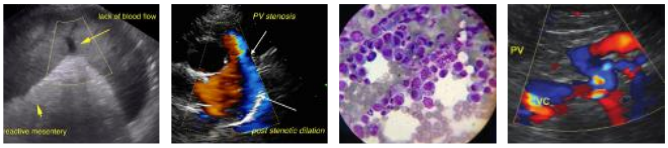
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Squeaky Toth

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6 years

WEIGHT

14.5 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Mandy Becker

INVOICE

14114

DATE

8.15.23

PRESENTING CLINICAL SIGNS

History: Recent 1-pound weight loss, on lab-work new azotemia (BUN 54, Creat 2.8), urine SpGr 1.013, UPC 2.1. Normotensive, urine culture negative.

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 are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 3.0 cm.

Both kidneys are hyperechoic and exhibit moderately decreased cortico-medullary differentiation. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureters are not visible (normal). The left kidney is 4.9 cm in length. The right kidney is 5.2 cm in length.

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 height is 3.8 mm at the caudal pole. The right adrenal gland height 3.3 mm at the caudal pole.

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. 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 9.8 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 subjectively normal in thickness, and exhibits appropriate wall layering, but cannot be accurately measured due to normal deviations of the rugal folds. The pylorus is of normal appearance.

The small bowel has diffuse changes to the normal 1:3 muscularis to mucosa ratio. Wall measurements are increased up to 2.8 mm for duodenum and 3.2 mm for jejunum. Overall wall layering is preserved. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness, up to 1.3 mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

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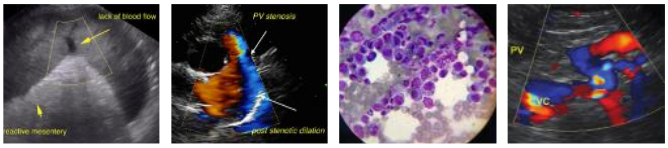

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Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. There is a cluster of small lymph nodes surrounded by hyperechoic omental fat in the region of the distal descending colon, with normal short to long axis ratio and appropriate echogenicity. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

ULTRASONOGRAPHIC FINDINGS

- Bilaterally hyperechoic renal cortices, consistent with interstitial nephrosis
- Diffusely thickened small bowel, typical of infiltrative bowel disease
- Reactive colic lymph nodes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes in the kidneys are of mild-to-moderate severity. It is possible that there a component of acute-on-chronic disease, perhaps secondary to the intestinal disease. Fluid therapy would likely be of benefit.

The appearance of the intestines is typical of infiltrative bowel disease. A GI panel is already pending which will hopefully shed more light on the severity of the underlying intestinal disease. Additional recommendations include:

- Treatment of proteinuria with telmisartan or an ACE inhibitor, if proteinuria is repeatable.
- Fecal parasite testing and empiric Fenbendazole treatment
- Trials with a novel protein or hydrolyzed diet
- 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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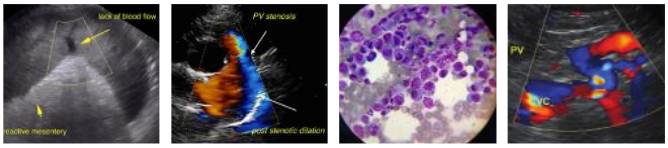

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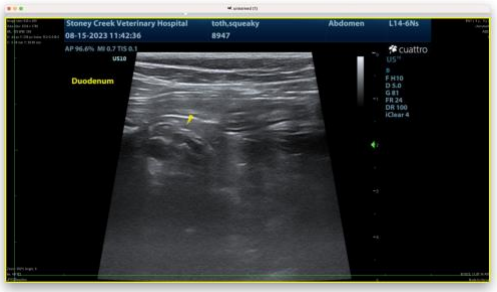

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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) info@SonoPath.com