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Clinical Sonography & Telecytology
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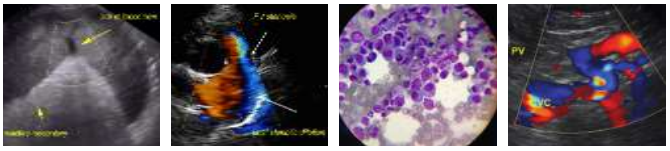

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Smitten Keller

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

15 Years

WEIGHT

3.58kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Moser

INVOICE

47437

DATE

9-19-21

PRESENTING CLINICAL SIGNS

Presented at our hospital for anorexia for 4 days. Weight loss, lethargy. Previous Health Concerns: CRF (stage 2 iris scale); chronic vomiting—stress related? Current Medications none Appetite/When did they eat last: not eating since 9/16; ate 3 treats on 9/17 Vomiting/Diarrhea: 9/15 4 times, 9/16 4 times, none since 9/15 vomit had paper/tissue material in it/none
Abnormal PE/Chem/CBC/UA Results: Epoc: pO2 25 L, cSO2 45.3 L, potassium 3.3 L, ica ++ 1.09 L, BUN 52 H, creatinine 2.35 H, glucose 144 H Liver panel: wnl T4: 1.24 Rads: loss of detail R cranial quadrant, slightly bunched intestines, soft tissue density on diaphragm in thorax R side.

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. Moderate dependent to nondependent 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.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination was present in the left kidney. The right kidney was borderline subnormal in size compared to the left and for normal renal size for the species. Probable cortical infarcts noted in both kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pyelonephritis was present. The left kidney measured 3.7 cm in length. The right kidney measured 3.0 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma.

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. The spleen measured 0.85 cm width.

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 with mild echogenic, nonmineralized gallbladder debris. The cystic duct was normal without evidence of dilation. Subtle proximal common bile duct dilation was present measuring 0.2 cm in diameter and was not consistent with post-hepatic obstruction yet may suggest some degree of low grade cholangitis or age related common bile duct changes.

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 - cm.

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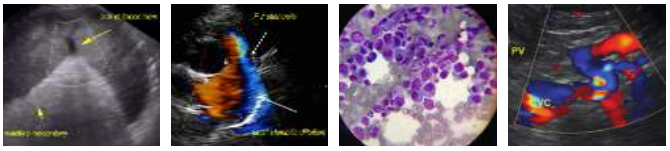

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The small intestine exhibited intact wall layering with subjective propensity for mildly prominent generalized muscularis layer. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The jejunum wall width measured up to 0.30 cm. The

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

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Intermittent isoechoic nodular changes as well as anechoic parenchymal cysts were present. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation.

Free Abdomen

No overt lymphadenopathy, masses, or peritoneal effusion were present.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sediment.
- Moderate chronic renal changes with cortical infarcts and borderline subnormal right kidney size.
- Active to chronic active pancreatitis with nodular to cystic parenchyma - minor potential for pancreatic neoplasia possible yet considered less likely.
- Probable IBD.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

The small intestine exhibited subtle mural changes potentially suggestive of inflammatory bowel disease given the patient's gastrointestinal signs. Minor potential for early neoplastic infiltrative enteropathy with round cell such as lymphoma, which may present in a similar sonographic manner, cannot be definitively excluded. Potential for triad disease may be considered in this patient if previous history of hepatic enzyme elevations. Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. No evidence of gastrointestinal foreign material or mechanical obstruction.

Intestinal +/- pancreatic biopsies are required for a definitive diagnosis. Empirically, hospitalization with correction of potential dehydration, electrolyte abnormalities, and reassessment of renal parameters as well as pancreatitis IBD therapy protocol would be appropriate empirically.

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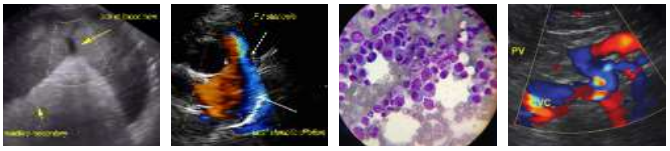

