

**DATE PRESENTING CLINICAL SIGNS**

10/26/22

Progressive mild weight loss despite increasing caloric density of food. Historically picky eater. History of chronic intermittent vomiting lifelong (~once per month) that has progressed to ~twice weekly. Two episodes of large bowel diarrhea within past one month. Two previous episodes of obstipation within 6 months. Large bowel diarrhea after obstipation. Physical exam unremarkable

**PATIENT**

Pearl Monti

**SPECIES**

Feline

Current Medications: Metronidazole 62.5 mg BID - 3 days, Mirataz transdermal PRN for appetite support  
 Lab Results: Minimum database performed in March, overall unremarkable. T4 low grey zone (2.3)  
 Date of Previous IntraPet Ultrasound: No previous.  
 Sedation: Oral gabapentin, no further sedation required to complete full diagnostic ultrasound.  
 Stat Report: Not requested.

**BREED**

DSH

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

Spayed Female

**Urinary System**

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. A small echogenic foci is noted with acoustic shadowing, consistent with Gabapentin administered before the ultrasound. No masses. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

**AGE**

9/1/10

**WEIGHT**

8.6 Pounds

The right kidney is normal in size (3.72 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

**INTERPRETED BY**Beth Johnson, DVM  
DACVIM

The left kidney is normal in size (3.6 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

**IMAGING PERFORMED BY**

Rachel Brillhart RDMS

**Adrenal Glands**

The right adrenal gland is normal in size (0.37 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**HOSPITAL NAME**

Paradise AH

The left adrenal gland is normal in size (0.51 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**REFERRING VET**

Dr. Pound

**Spleen**

The 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.

**INVOICE**

42371

**Liver**

The 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.

The 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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

### ***Pancreas***

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Pancreatic duct dilation is noted.

### ***Free Abdomen***

There is no evidence of free peritoneal effusion noted in these images.

The mesenteric lymph nodes are mildly prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

## **ULTRASONOGRAPHIC FINDINGS**

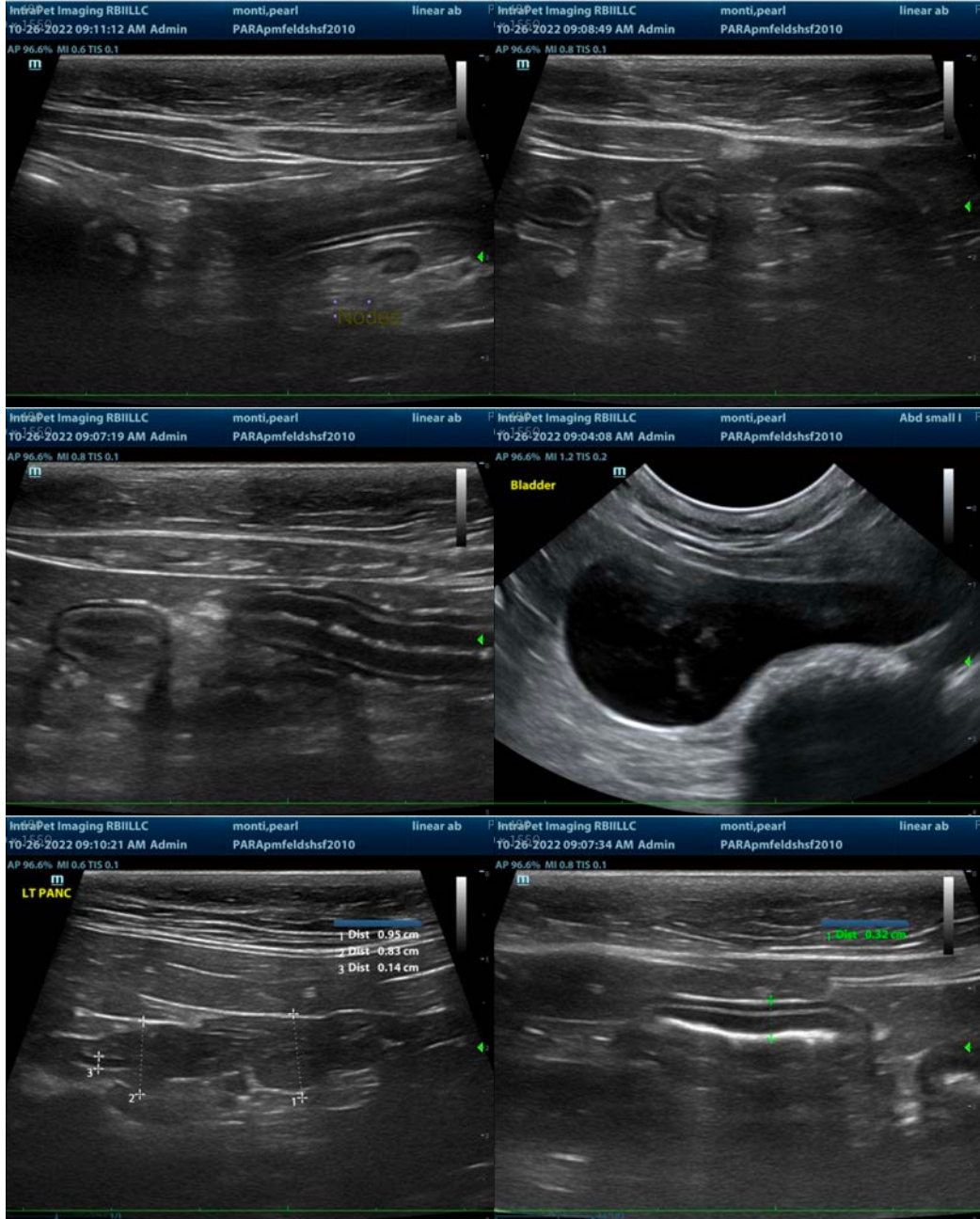
- Chronic active pancreatitis
- **Reactive mesenteric lymph nodes** – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Urinary bladder debris

