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Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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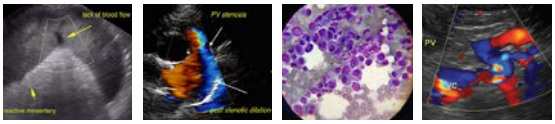


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT
Yoda Scott

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
16 Years

WEIGHT
7.8 Pounds

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

IMAGING PERFORMED BY
Sara Hansen

HOSPITAL NAME
Better Vet – Eugene

REFERRING VET
Dr. Graham

INVOICE
44942

DATE
8/24/23

PRESENTING CLINICAL SIGNS

Not eating for several days, no BM's, weight loss noted for about 2 weeks by owner Loose skin consistent with significant weight loss, dehydration, dental disease, painful on abdominal palpation, ropy intestines.

Abnormal PE/Chem/CBC/UA Results: ABNORMAL Labratory Findings Bilirubin - Total 1.1 mg/dL Bilirubin - Unconjugated 0.4 mg/dL Bilirubin - Conjugated 0.7 mg/dL Otherwise WNL (Chem, CBC, T4) Current Medications Mirtazapine 7.5mg 1/4 tab SID, SQ fluids 48 hours ago Radiographic Findings None taken

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. Mild non-dependent particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

Normal renal size with asymmetrical margination and probable cortical infarcts 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. The left kidney measured 3.4 cm. The right kidney measured 3.7 cm.

Adrenal Glands

The adrenal glands were overtly normal in size, position, and shape. The left adrenal gland measured 0.36 cm. The right adrenal gland measured 0.37 cm.

Spleen

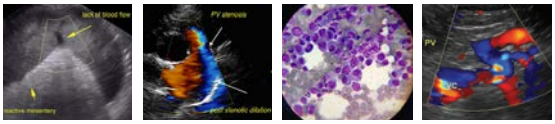
The spleen measured 0.65 cm in width at the level of the mid spleen and exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal 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 mild, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

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. Gastric body wall measured 0.24 cm.



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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. Small intestinal wall measured 0.20 cm.

The colon presented subjective thickened proximal colon wall. The colon contained potential mild nonformed to primarily formed shadowing proximal to transverse colon fecal matter. Subjective potential for indistinct to loss of proximal colon wall layer detail. Proximal colon wall measured up to 0.63 cm. Concurrent intact mildly prominent transverse colon wall measured 0.27 cm. The visualized distal descending colon at the level of the urinary bladder exhibited overtly normal wall layering and contained formed fecal matter without overt evidence of distal descending colon fecal distention.

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 was evident.

Free Abdomen

No omental masses, lymphadenopathy, or peritoneal effusion.

ULTRASONOGRAPHIC FINDINGS

- Mild urinary bladder sediment
- Chronic interstitial nephrosis renal pattern with cortical infarcts
- Overtly normal stomach/small bowel
- Subjective mild to variable thickened proximal to transverse colon containing formed to nonformed fecal matter.
- Sonographically unremarkable liver
- Non-distended gallbladder with minor gallbladder sediment

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although non-specific, the subjective mild to variably thickened proximal colon wall may indicate inflammatory infectious, granulomatous, or emerging neoplastic mural etiologies. A GI panel to include PLI, TLI, cobalamin and folate is suggested, given the patient's weight loss, to assess for or rule out non-structural small intestinal or pancreatic disease as a contributing factor.

3-vew chest radiographs suggested if not done. No evidence of post-hepatic obstructive criteria. The gallbladder sediment is non-specific, yet at times may be associated with hepatobiliary inflammation or non-obstructive cholestasis, given short half-life of hepatic enzymes in cats.

Pending additional diagnostics, sonographic monitoring of the proximal to transverse colon wall for evidence of progressive mural changes, with empirical therapy for constipation if clinically indicated and as needed gastrointestinal support, would be reasonable. Enterocolic biopsies likely required for definitive diagnosis.

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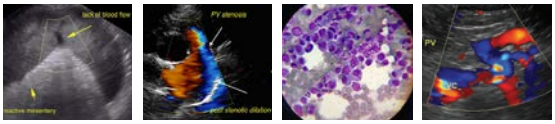