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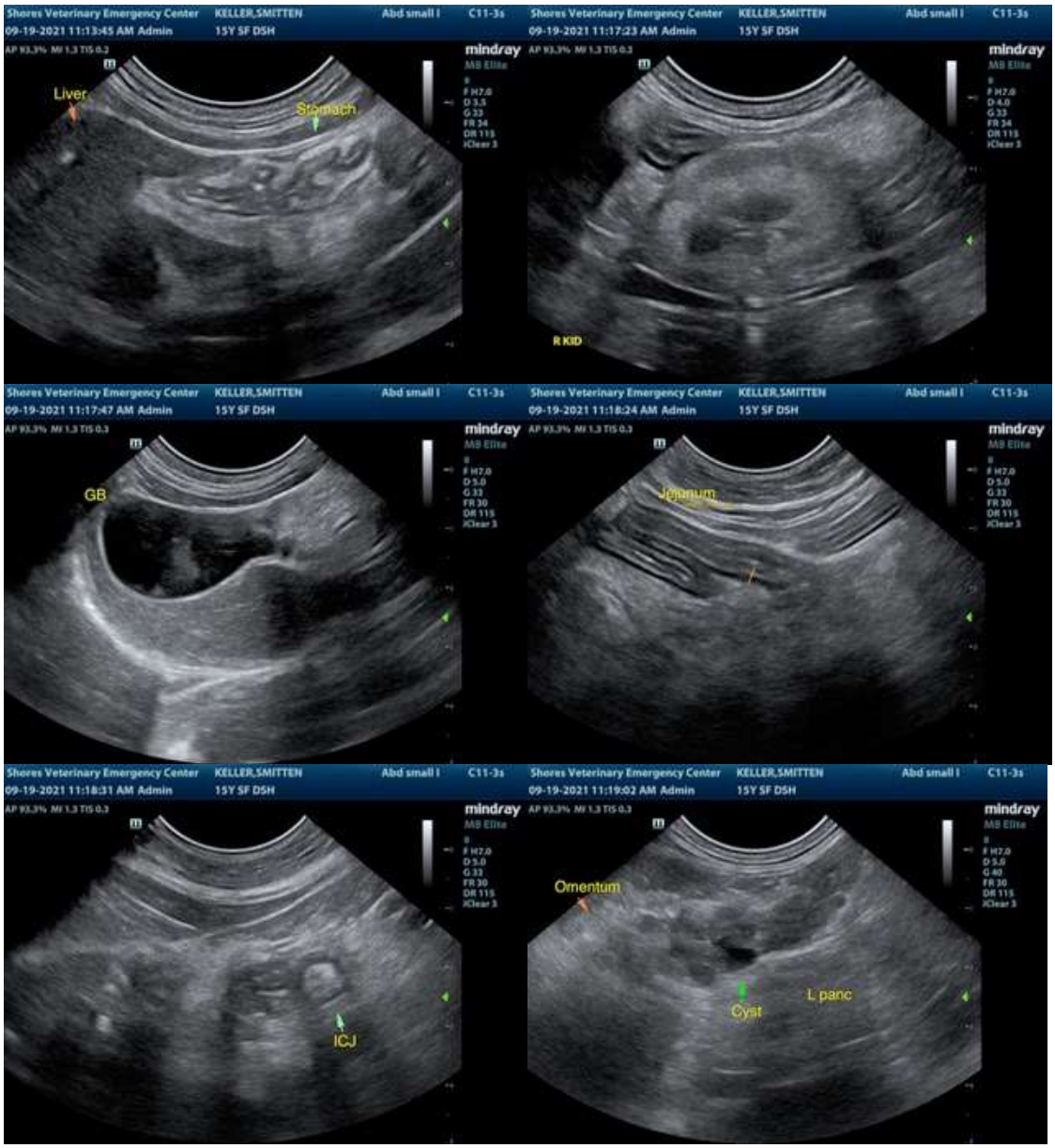

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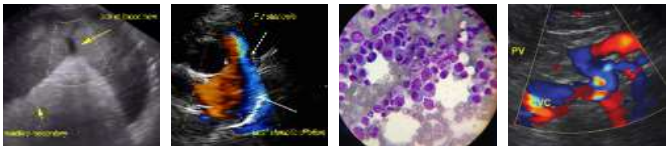

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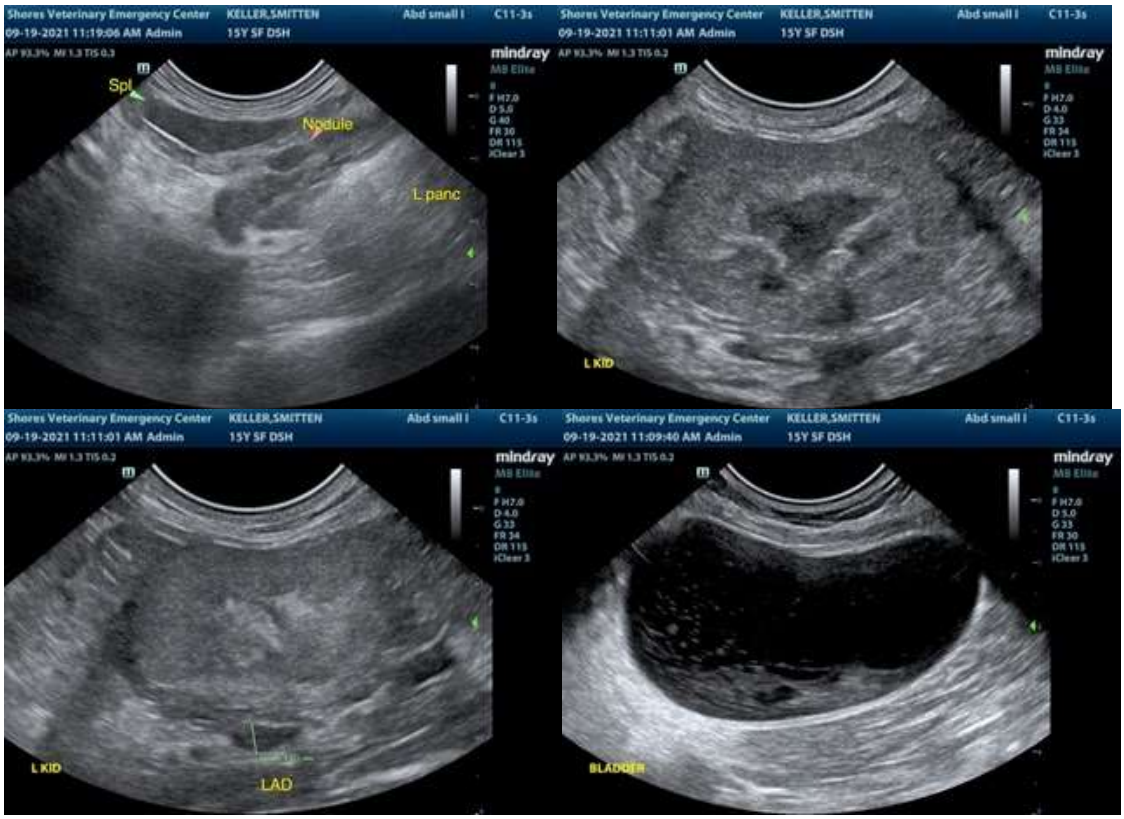

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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