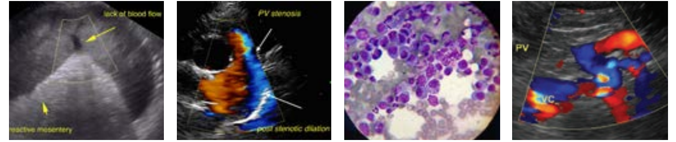


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Big Head Errera

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

16 Years 7 Months

WEIGHT

7.25 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Rivera

HOSPITAL NAME

DPC Vet Hospital

REFERRING VET

Dr. Rivera

INVOICE

25066

DATE

8/31/21

PRESENTING CLINICAL SIGNS

Date: 8/28/2021 Chief Complaint: LOSING WEIGHT History: p presents for loss of appetite. o states over the last week or so p hasn't been wanting to eat much. will pick at food and walk away. drinking excessively as well. no v/d happening, seems a bit lethargic.
Abnormal PE/Chem/CBC/UA Results: Hydration: N Mentation: N EENT: NO PALPABLE THYROID NODULE Oral Cavity: MM PALE PINK, UNABLE TO LOOK AT TEETH Lymph Nodes: N Skin: POSITIVE SKIN TENT, POORLY KEPT HAIRCOAT CV/Respiratory: MILDLY TACHYCARDIC, NO MURMUR Abd/GI: KIDNEYS ON SMALL SIDE, INTESTINES EMPTY Uro/Perineum: N Musculoskeletal: EMACIATED (5 LB WEIGHT LOSS) Neurological: N CBC: LYMPHOPENIA 820 - R/O SEC TO FIV, GI LOSS CHEM: GLOBS 5.4 - FIV, NEOPLASIA, INFECITON BUN 68 - GI VS RENAL CREAT WNL 1.2 CALCIUM 11.5 (EXPLAINS THE PU/PD) - R/O MALIGNANCY (LSA), IDIOPATHIC, RENAL AMYLASE 1245 - GI VS RENAL T4 WNL 1.6 UA: USG 1.046 3+ PROTEINURIA - R/O GLOMERULAR DZ +/- SECONDARY TO CHRONIC FIV, NEOPLASIA

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. 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 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 subtle hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is likely an idiopathic finding. The left kidney measured 3.9 cm. The right kidney measured 4.5 cm.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was mildly enlarged in size with primarily symmetrical contour and uniform hypoechoic parenchyma. The left adrenal gland measured 0.58 cm in width.

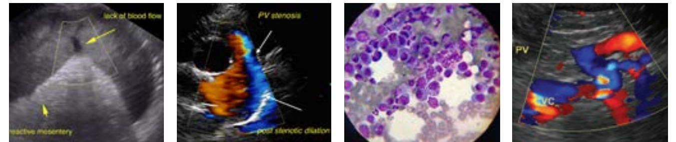
The right adrenal gland was indistinctly visualized, subjectively measuring 0.35 cm in width.

Spleen

The spleen was subnormal in size, measuring 0.45 cm in width at the level of the hilus, potentially owing to volume contraction. It 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 cystic and common bile ducts were normal.



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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Mild subjective gas distention present. Gastric body wall measured 0.20 cm.

The visualized intestinal tract exhibited primarily subjective intact wall layering and maintained 1:3 muscularis/mucosa ratio with segmental non-obstructive gas pattern. A focal area of intestinal mural hypertrophy subjectively owing to muscularis hypertrophy and decreased mural echogenicity was present in the mid abdomen. Normal appearing intestinal wall measured 0.2 cm wall width. Wall width within the area of intestinal mural hypertrophy measured up to 0.47 cm wall width. No overt lymphadenopathy. No effusion.

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

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.

ULTRASONOGRAPHIC FINDINGS

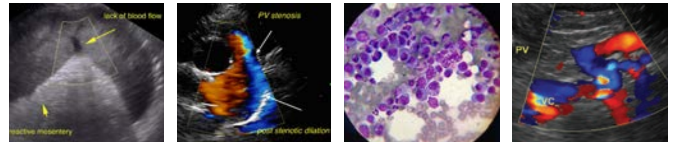
- Bilateral subtle non-specific medullary rim sign
- Focally thickened intestine, potential emerging intestinal mural mass
- Mildly prominent left adrenal gland

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The mildly prominent left adrenal gland is of unclear clinical significance given the lack of hypokalemia. This may be a patient variant or potentially secondary to stress hyperplasia. Screening blood pressure is suggested with continued monitoring of potassium levels suggested.

The focally thickened intestine was only visualized in one video, therefore ideally sonographic reassessment with concentration on the area of the thickened intestine is recommend for further clarification. The exact location of the focally thickened intestine was unclear, yet suspected to be involving the small bowel. Potential considerations (if verified) may include inflammatory, granulomatous (dry form FIP) or neoplastic etiologies.

A GI panel to include PLI, TLI, cobalamin and folate, and (if not done) 3-view chest radiographs to assess for or rule out occult thoracic pathology given the patient's weight loss is warranted. Potential for concurrent low-grade or chronic pancreatic inflammation may be present, yet ultrasonographically normal. Empirically, continued gastrointestinal support +/- hospitalization with 24 hour IV fluids may prove beneficial. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.



