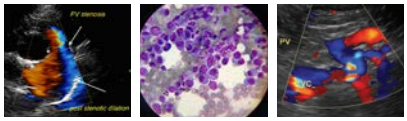
IMAGING PERFORMED BY

IntraPet.com



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DATE

10/27/22

PATIENT

Ollie Larson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9/1/15

WEIGHT

13 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Stephanie Warga RDCS, RVT

HOSPITAL NAME

Stay Pet Veterinary

REFERRING VET

Dr. Klimovitz

INVOICE

42442

PRESENTING CLINICAL SIGNS

Occasional vomiting liquid and some food a few times over the last week, unlike him, no vomiting hx. Hx of urinary issues (actual bladder worms - Capillaria) when rescued but no urinary signs at the moment. BCS 7/9 tense abd, rest is wnl.

Current Medications: None.
Lab Results: mild elevated lymphocytes, rest was wnl (Need urine at time of u/s if possible)
Radiographs: Xray report calls out constipation, possible gastric FB vs linear FB cannot be ruled out.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (4.19 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.

The left kidney is normal in size (4.29 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.

Adrenal Glands

The right adrenal gland is normal in size (0.45 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.32 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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.

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), except in the mid abdomen, where an approximately 1.5 cm long focal area of small bowel appears mildly corrugated/hyperperistaltic with some emerging loss of layering suspected. No visible foreign material is evident. Small intestinal motility appears adequate (1-3 contractions per min).

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

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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

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

PRIMARY FINDINGS

- **Focal small bowel loop with evidence of corrugation** - Possibly secondary to a gastroenteritis. However, given the focal nature and suspicion for emerging loss of layering, a focal infiltrative process, even neoplasia, cannot be ruled out.

- **Reactive mesenteric lymph nodes –** infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

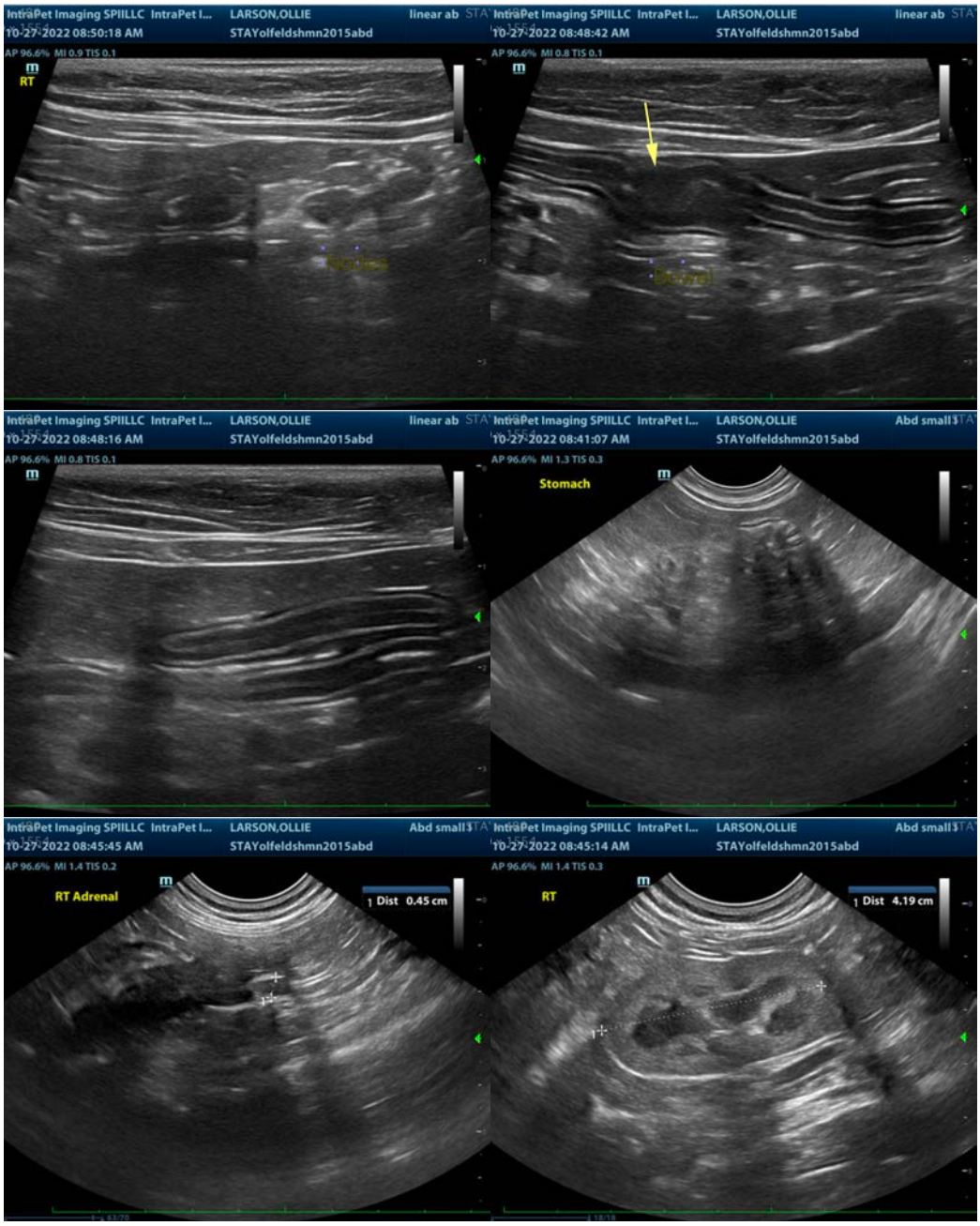
Given this patient's history, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

