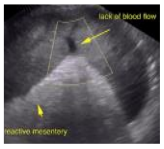
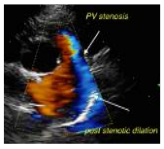
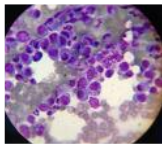
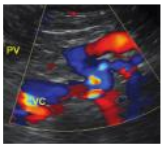
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™





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

PATIENT

Sadie MacDonald

SPECIES

Feline

BREED

DSH

SEX

F/S

AGE

10

WEIGHT

4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Belan

HOSPITAL NAME

Sanctuary VC

REFERRING VET

Dr Warnakulasooriya

INVOICE

14613

DATE

8/13/22

PRESENTING CLINICAL SIGNS

Poor appetite for last 2 weeks weight loss intermittent lethargy Chest x ray taken no sign of thoracic or mediastinal pathology
Abnormal PE/Chem/CBC/UA Results: Non diagnostic

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.

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 and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. A solitary small cortical infarct was present in the right kidney. The left kidney measured 3.4 cm in length. The right kidney measured 3.7 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 0.33 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.34 cm width.

Spleen

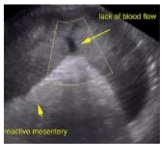
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

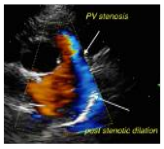
Liver/ Gallbladder

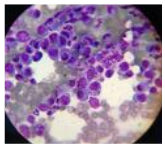
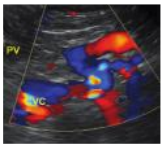
The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with anechoic content with mild nondependent mildly hyperechoic luminal debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact and overtly normal wall layering in the area of the fundus and gastric body. The ventral gastric body wall width measured 0.24 cm. Variable mild to moderate mural thickening was present in the area of the antrum and pylorus extending potentially into the area of the gastroduodenal junction or possible upper duodenum. The thickened antrum and pylorus walls exhibited intact to indistinct wall layer detail and mild asymmetrical luminal surface contour. A mild





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amount of retained anechoic fluid was present in the antrum and pylorus lumen with a small amount of nonspecific hyperechoic mildly shadowing ingesta to potential echoes. This ingesta to potential echoes did not overtly appear to be obstructive to pyloric outflow.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The duodenum wall measured 0.23 cm width. The jejunum wall measured 0.21 cm width. The ileocolic wall measured 0.36 cm width.

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

Pancreas

The pancreas was normal in size and overt contour with subtle nonhomogeneous to mildly hypoechoic pancreatic parenchyma compared to adjacent mildly hyperechoic peripancreatic omentum.

Free Abdomen

Solitary gastric lymph node was present cranial to the pylorus. The lymph node exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). The enlarged lymph node was bordered by echogenic to perilymphatic to regional mild perigastric reactive mesentery. The lymph node measured 1.2 cm x 0.9 cm. No free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- Mild to variably thickened gastric antrum and pylorus exhibiting indistinct wall layer detail, mild retained pyloric fluid with a small amount of nonspecific yet subjectively nonobstructive hyperechoic ingesta to potential echoes
- Associated focal gastric lymphadenopathy with mild regional perilymphatic to perigastric reactive mesentery
- Overtly normal small bowel
- Mild heterogeneous pancreas - age/patient variant, potential for concurrent low-grade pancreatitis possible

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary finding in this case and likely primary factor in the patient's clinical signs Is the mild to variably thickened gastric antrum and pylorus with evidence of pyloric hypomotility. Potential for a small amount of nonobstructive foreign material in the pylorus could be possible yet not definitive.

Considerations for the antrum and pyloric walls may include; inflammatory, infectious (helicobacter) or emerging neoplastic etiologies. Given this presentation, gastroscopy for further assessment of the gastric interior, as well as biopsies would likely be Ideal. If accessible, ultrasound-guided FNA of the gastric lymph node could also be considered for screening cytology. A GI panel to include PLI/TLI/Cobalamin/Folate is warranted to assess for or rule out occult small bowel or pancreatic pathology as a contributing factor.

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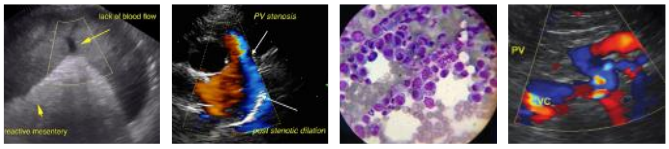

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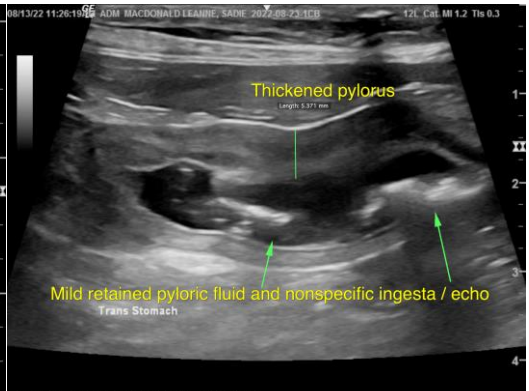
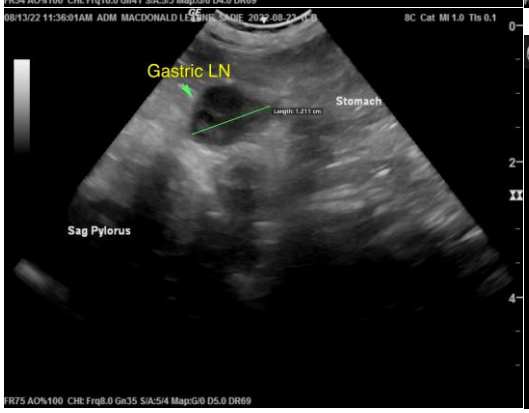
Empirically, as-needed gastrointestinal support such as gastroprotectant protocol +/- empirical coverage for helicobacter with assessment of clinical response and sonographic monitoring of the stomach would be a more conservative approach.





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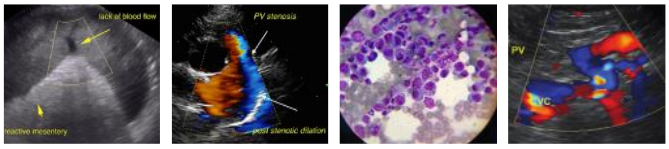

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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