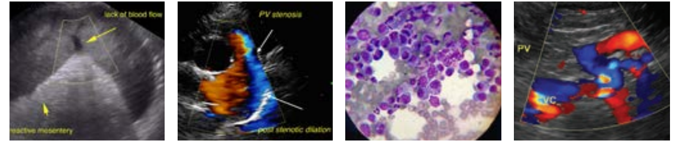
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Lilo Coyne

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
13 Years

WEIGHT
7.3 Pounds

INTERPRETED BY
Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY
Dr. Tam Mengine

HOSPITAL NAME
Stoney Creek VH

REFERRING VET
Dr. Gerald Latterner

INVOICE
42741

DATE
11/15/22

PRESENTING CLINICAL SIGNS

1 month of daily vomiting and 1/2 pound weight loss. Appetite normal. CBC / Chem / T4 / U/A all unremarkable. No improvement with diet change.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra (visualized to 3.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney measures 3.5 cm. The right kidney measures 3.5 cm.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland measures 2.6 mm. The right adrenal gland measures 3.8 mm.

Spleen

The splenic parenchyma is diffusely mottled with small hypoechoic nodules up to 1.0 mm in size. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. Thickness at the splenic hilus is normal at 7.7 mm.

Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

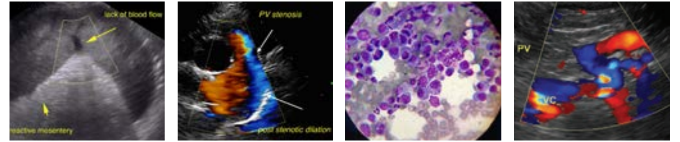
The stomach is empty. The gastric wall is thickened at 3.5 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering, however the submucosal layer is disproportionately thickened relative to other layers. The pylorus is of normal appearance.

The small bowel has focal changes to the normal 1:3 muscularis to mucosa ratio. Wall measurements are mildly increased up to 2.6 mm for duodenum and 2.8 mm for jejunum. Overall wall layering is preserved. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness (1.2 mm) with intact wall layering. The ileocecal junction is visualized and normal.

Pancreas

The left limb of the pancreas is hypoechoic, but of normal size and with no changes to the surrounding mesenteric fat. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.



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Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Mildly thickened gastric wall – typical of chronic gastritis.
- Mild intestinal thickening – typical of infiltrative bowel disease.

SECONDARY FINDINGS

- Hypoechoic pancreas with no evidence of active inflammation
- Subtle mottling to the spleen

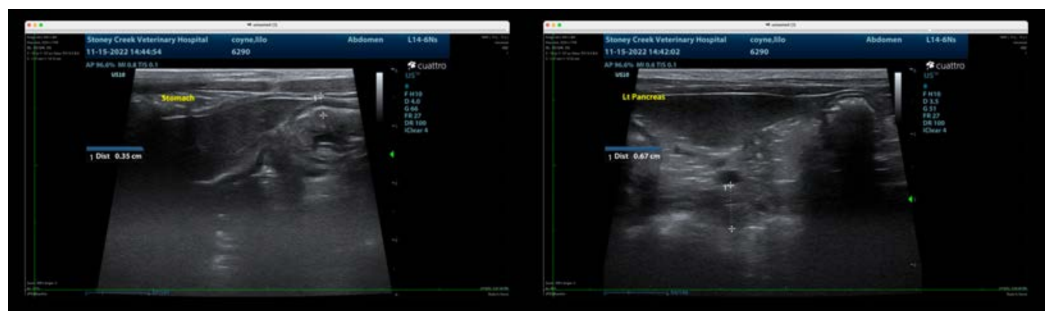
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The mottled splenic parenchyma is most likely normal. However, if clinical signs persist and no other cause can be found, then fine needle aspiration could be considered to rule out splenitis or infiltrative neoplasia.

The changes to the stomach wall are most consistent with chronic inflammation, but again, early neoplastic disease could not be ruled out without a biopsy. Thus, if symptoms persist, then endoscopic or ultrasound guided biopsy could be considered.

