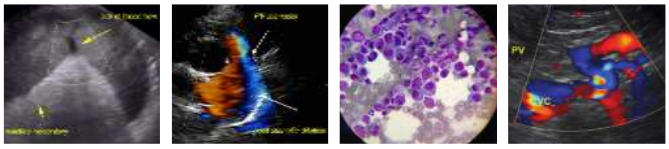
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Fred Malone

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 years

WEIGHT

6.1 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Callihan/AEC

HOSPITAL NAME

Animarl Emergency Care

REFERRING VET

Dr. Johnson/AEC

INVOICE

12267

DATE

9/18/21

PRESENTING CLINICAL SIGNS

Presented yesterday evening 9/17 following owner's return home to find "piles of blood everywhere"- said it looked like a crime scene. Thinks it appeared to be rectal origin. No history of vomiting or straining to urinate. Fred has had diarrhea for maybe 2 mos but never bloody. Owner says he has lost quite a bit of weight though appetite seems normal- she has done some food changes to try an address the diarrhea. He is the only pet in the home. He is indoor/outdoor but rarely goes outdoors. Abnormal PE/Chem/CBC/UA Results: Some loss of condition along topline though still BCS 6/9; dull coat; severe flea infestation (rectal capstart given while he was sedate and was effective- at least 100 fleas dropped off him) ; severe tartar but no lesions in mouth otherwise; murmur 2/6 parasternal ; on rectal exam (sedated- he is fractious) there is a formed bit of stool but otherwise dark liquid blood. FELV/FIV: Neg CBC: mild leukocytosis 18K (mature neutrophilic); Regenerative anemia w HCT 15% Chem panel all normal except hypoproteinemia (5.5) and slight elev SDMA

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 particulate sediment was present without evidence of calculus formation. The sediment is likely consistent with mild cellular or crystalline debris or potential 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 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. A focal area of increased cortex echogenicity, consistent with cortical infarction, was present in the right kidney. The right kidney measured 3.5 cm in length.

Adrenal Glands

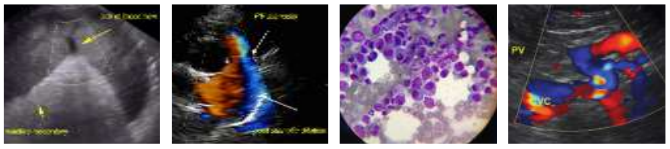
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.4 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.49 cm width.

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



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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.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild, echogenic, nonshadowing ingesta / chyme most consistent with post prandial presentation without signs of ileus, obstruction or foreign material. The gastric body wall width measured 0.25 cm.

The small intestine presented intact wall layering with segmental to generalized propensity for prominent muscularis layer and subjective generalized mild mural hypertrophy. No evidence of loss of intestinal wall layering or intestinal masses was noted. The jejunum wall width measured 0.36 cm. The ileocolic wall width measured 0.34 cm.

Normal visible colon wall layers were present with segmental formed shadowing feces as well as semi-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 were evident.

Free Abdomen

No evidence of intraabdominal masses, lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

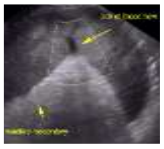
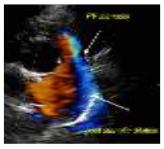
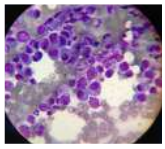
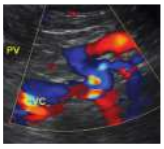
Primary Findings

- IBD intestinal pattern with suspect mild colitis
- Bilateral mild chronic renal changes with right kidney cortical infarction
- Mild retained gastric ingesta / chyme

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine exhibited Intact wall layering yet subtle mural changes including propensity for prominent muscularis layer, suggestive of inflammatory enteropathy / IBD, given the patient's clinical signs, weight loss and loss of muscle mass. A minor potential for early neoplastic infiltrative enteropathy with round cells such as lymphoma, which may present as sonographically similar, cannot be excluded yet considered less likely.

Further assessment may include fresh fecal analysis to assess for parasitic ova +/- diarrhea PCR panel, as well as a GI panel to include PLI/TLI/Cobalamin/Folate. Intestinal sampling i.e., full-thickness intestinal biopsies would be required for a definitive diagnosis.

