

**DATE PRESENTING CLINICAL SIGNS**

1/16/23

**PATIENT**Dr. Indiana Jones  
Pevear**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

3/2/09

**WEIGHT**

4 Pounds

**INTERPRETED BY**Beth Johnson, DVM  
DACVIM**HOSPITAL NAME**Animal Emergency  
Hospital**REFERRING VET**

Dr. Nacke-Horney

**INVOICE**

20603

History: Known to be a picky eater 2 years ago, Dec 2021: was vomiting so was evaluated by ER - gave fluids, were concerned about renal failure - recommend hills k/d, sent home with SQ fluids - seemed to help for a while Has been consistently losing weight - will not eat the k/d diets - owners have tried various diets - will eat FF savory chicken and turkey, make sure he has a lot of water, feed foods with <40% protein Friday started to not feel well again: was laying in an abnormal spot, was vomiting Saturday: seemed improved This AM: laying in the abnormal area again, was breathing poorly, face look unkempt - not urinating or defecating - not eating or drinking - vomiting today, some were projectile stomach acid with a very foul smell - has not vomited since the owner saw him drink Have not had his values rechecked

Current Medications: Protonix, Cerenia, Buprenorphine.

Lab Results: See attached.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Rachel Brillhart, RDMS.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are normal in size and contour. A relatively uniform hyperechogenicity is observed with mildly decreased corticomedullary distinction. There is no pyelectasia noted and no mineral is observed. No overt masses/nodules are observed. The left kidney measures 4.23 cm. The right kidney measures 3.48 cm.

**Adrenal Glands**

Left adrenal gland is normal in size (0.56 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.61 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

**Liver**

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

### ***Gastrointestinal***

The visible stomach is mildly thick. The area of the pyloric antrum measures up to 0.84 cm thick with a hypoechoic loss of layering noted. The stomach is moderately overdistended with fluid and echogenic debris/chyme.

The visible small intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

### ***Pancreas***

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

### ***Free Abdomen***

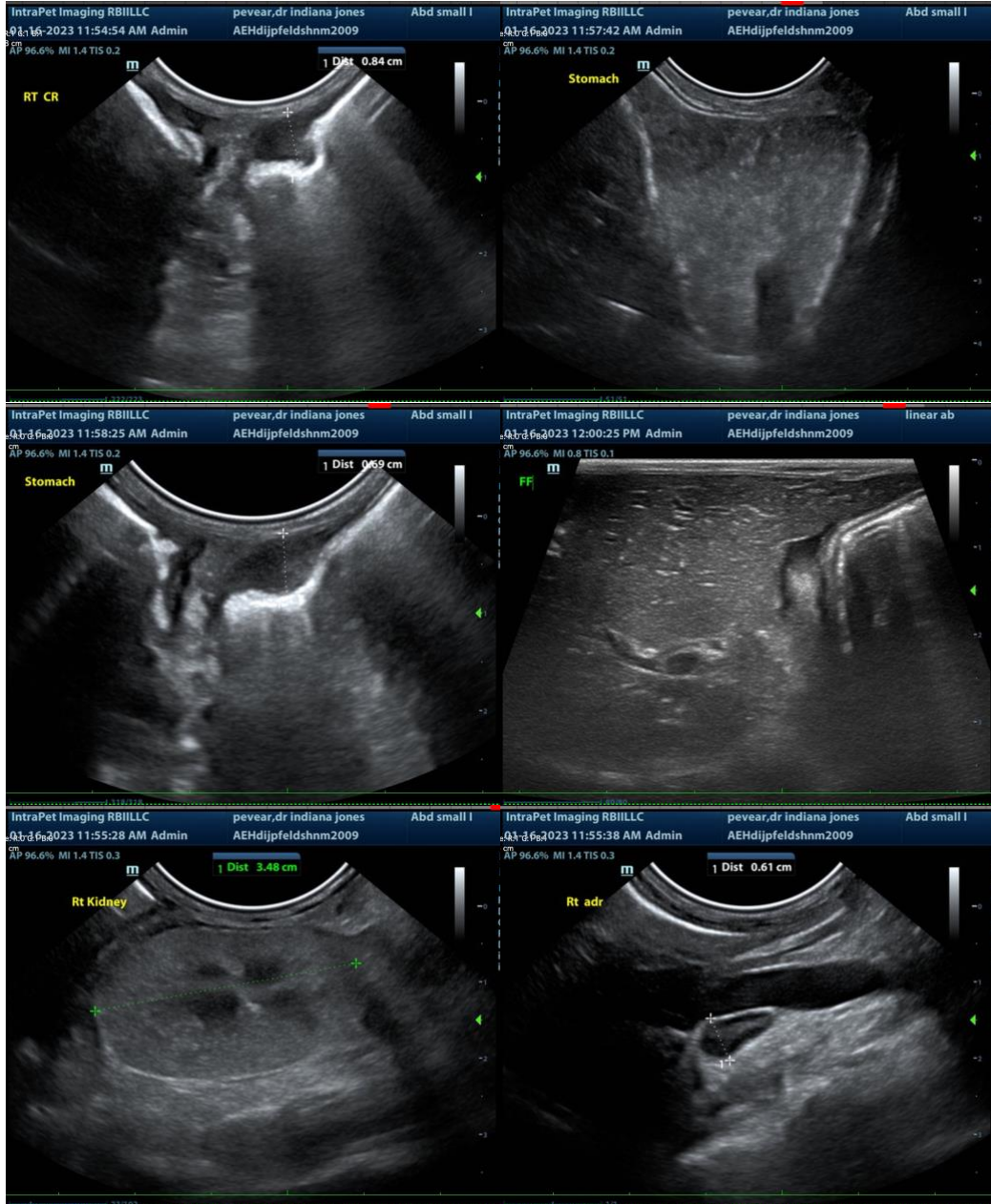
There is a scant amount of anechoic free fluid surrounding the kidneys and the gastric thickening, as well as cranial abdominal and mesenteric lymphadenopathy.