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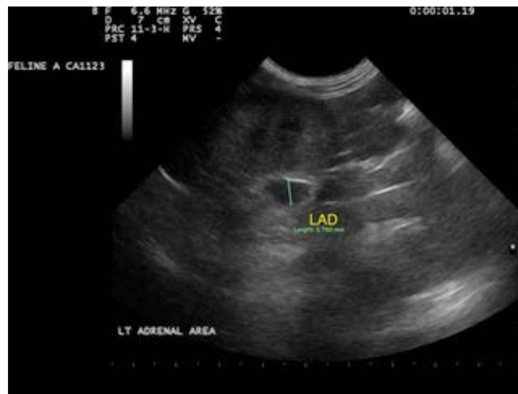

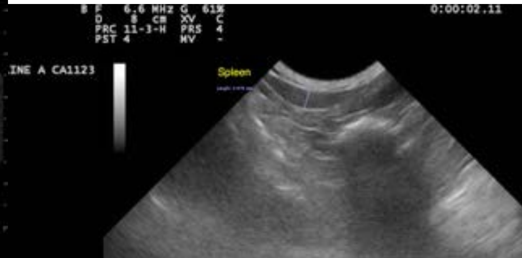

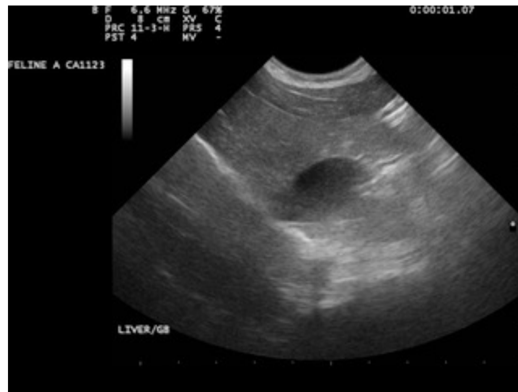

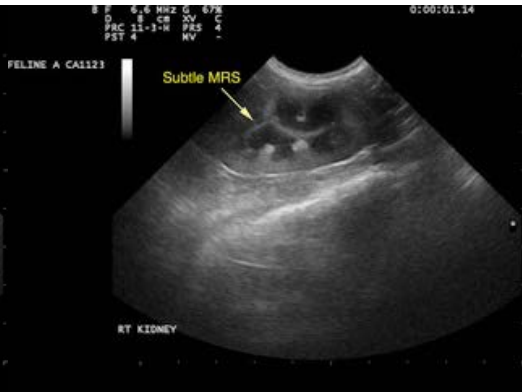

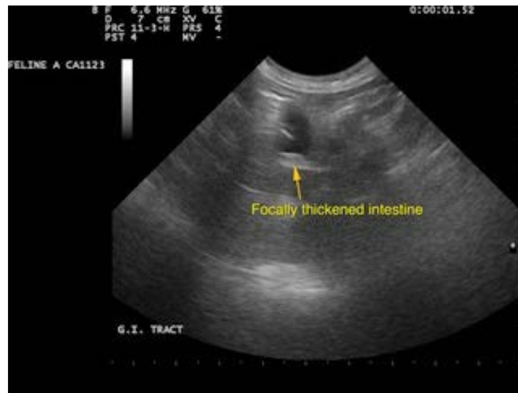

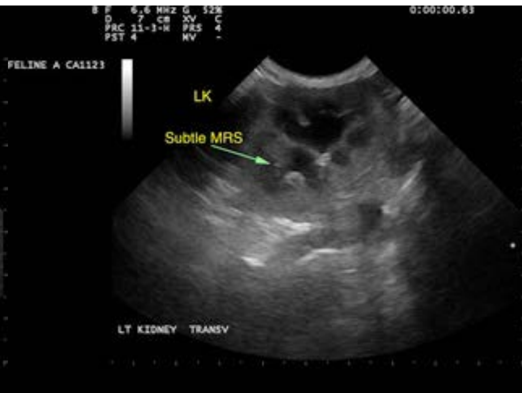

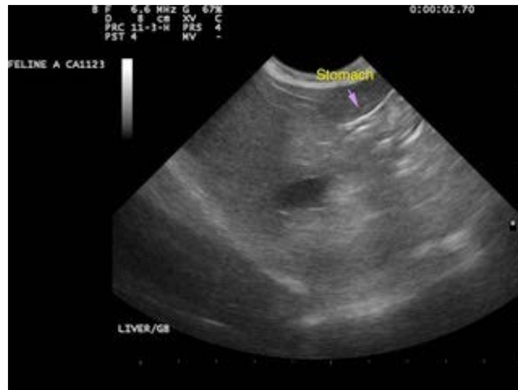

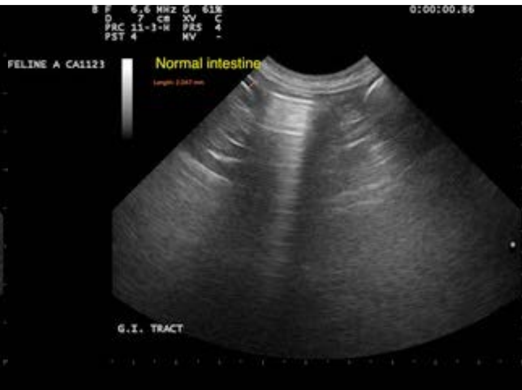

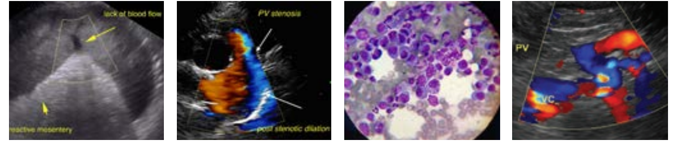

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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