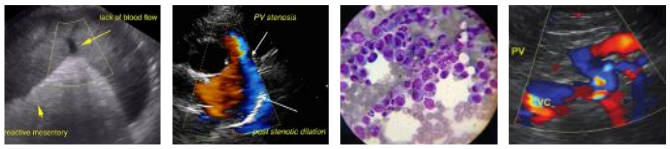
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Callie Smith

SPECIES
Feline

BREED
DSH

SEX
FS

AGE
13yr

WEIGHT
6.5lb

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

IMAGING PERFORMED BY
Robyn Lantz

HOSPITAL NAME
Eastgate Veterinary Clinic

REFERRING VET
Josiah Moses

INVOICE
14641ag

DATE
08/17/2023

PRESENTING CLINICAL SIGNS

P has intestinal cancer and does vomit occasionally but its been improving. otherwise doing very well. Prednisolone 5 mg/ml grilled chick susp - 0.5ml by mouth BID . Suspected GI lymphoma -historical, doing well on prednisolone Suspected GI lymphoma Elevated liver enzymes Leukocytosis with mature neutrophilia and eosinophilia Discussed lab results, focus on liver and white blood cells. Sounds like previous suspect for GI lymphoma Workup via endo bx vs abdo ultrasound IBD still possible and rec the above meds as well as starting RC HP/ultamino diet trial for a few month. O notes on 8/10/23: Since her blood test on 8/8/23, she has been more sleepy than usual. asked about how much blood, discussed that is not likely the cause as thats a very small % of blood that is taken via tubes. Recommendations - the above meds, will fill and call owner abdo ultrasound, owner intersted and can perform likely next week when RLE back. Can start hp diet prior to but rec doing ultrasound earlier than later to see if there is inflammation in gut wall. ok to continue Prednisolone. O said it didn't get faxed, will refax. Currently on prednisolone, clavamox, proviable-Forte, given drontal dewormer and RC feline hydrolyzed diet.

Abnormal PE/Chem/CBC/UA Results: Feline senior lab work: ALT (SGPT) 158 (HIGH) 10-100 BUN/CREAT RATIO 43 (HIGH) 4-33_ WBC 22.9 (HIGH) 3.5-16.0 Neutrophils 14,885 (HIGH) 65 2,500-8,500 Eosinophils 3,435 (HIGH) 15 0-1,000

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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 were noted.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. A right kidney cortical cyst was present. The left kidney measured 3.5 cm in length. The right kidney measured 3.9 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral 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/Gallbladder

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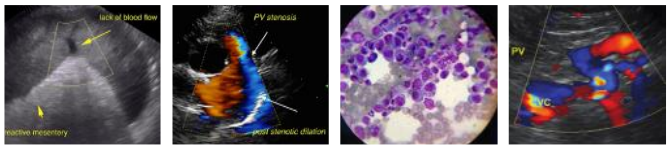

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The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content and mild echogenic non-mineralized debris. 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 mild variably echogenic ingesta with no signs of ileus, obstruction or foreign material.

The small intestine presented intact subjective mild prominent to thickened wall layering. The lumen of the small intestine contained similar appearing non-shadowing ingesta/chyme and segmental lumen gas. No evidence of obstruction or foreign material.

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

Pancreas

The pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Gastric ingesta-sonographically suggestive of food.
- Intact mildly prominent to thickened small bowel wall with segmental to generalized similar appearing intestinal ingesta and luminal gas.
- Chronic/chronic active pancreatitis pattern.
- Mild chronic renal changes.
- Mild hepatopathy with mild gallbladder sediment-suggestive of mild cholangiohepatitis pattern.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, there is no overt evidence of significant abdominal visceral pathology. No evidence of GI or intra-abdominal masses or overt neoplastic criteria. Potential suppression of GI mural changes secondary to prednisolone therapy is possible. If documented NPO prior to the ultrasound, the presence of gastric ingesta may indicate some degree of inefficient peristalsis or non-obstructive GI ileus.

Recheck GI panel to include PLI/TLI/Cobalamin/Folate is recommended if not already done. Chronic triad disease may be a strong consideration in this case. A full thickness/surgical hepatic/intestinal biopsy may be required for a definitive diagnosis.

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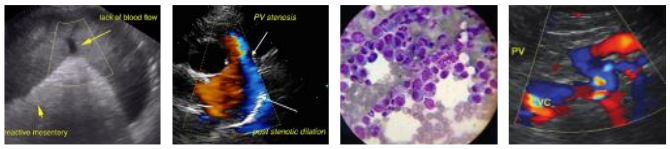

