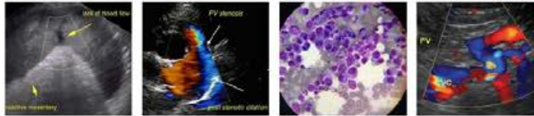


PATIENT

Jeffrey Krebs

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6 Years

WEIGHT

8.5 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Fairgrounds AH

REFERRING VET

Dr. Renee Krebs

INVOICE

42747

DATE

11/15/22

PRESENTING CLINICAL SIGNS

Update/Notes: 11/15/22: P presented for abdominal ultrasound today. Per O, P has chronic diarrhea, going on for several years and has not resolved despite esclating treatments. RDM CASE SUMMARY: occassional vomiting (once every week to two weeks) - typically right after eating and usually if feeding was delayed for some reason, undigested food. chronic diarrhea, small bowel (no mucus, fresh blood or tenesmus), for the past 4 years, recently number of BM's per day has increased from 1 BM per day 3 months ago to up to 4 per day in the past month; passing large amount of gas with BM's and liquid, light brown, fetid stool • partial response (improved feces to normal firmness and freq - improvement lasted for about 2 years) to diet change from purina one to Purina HA • cat is still eating this food, has been for the past 3 yrs • partial response (improved to firm, normal freq feces for 6-7 mos) tx for tritrichamonas fetus (ronidazole, one tx, 3 yrs ago, improvement lasted ~8 mos) • current medications: • prednisolone 5mg q24 hrs in the a.m. • chlorambucil EUD (compounded Wedgewood, can't remember mg....2.5 maybe?; improved firmness to soft formed, improvement lasted 6mos, started 2 yrs ago • Purina Forta Flora Plus probiotic q24 hrs

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 (4.47 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 (4.02 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

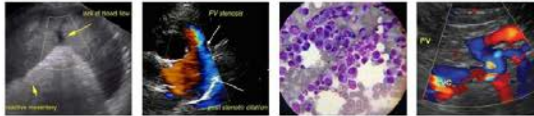
The right adrenal gland is normal in size (0.52 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.45 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



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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. **In some views, there is some concern for some hypoechoic pyloric thickening, potentially even a pyloric mass. However, the finding is not repeatable in all views, and in some videos, it appears to be external tissue (liver, pancreas, etc.) adjacent to the pylorus versus involved in the pyloric wall layering.

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 colon, primarily the descending colon, is thick, measuring approximately 0.34 cm thick with a subjectively thick, hyperechoic, irregular submucosal layer.

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.

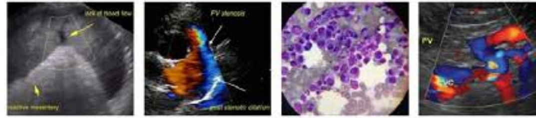
Free Abdomen

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

The mesenteric lymph nodes are 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

- **Thick colon wall with subjectively prominent submucosal layer** – This is a non-specific finding that can be seen with a variety of infiltrative, inflammatory, or even neoplastic diseases. However, often times this suggests parasitic or infectious disease.
- Chronic active pancreatitis
- **Reactive mesenteric lymph nodes –** infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Possible pyloric thickening, yet cannot be definitively diagnosed