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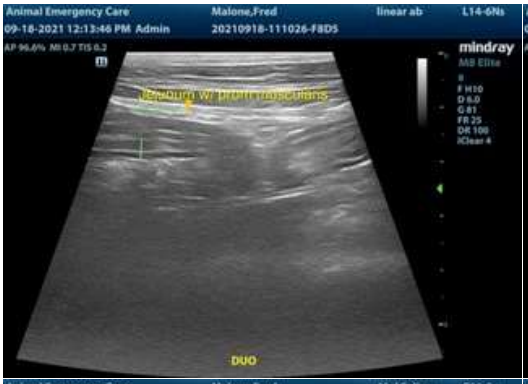
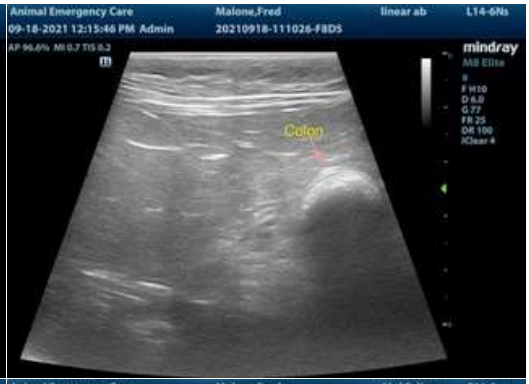
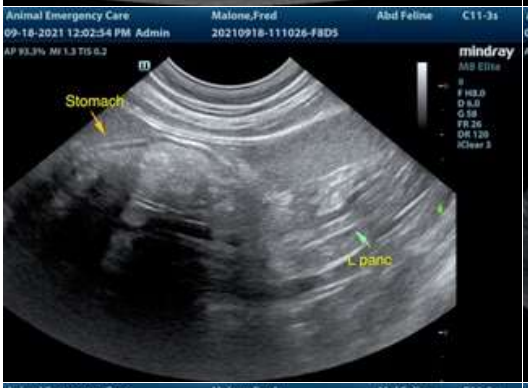
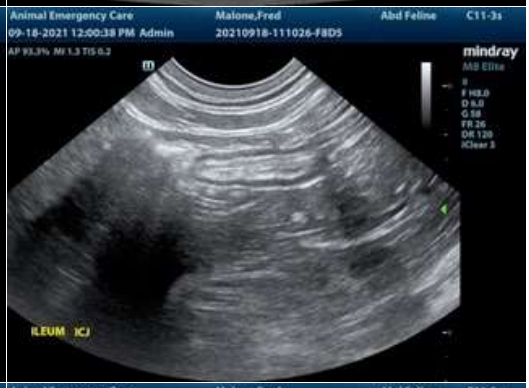
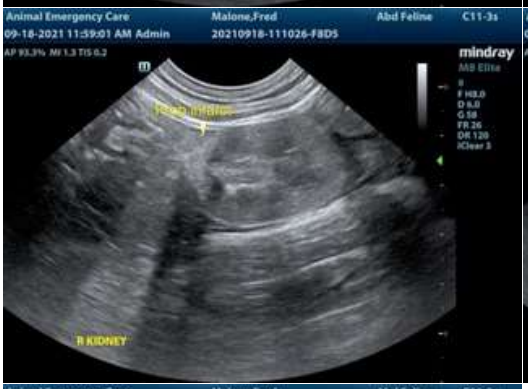
If biopsies are not possible, empirical IBD protocol which may include cobalamin supplementation, hydrolyzed diet trial, broad-spectrum deworming If clinically indicated, appropriate antibiotics +/- Prednisolone at lowest effective dose to clinical signs with as-needed GI support could be considered.

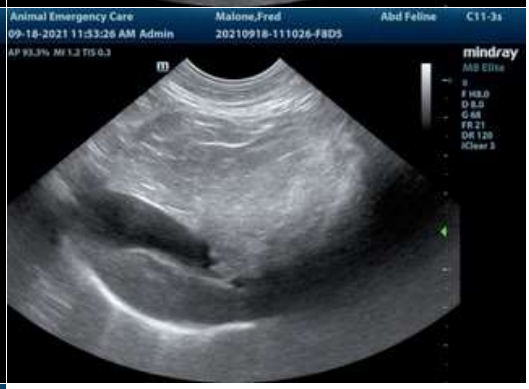


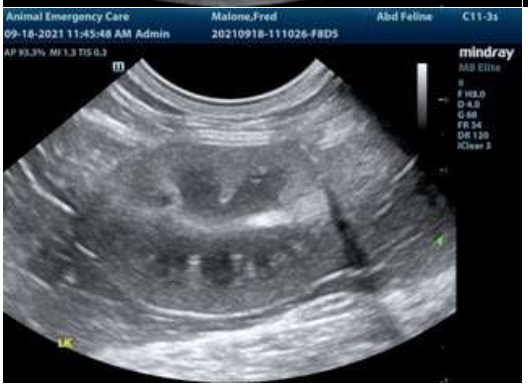












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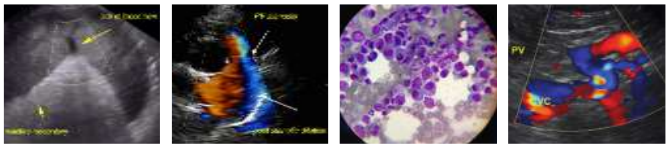

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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