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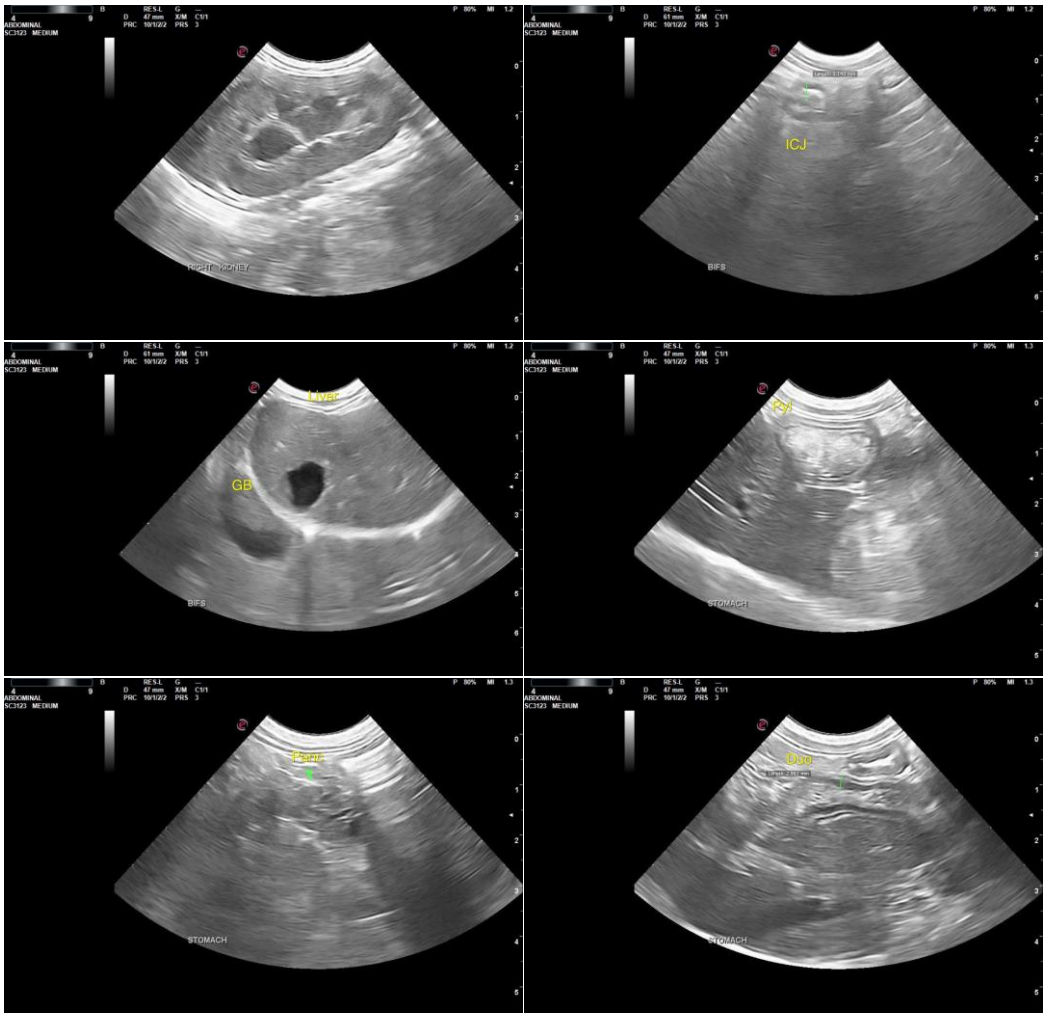
Empirically continued GI support and triaditis protocol would be reasonable since patient is reportedly stable.



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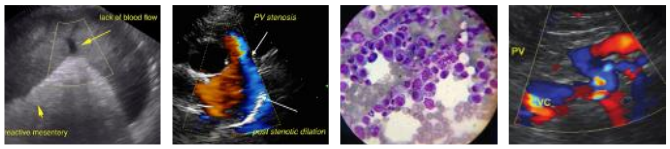

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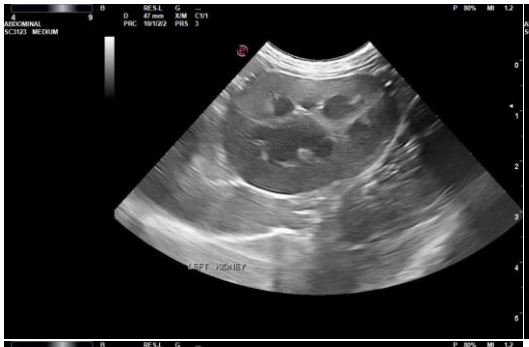

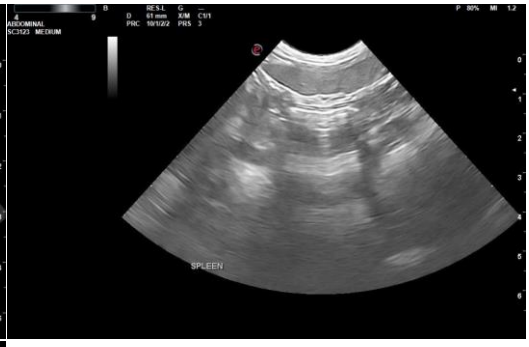

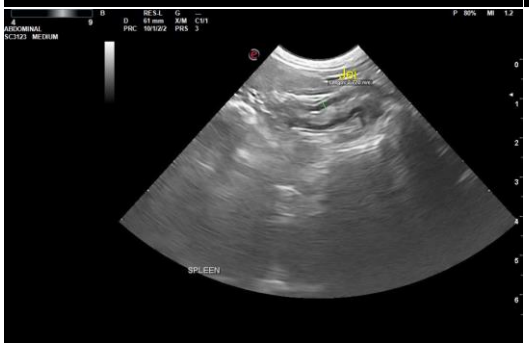

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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