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SECONDARY FINDINGS

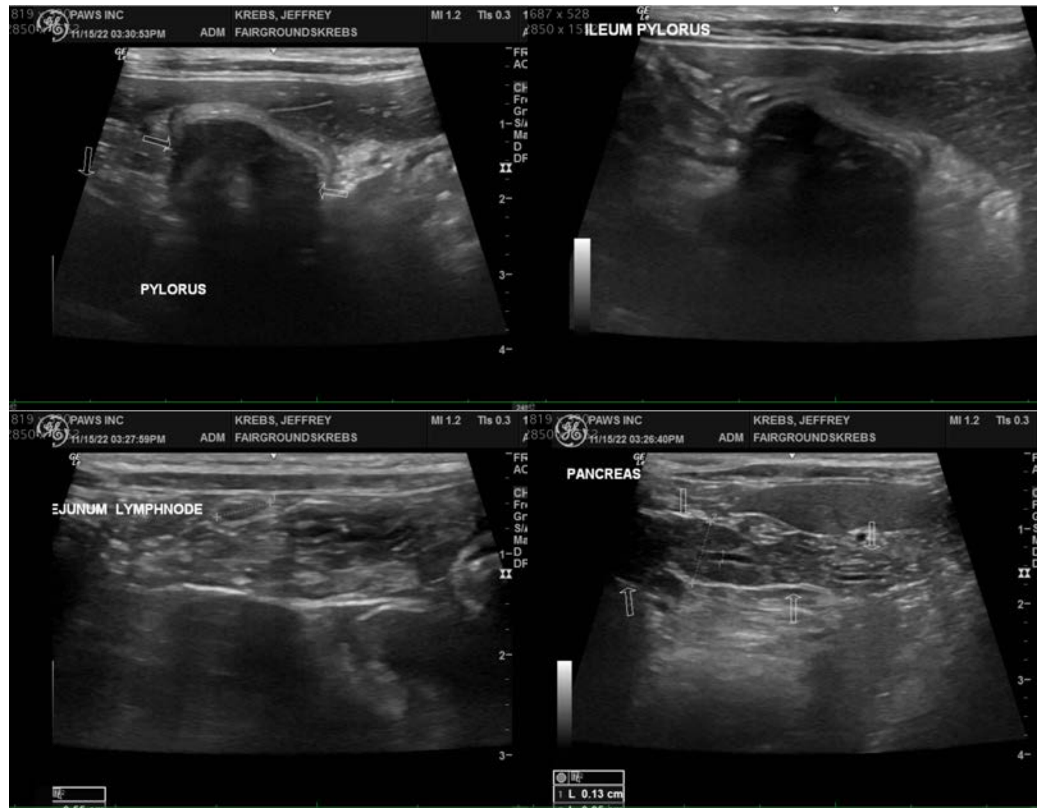
- Urinary bladder debris

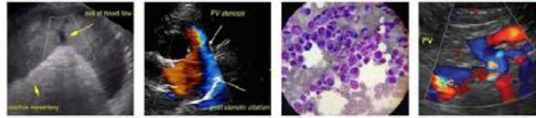
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fecal exam is recommended if not very recently evaluated. Additionally, a fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. If geographically appropriate, histoplasma antigen to MiraVista could be considered, given the colonic wall changes.

Ultimately, if a parasitic, infectious (including fungal), etc. disease cannot be diagnosed, tissue sampling in the form of a biopsy or biopsies obtained via colonoscopy are recommended to definitively diagnose and therefore ultimately manage this patient's chronic diarrhea. Given the concern for possible pyloric thickening, recommendations are an upper gastroscopy/endoscopy for evaluation and biopsies at the same time as the colonoscopy.

In the meantime, in addition to the empirical therapies in place, a transition to Visbiome or Proviable as a probiotic could potentially be helpful.





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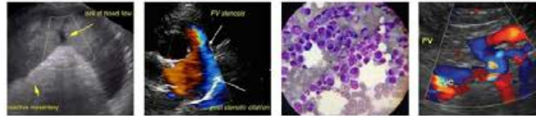

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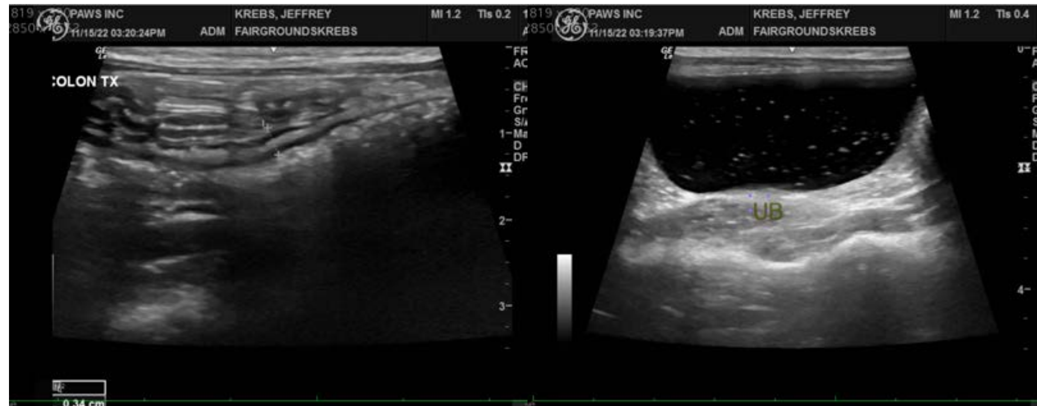

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com