



PATIENT

Callie Falconridge

PRESENTING CLINICAL SIGNS

Vomiting. Clinic cat.

SPECIES

Feline

BREED

DSH

SEX

F/S

AGE

13 years

WEIGHT

4.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dave Stasiuk RDMS,
RDMS

HOSPITAL NAME

Falconridge AH

REFERRING VET

Dr. Rix

INVOICE

14678

DATE

8/23/22

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. Primarily anechoic urine was present in the lumen. Minor nondependent particulate sediment was present without evidence of calculus formation. This may indicate minor cellular debris/ protein, crystalline debris, lipid, or mucus. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were 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 to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.6 cm in length. The right kidney measured 3.8 cm in length.

Adrenal Glands

The bilateral adrenal glands were normal in size with subtle capsule asymmetry exhibiting primarily homogeneous parenchyma with potential for minor left and right adrenal cystic changes. No evidence of neoplastic criteria was noted. The left adrenal gland measured 0.32 width and the right adrenal gland measured 0.44 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 containing mild, nondependent, particulate 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 was empty with no signs of ileus, obstruction, or foreign material. The gastric body wall width measured 0.30 cm.



PATIENT	The small intestine presented intact wall layering and maintained a 1:3 muscularis/mucosa ratio with segmental propensity for mildly prominent intestinal muscularis layer, yet without evidence of overt or significant mural thickening, loss of intestinal wall layering, or intestinal masses. The duodenum wall measured 0.25 cm width. The jejunum wall measured 0.26 cm width.
Callie Falconridge	
SPECIES	
Feline	The colon exhibited sonographically unremarkable wall layering with subjective mild generalized distention containing semi-formed to soft fecal matter.
BREED	Pancreas
DSH	The pancreas was mildly prominent in size exhibiting areas of mild capsule asymmetry with isoechoic to mild nonhomogeneous parenchyma compared to adjacent omentum with pancreatic duct dilation.
SEX	
F/S	Free Abdomen
AGE	Intermittent mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 1.4 cm x 0.54 cm. No effusion or omental masses were noted.
13 years	
WEIGHT	ULTRASONOGRAPHIC FINDINGS
4.8 kg	<ul style="list-style-type: none"> • Mild urinary bladder sediment • Mild to moderate bilateral chronic renal changes • Mildly prominent to irregular pancreas exhibiting pancreatic duct dilation - age-related pancreatic changes, potential for mild chronic pancreatitis possible • Intact yet segmentally prominent small intestinal walls - suspect IBD intestinal pattern • Overtly normal colon containing generalized semi-formed soft fecal matter • Minor gallbladder debris - likely incidental assuming no evidence of cholestasis • Probable minor mesenteric lymphadenitis vs. lymphoid hyperplasia - suspect owing to underlying Inflammatory intestinal disease
INTERPRETED BY	INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.
IMAGING PERFORMED BY	Potential for chronic pancreatitis may be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation. Correlation of both the appearance of the pancreas and small bowel may include a GI panel to include PLI/TLI/Cobalamin/Folate.
Dave Stasiuk RDMS, RDCS	Technically, a minor potential for early neoplastic infiltrative enteropathy and neoplastic lymphadenopathy is possible yet considered less likely.
HOSPITAL NAME	As-needed gastrointestinal support, which may include hydrolyzed diet trial, gastroprotectants, +/- empirical IBD protocol, and assessment of clinical response would be reasonable. Full-thickness intestinal +/- pancreatic and lymphatic biopsies would be required for a definitive diagnosis.
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Alternatively, if accessible, ultrasound-guided FNA of an enlarged mesenteric lymph node for screening cytology could be considered.

