

**DATE PRESENTING CLINICAL SIGNS**

4/18/22

Presents for a chronic (> 6 mo) hx of general lethargy- decrease energy and appetite. Currently 1-week hx of vomiting clear fluid. Appetite is still present. Stools are darker than normal.

**PATIENT**

Kittah Busatti

Current Medications: Started 4/16: Cerenia 1 mg/kg PO SID, Sucralfate 0.5 mg PO TID. Has systemic hypertension currently managed on Amlodipine 2.5 mg- 0.625 mg PO SID. Gabapentin 50mg 2-3 hours prior. Radiographs: Significantly dilated stomach (same finding Dec 2021 when rads were taken) Very poor serosal detail generalized

**SPECIES**

Feline

Date of Previous IntraPet Ultrasound: No previous.  
 Sedation: Not required to complete full diagnostic ultrasound.  
 Stat Report: Not requested.  
 Imaging Performed By: Stephanie Pearce RDCS, RVT.

**BREED**

Domestic shorthair

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****SEX**

Male, neutered

**Urinary System**

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended. A moderate amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

**AGE**

6/1/2009

The left kidney is normal size (4.83 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**WEIGHT**

10.9 lbs.

The right kidney is normal size (4.68 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**INTERPRETED BY**

Andrea Nicastro, DVM,  
 Diplomate ACVIM  
 (Small Animal Internal  
 Medicine)

**Adrenal Glands**

The left adrenal gland is mildly enlarged (1.42 cm length; 0.61 cm width) with a normal shape and smooth peripheral contours. There is normal echogenicity and detail. Surrounding vasculature appears normal.

**HOSPITAL NAME**

Eastern AH

The right adrenal gland is mildly enlarged (1.40 cm length; 0.54 cm width) with a normal shape and smooth peripheral contours. There is normal echogenicity and detail. Surrounding vasculature appears normal.

**REFERRING VET**

Dr. Haviland

**Spleen**

The spleen is normal in size (0.71 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal.

**INVOICE**

13213

**Gastrointestinal**

The gastric lumen is not distended. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pylorus, the wall is thickened (up to 0.81 cm) and asymmetrical with a prominent muscularis layer. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal to mildly thickened (up to 0.27 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in some segments. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

### ***Pancreas***

The pancreas is diffusely visible with a prominent left limb. The peripheral margins are slightly irregular. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.14 cm in diameter).

### ***Free Abdomen***

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary Findings:**

- The pyloric wall changes could be consistent with an inflammatory process, hypertrophy or emerging neoplasia (i.e., lymphoma, adenocarcinoma).
- The pancreatic changes are suggestive of chronic pancreatitis.
- Trace ascites, likely secondary to bowel and/or pancreatic pathology.