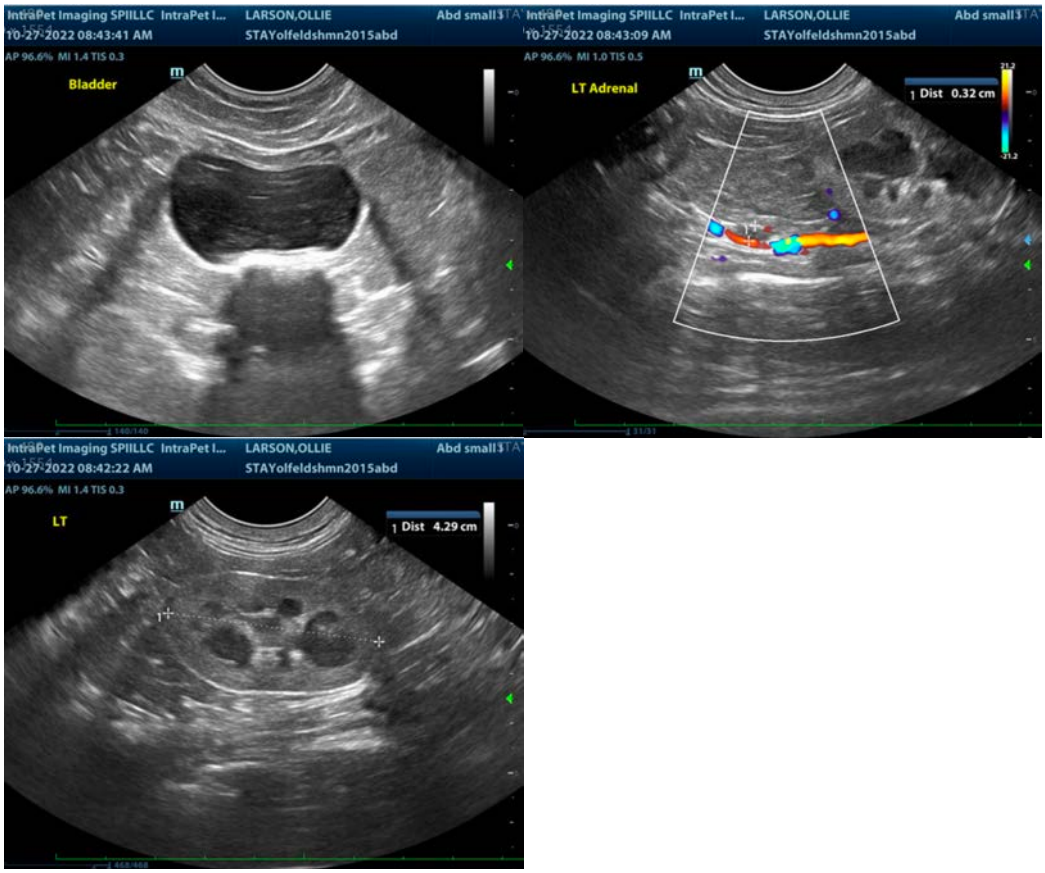
Additionally, given the radiographic concern for constipation, if constipation matches the clinical picture, that could be an underlying reason for the vomiting and management of the constipation with adequate hydration or fluid support, stool softeners, potentially a diet change to a fiber responsive diet, etc. may be helpful.

For further evaluation of the small bowel, 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.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended, and if constipation is not believed clinically to be the problem, a transition to a hydrolyzed protein diet can be considered.

If clinical signs persist beyond empirical therapies recommended above, and an underlying diagnosis is not obtained, then further evaluation of the focal bowel loop described above, either via recheck ultrasound or potentially an exploratory laparotomy with intra-op ultrasound for planned biopsy of the abnormal area may be necessary to definitively diagnose and therefore adequately manage the cause of this patient's vomiting.





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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