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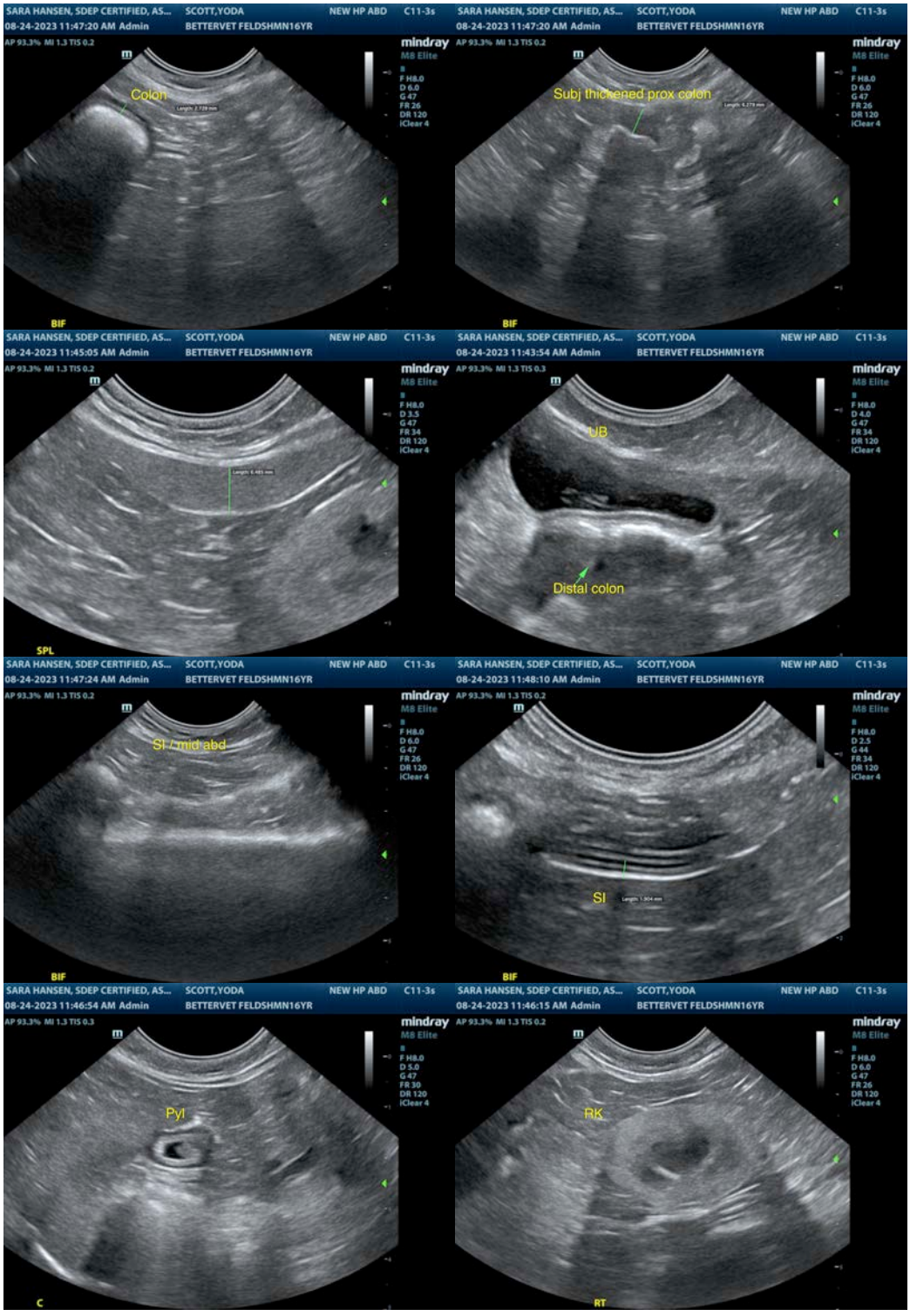

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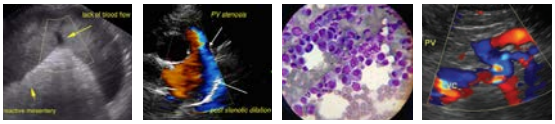

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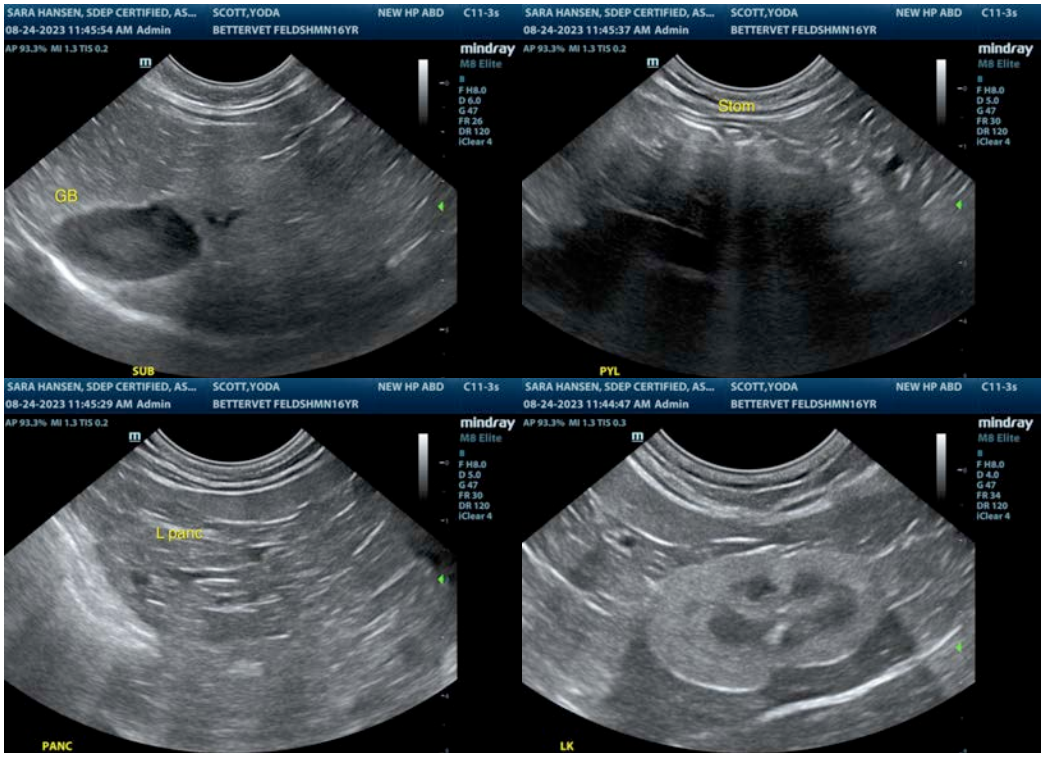

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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