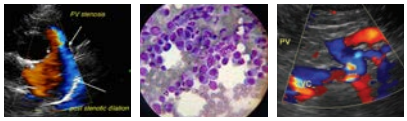
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

2/24/23

PATIENT

Peanut Hanson

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

6/1/18

WEIGHT

10.75 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Cat Sense Feline Hospital

REFERRING VET

Dr. Sinclair

INVOICE

45480

PRESENTING CLINICAL SIGNS

Awoke owners Thursday around 4am with vomiting foam. She ate at 6am and promptly vomited it up. She vomited about 8-10 times and it is very shortly after eating. She does eat things she shouldn't. PE was fairly unremarkable. X-rays of abd show a possible thickened stomach wall and possible early plication of SI.

Current Medications: LRS sq, 0.5ml ondansetron (40mg/ml) sq, MIrataz
Radiographs: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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.

The right kidney is normal in size (3.61 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 (3.46 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 (0.48 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 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. There is some enhanced hyperechoic mesenteric fat adjacent to the gastric wall, and a

round hypoechoic 0.40 cm x 0.60 cm gastric or potentially pancreaticoduodenal node embedded within the fat.

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 is empty with no evidence of obstruction or foreign material.

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

Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat 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.

ULTRASONOGRAPHIC FINDINGS

- **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. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

- Mild concurrent acute or potentially acute on chronic smoldering pancreatitis suspected.

- **Evidence of perigastric inflammation and lymphadenopathy** – This may represent concurrent gastritis or infiltrative inflammatory bowel disease also affecting the stomach or could potentially be secondary to mild pancreatitis as is seen with “Triaditis”.

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

- Gastric/pancreaticoduodenal lymphadenopathy as described above.

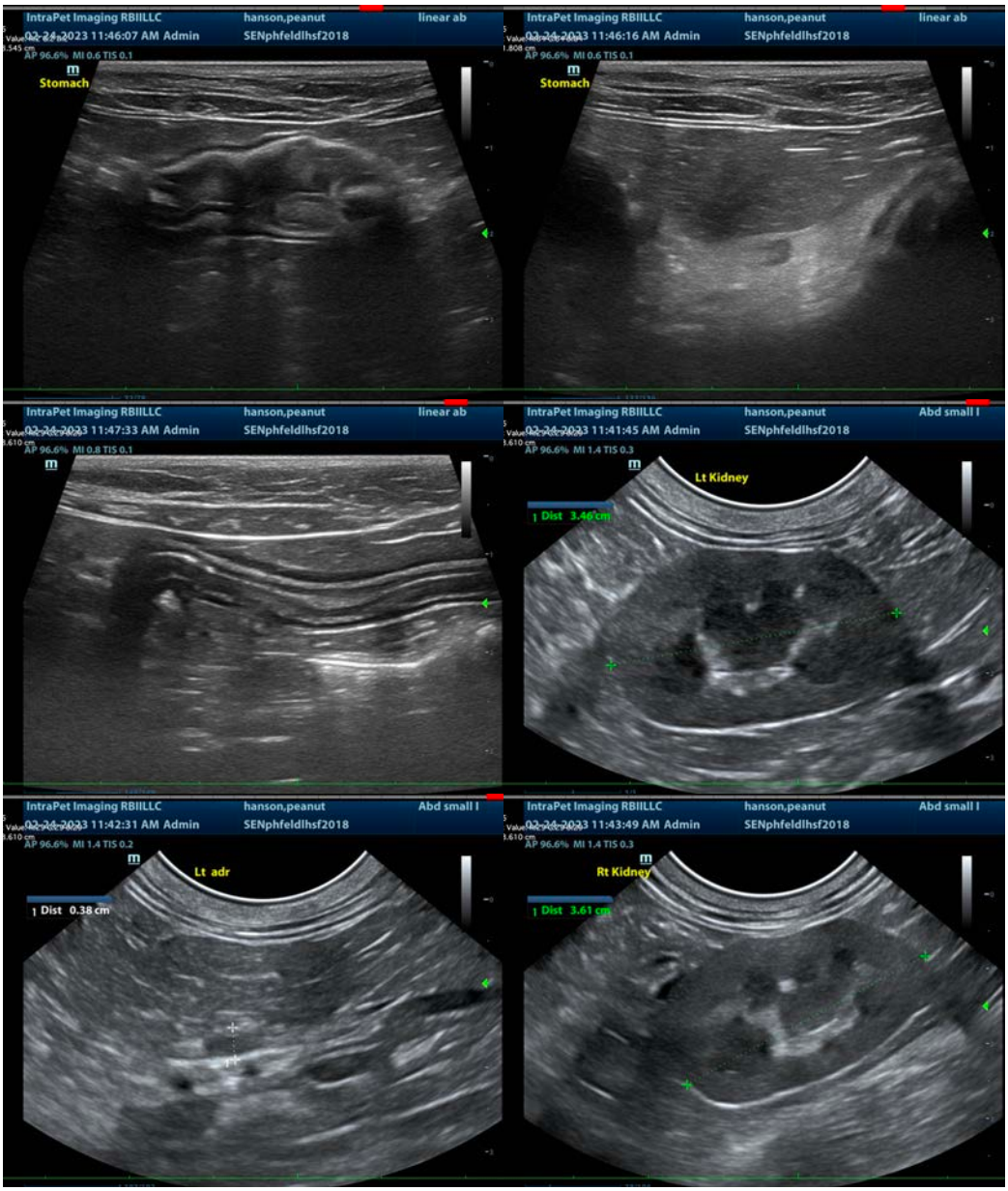
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

