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Clinical Sonography & Telecytology
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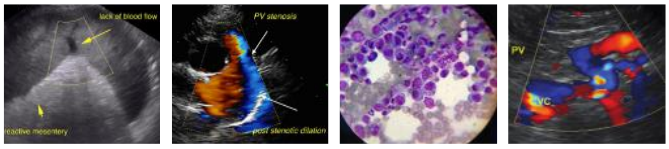

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Dude Peccia

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years

WEIGHT

10.94 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Jasmine Palacios

HOSPITAL NAME

Rivers Edge PMC

REFERRING VET

Dr. Marine Lugo

INVOICE

23644

DATE

7/27/23

PRESENTING CLINICAL SIGNS

Recent history of weight loss. Anorexic for 4 days duration with vomiting. Seen straining at litterbox but has not defecated in 3 days. Urinating fine. Physical exam found a tense abdomen that seemed painful. Unkept haircoat. Heart and lungs WNL.

Abnormal PE/Chem/CBC/UA Results: See attached labs: CBC: Mild neutrophilia and mild Lymphocytosis Chemistry: Mild increase in ALP, glucose and amylase See attached rads: small stomach with thickened wall. Gas filled small intestines with area of dilation on cranial abdomen. Heterogenous material in ventrocranial abdomen silhouetting with small intestines. No gas or feces seen in large intestine. Kidneys normal size and shape. Liver looks small.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in size and tone with primarily anechoic urine with mild to moderate nondependent particulate sediment. No evidence of inflammatory or neoplastic urinary bladder criteria. Urethra was normal to a depth of 2.0 cm.

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. Focal mild medullary mineral was present bilaterally. The left kidney measured 3.9 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No overt pathology in the area of the left or right adrenal glands.

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 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 proximal common bile duct was dilated and tortuous without overt post hepatic obstruction. The proximal common bile duct measured 0.2 cm diameter with anechoic content.

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.

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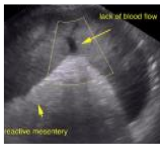
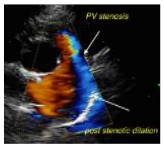
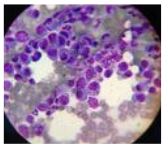
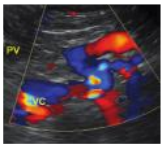

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The small intestine presented intact overtly normal wall layering with 1:3 muscularis/mucosa ratio. No evidence of mechanical or metabolic ileus. The lumen of the small intestine was empty with no signs of obstruction or foreign material. The small intestinal wall measured 0.25 cm.

The distal descending colon and colorectum exhibited variable wall thickening with suspect distal descending colon to colorectal mural lesion, measuring approximately 2.2 cm x 1.3 cm. Thickened colon wall measured up to 0.60 cm wall width. The distal descending colon and colorectum contained soft fecal matter.

Pancreas

The left pancreatic limb was subtly prominent in size with minor capsule asymmetry. Mild nonhomogenous hypoechoic parenchyma was noted compared to adjacent omentum.

Free Abdomen

Focal to intermittent, enlarged, hypoechoic medial iliac lymph nodes were present. The lymph nodes exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). The enlarged lymph nodes were bordered by echogenic to reactive mesentery. An example measured 1.4 cm in diameter.

Generalized mild nonuniform omentum with mild volume peritoneal effusion was noted. No overt omental masses or visualized significant omental lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

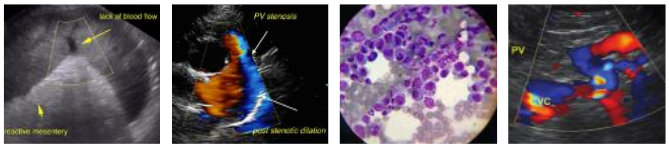
- Variably thickened descending colon/colorectal wall with indistinct distal colon to colorectal mural lesion- nonspecific chronic colitis (infectious, granulomatous, or other), or early infiltrative colon neoplasia is possible.
- Nonhomogenous mildly prominent medial iliac lymphadenopathy- hyperplasia, reactive lymphadenitis, early neoplastic or metastatic lymphadenopathy is possible.
- Urinary bladder sediment
- Bilateral chronic nephropathy with mild medullary mineral.
- Possible low grade chronic active pancreatitis in the left pancreatic limb.
- Sonographically normal liver with mild nonobstructive proximal common bile duct dilation- age-related common bile duct variant, potential for low grade cholangitis.
- Generalized nonuniform omentum and mild volume peritoneal effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