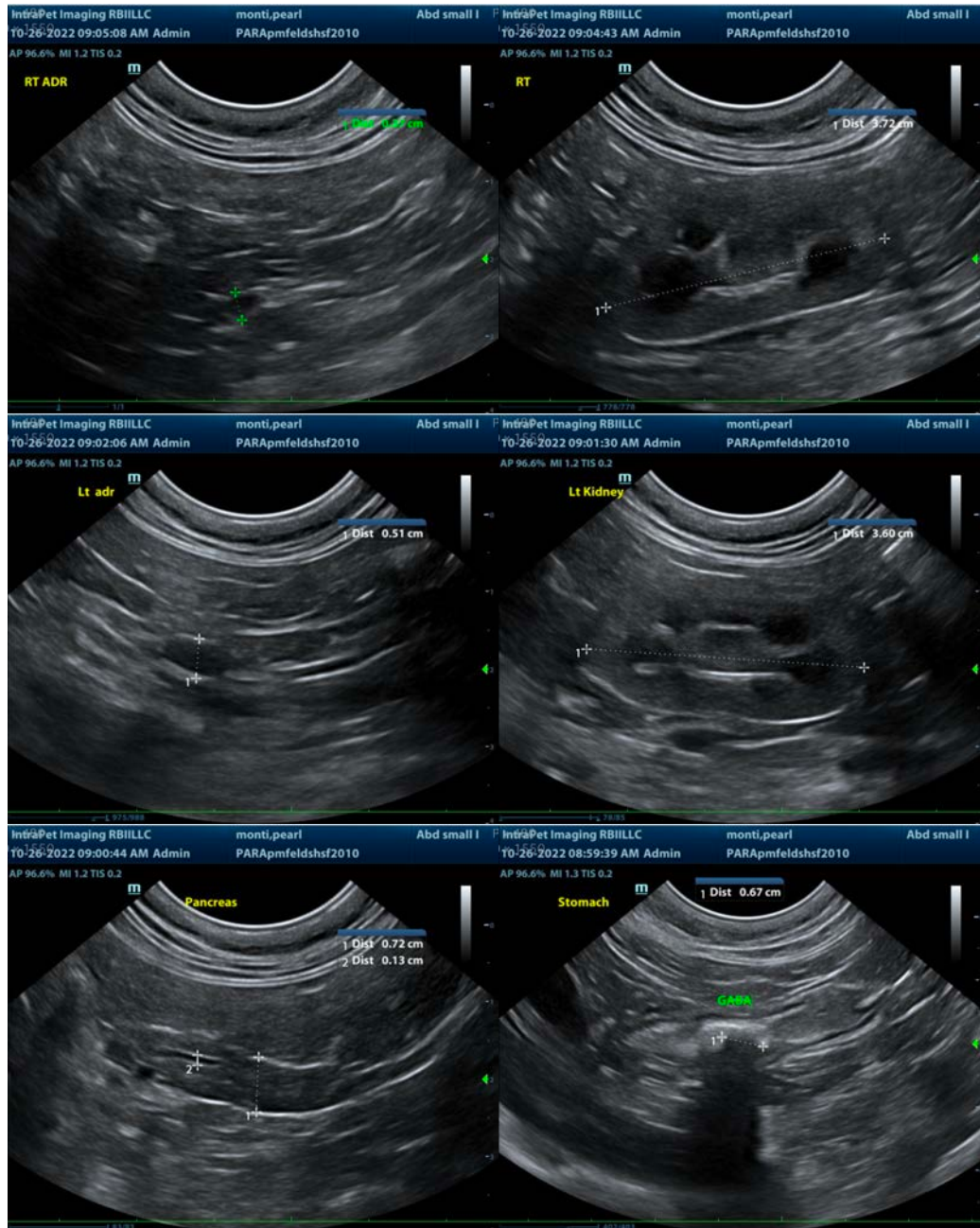
## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There is no obvious ultrasonographically visible explanation for this patient's vomiting and weight loss, although a relatively normal ultrasound does not rule out infiltrative gastrointestinal disease. Therefore, recommendations include (for further evaluation of GI function and the pancreas) a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory.

Given the high normal/grey zone T4 in March, other recommendations include a recheck T4 and free T4 to rule out hyperthyroidism as cause of the vomiting and weight loss. Additionally, if not recently evaluated, a 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.

In the meantime, if tolerated, a diet transition to a hydrolyzed protein diet could be considered, as well as empirical deworming with a 5-day course of Panacur.





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.

**Beth Johnson, DVM, DACVIM**  
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