The changes in the gastrointestinal tract are suggestive of infiltrative bowel disease, including both inflammatory bowel disease or low grade gastrointestinal lymphoma. Recommendations include:

- ❖ fecal parasite testing and empiric fenbendazole treatment
- ❖ trials with a novel protein or hydrolyzed diet
- ❖ A complete GI panel, or empiric cobalamin supplementation
- ❖ Empiric therapy with prednisolone at 2-4mg / kg daily could be considered if a diet trial is unsuccessful.
- ❖ Definitive diagnosis would require biopsy of the affected tissue, ideally with intra-operative ultrasonographic guidance . If there is concurrent lymphadenopathy, ultrasound-guided sampling of the lymph node using a 25 or 22G needle could be considered.



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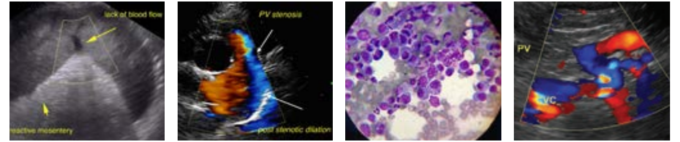

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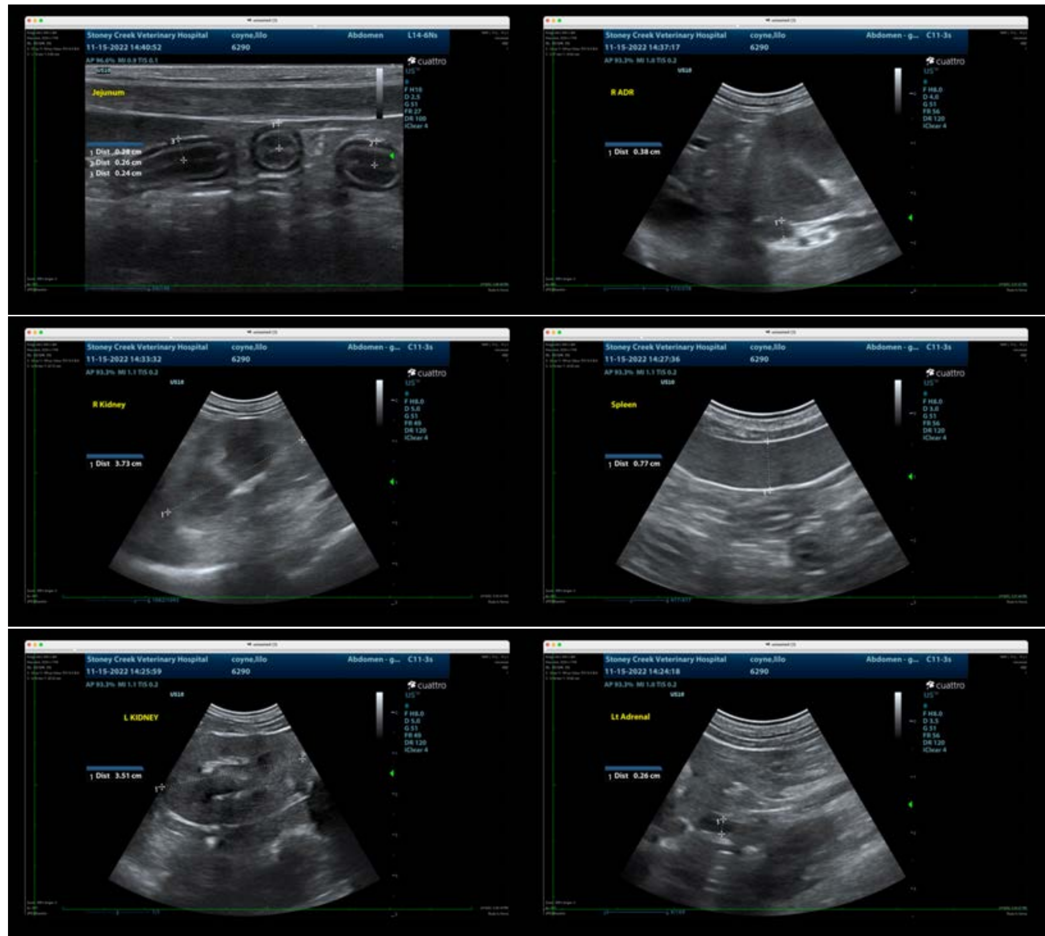

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

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