Abdominal effusion analysis, cytology +/- culture and sensitivity, if evidence of inflammatory sediment is recommended.

A GI panel to include PLI/TLI/Cobalamin/Folate may be considered for further clarification of the pancreas, as well as assessment of occult concurrent intestinal disease as a contributing factor to the weight loss.



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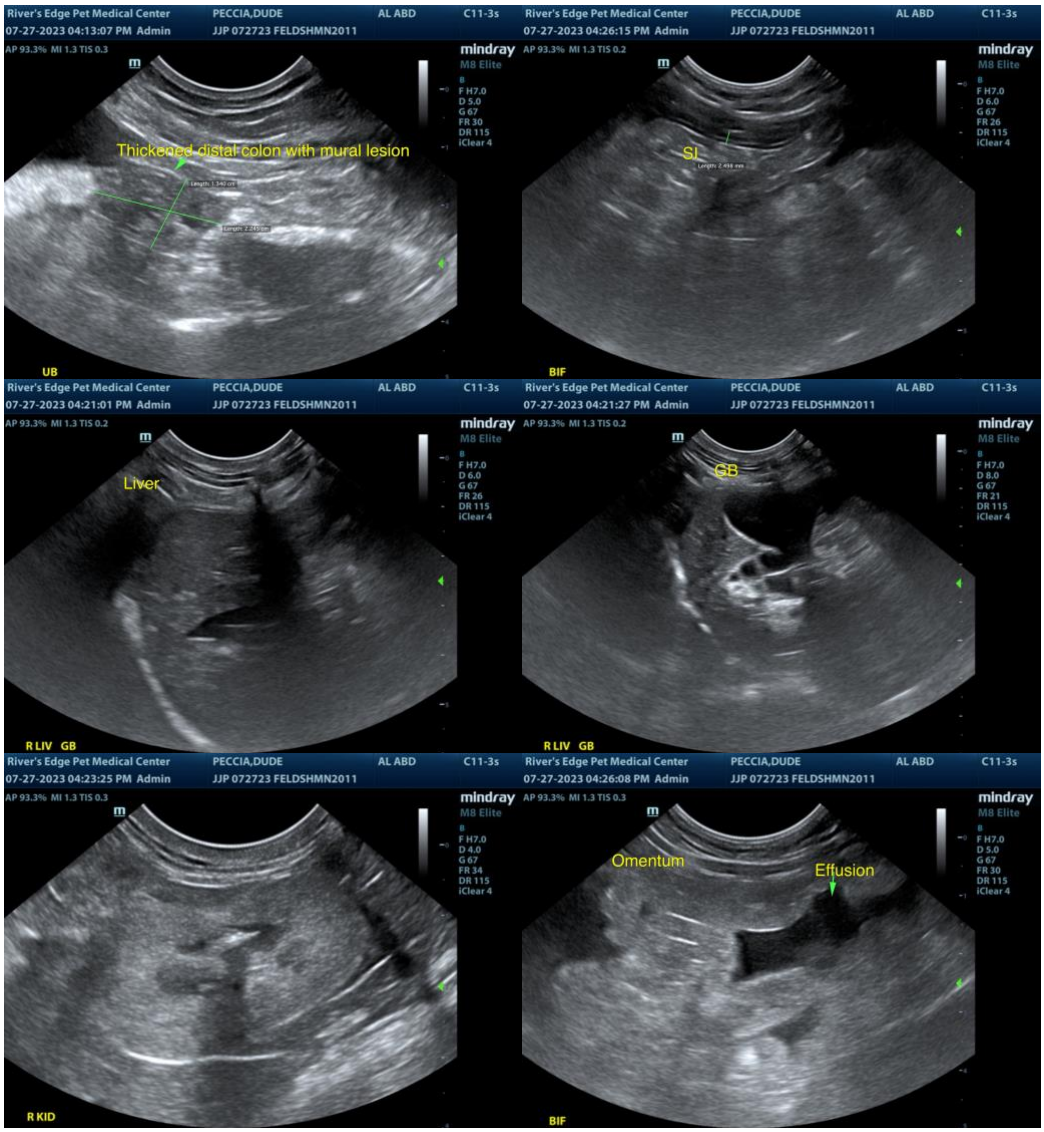
Potential for concurrent emerging carcinomatosis, lymphomatosis, or less likely FIP given the patient age is possible. Colorectal biopsies are likely required for a definitive diagnosis.