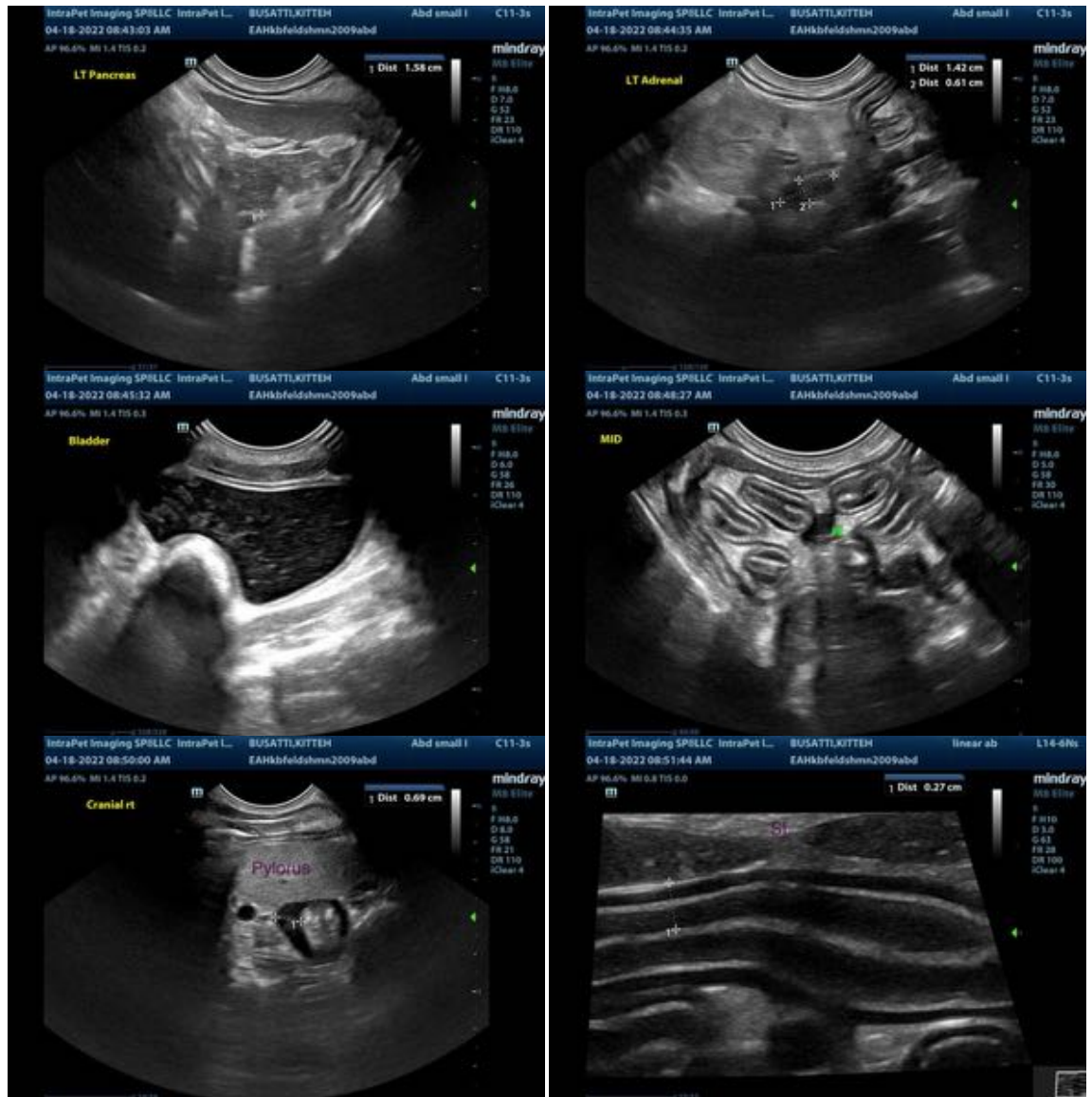
### **Secondary Findings:**

- The hepatic parenchymal changes are non-specific and could be secondary to emerging hepatic lipidosis, an inflammatory hepatopathy, infiltrative neoplasia (i.e., lymphoma), other hepatopathy.
- The bilateral adrenomegaly may be a normal variant for this patient or may be secondary to stress or hyperplastic change.
- Urinary bladder debris.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Consider thoracic radiographs to assess for occult neoplasia and esophageal disease.
- Additional diagnostic considerations include:
  1. A malabsorption panel (i.e., serum cobalamin, folate, TLI and PLI)
  2. A fecal evaluation for ova/Giardia
  3. GI biopsies (i.e., endoscopic or surgical). If surgical biopsies are pursued, a liver biopsy should also be obtained.

- Given the hepatic changes and the history of inappetence, nutritional support (i.e., via temporary feeding tube) is recommended to help prevent/treat hepatic lipidosis.
- Given the urinary bladder debris, a urinalysis +/- urine culture and sensitivity are recommended, if not already performed.





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.

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)  
Andrea.nicastro@sonopath.com