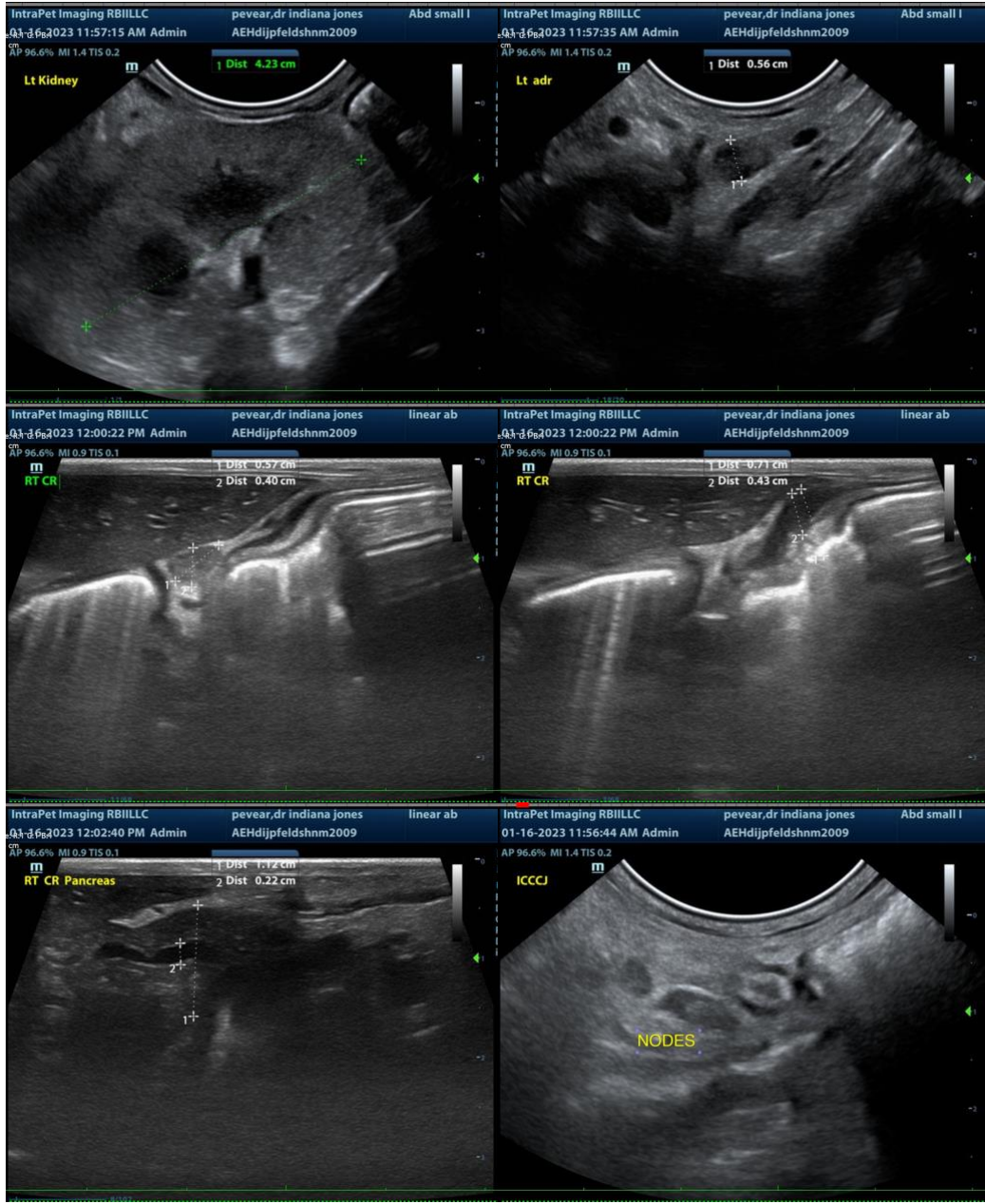
## **ULTRASONOGRAPHIC FINDINGS**

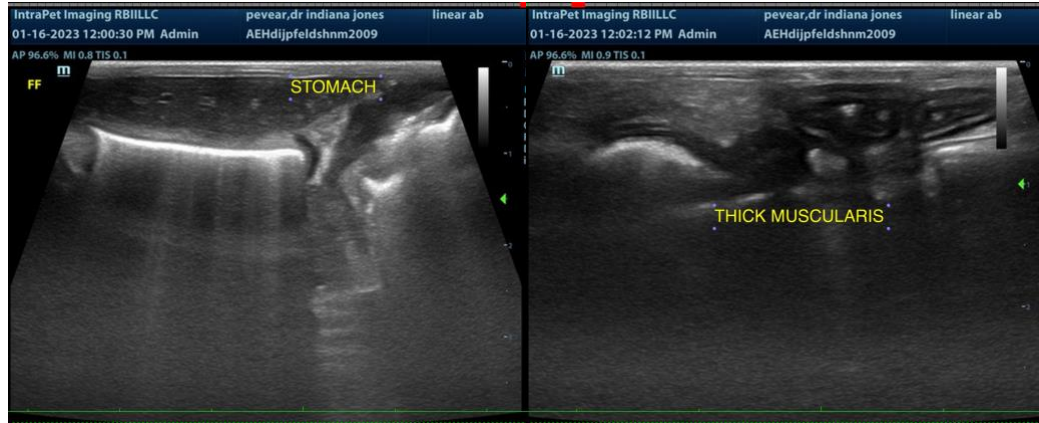
- Nephritis
- Focal gastric wall thickening with loss of layering is concerning for early infiltrative neoplasia, such as lymphoma. A benign inflammatory process cannot be ruled out but is considered less likely given the emerging loss of layering.
- Inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma.
- Scant amount of anechoic free fluid may be secondary to an acute on chronic kidney insult, i.e., infection vs other vs a neoplastic effusion, can't be ruled out. Lymphadenopathy may represent reactive process, but infiltrative neoplasia cannot be ruled out without tissue sampling.
- Chronic active pancreatitis

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

This patient appears to likely have an acute on chronic kidney insult, possibly a secondary infection vs other. However, the majority of the clinical signs are most likely secondary to infiltrative bowel disease, primarily affecting the stomach. Therefore, recommendations include, if not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended. A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function. Biopsies of the stomach and bowel, being sure to include ileum, if possible, are recommended to definitively diagnose, and therefore guide management of the suspected infiltrative bowel disease.







**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.

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