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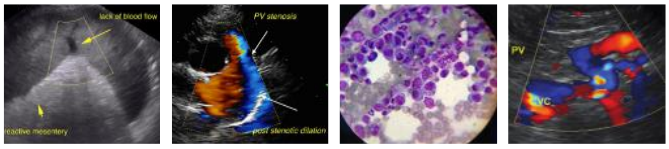

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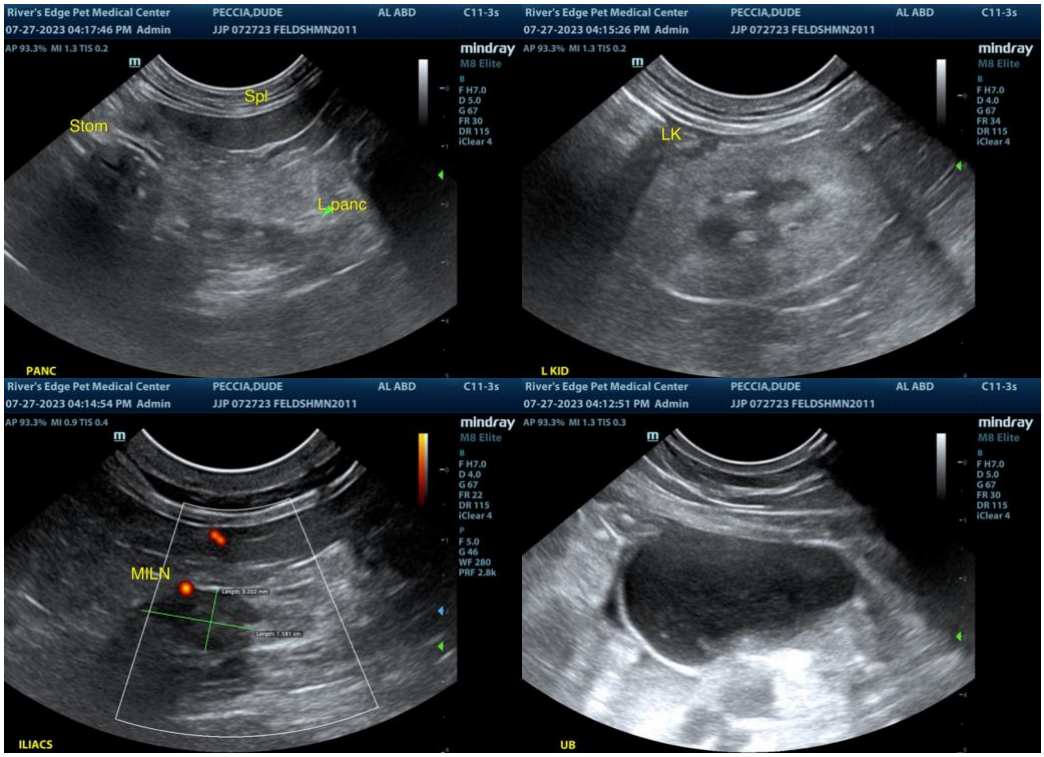

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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