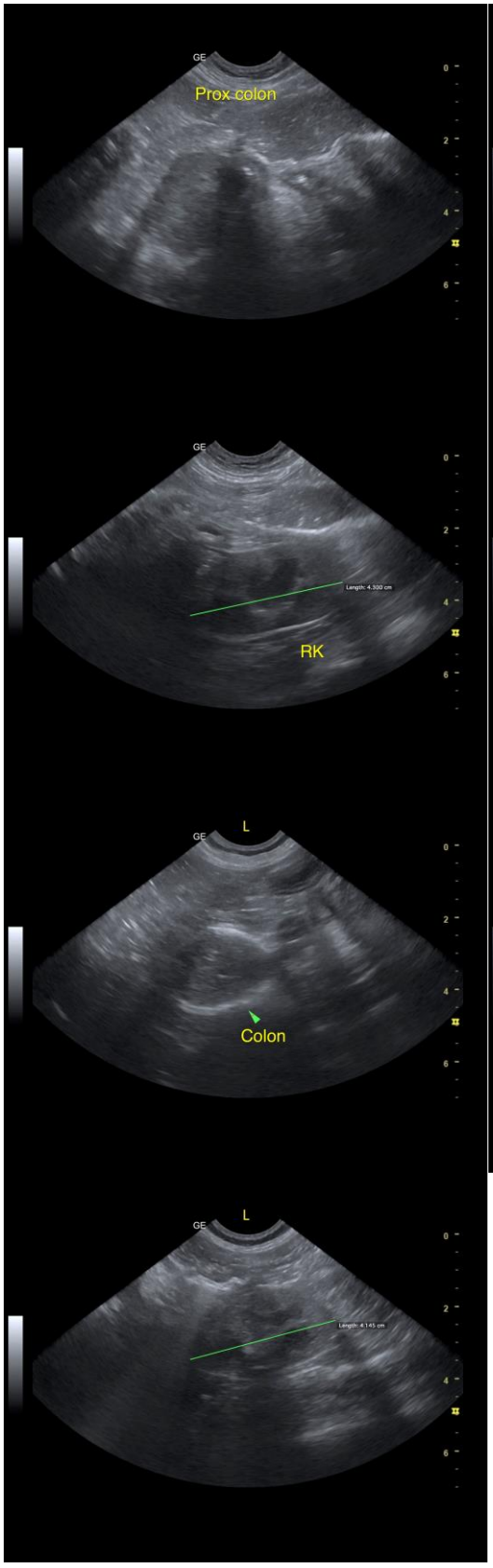

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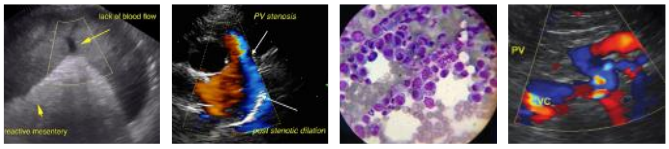


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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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