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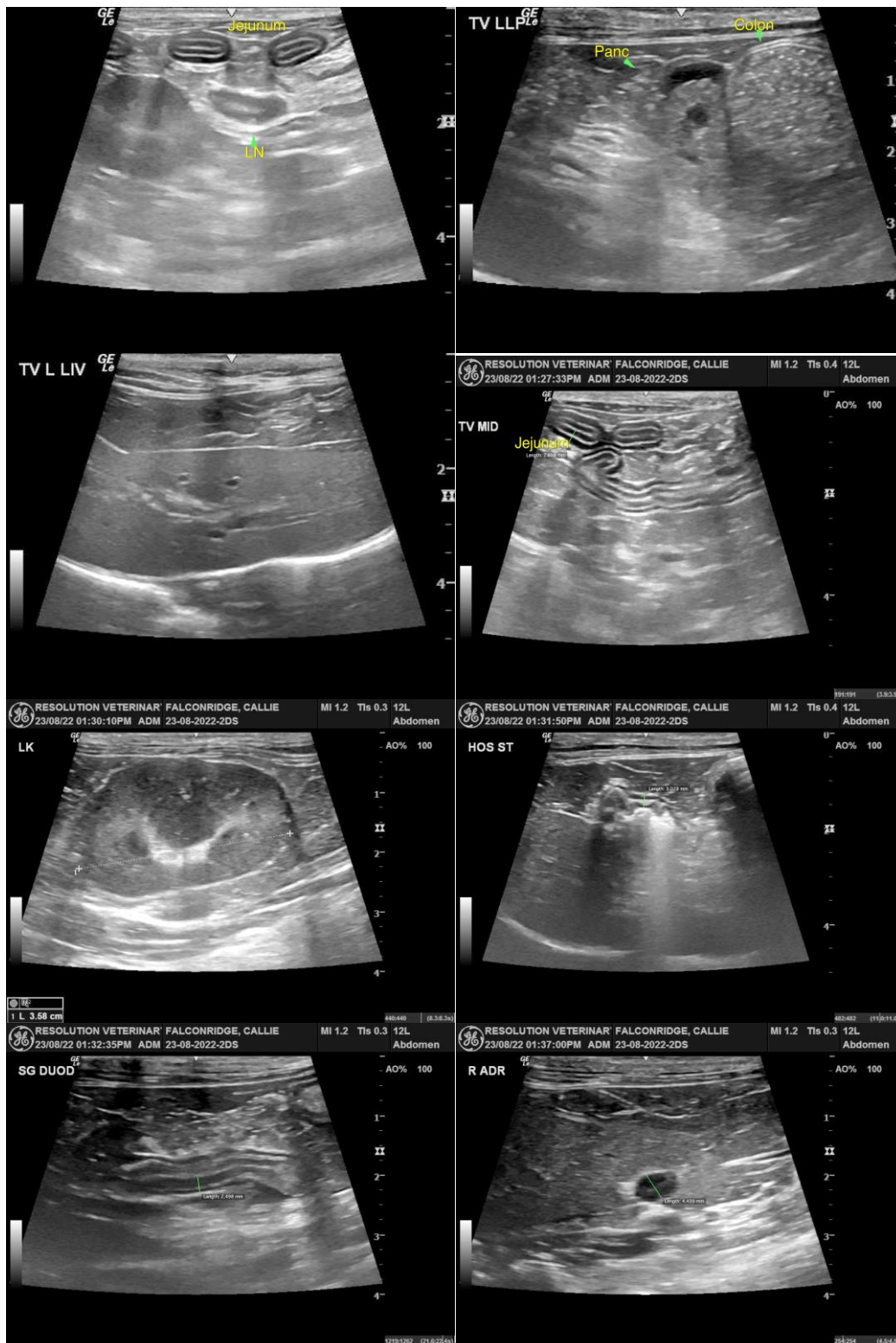
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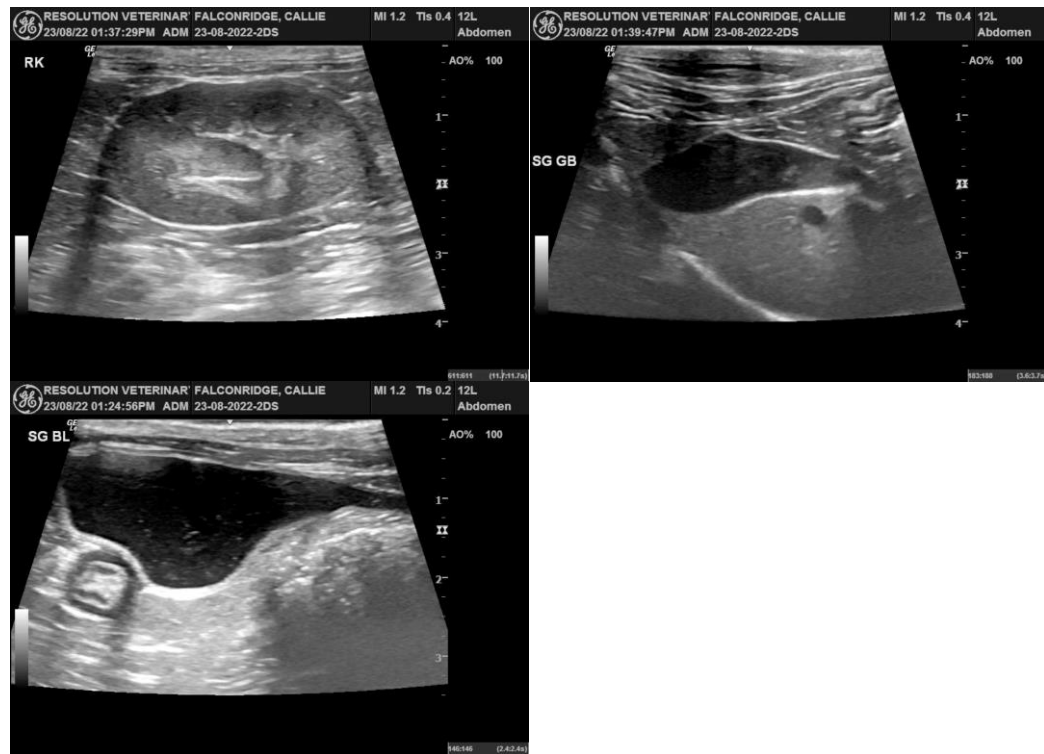
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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