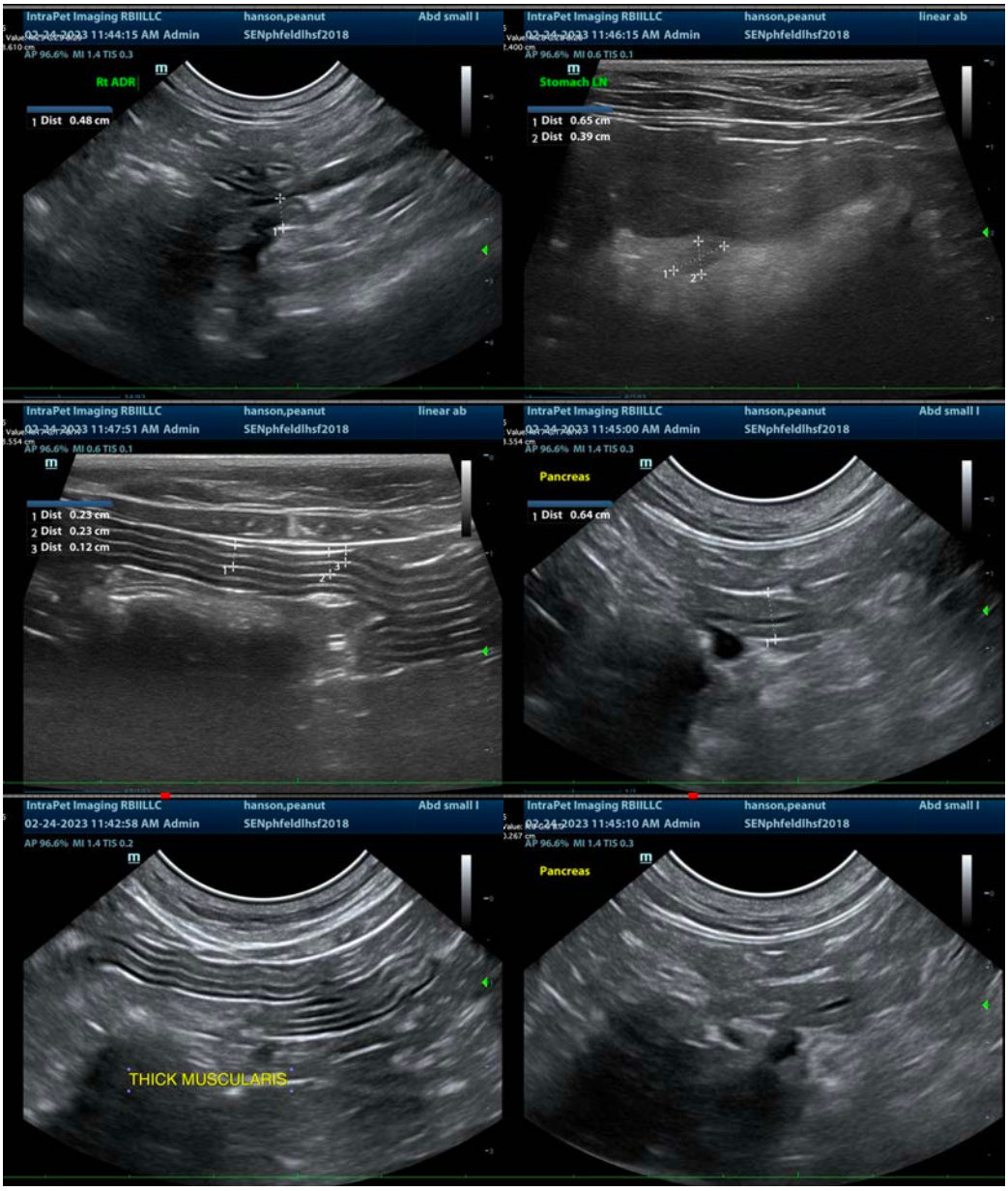
There is no ultrasonographically visible evidence of foreign body or obstruction at this time, and the gastrointestinal signs appear most likely related to an infiltrative bowel process, potentially also affecting the stomach or potentially concurrent gastritis/pancreatitis.

If not recently evaluated, recommendations include a general metabolic health screen including CBC/Chem panel, electrolytes, a urinalysis and, if indicated based on urinalysis results, urine culture. 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.

Ultimately, biopsies of the GI tract may be necessary to definitively diagnose and therefore manage this patient's suspected infiltrative bowel disease. However, in the meantime, supportive/symptomatic medical management with antiemetics, gastroprotectants, an appetite stimulant if needed, pain management if clinically indicated, empirical deworming with a 5-day course of Panacur, and potentially, if tolerated, transition in diet, beginning with a hydrolyzed protein diet based on trial-and-error response, are all recommended. It is important to know that some patient's response better to one brand of hydrolyzed diet versus another, so sometimes several trials with different brands are ultimately required prior to success.




IntraPet Imaging RBIILLC
hanson,peanut
Abd small I
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SENphfeldlhsf2018
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Rt ADR
1 Dist 0.48 cm
IntraPet Imaging RBIILLC
hanson,peanut
linear ab
02-24-2023 11:46:15 AM Admin
SENphfeldlhsf2018
AP 96.6% MI 0.6 TIS 0.1
Stomach LN
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2 Dist 0.39 cm
IntraPet Imaging RBIILLC
hanson,peanut
linear ab
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SENphfeldlhsf2018
AP 96.6% MI 0.6 TIS 0.1
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2 Dist 0.23 cm
3 Dist 0.12 cm
IntraPet Imaging RBIILLC
hanson,peanut
Abd small I
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Pancreas
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IntraPet Imaging RBIILLC
hanson,peanut
Abd small I
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SENphfeldlhsf2018
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THICK MUSCULARIS
IntraPet Imaging RBIILLC
hanson,peanut
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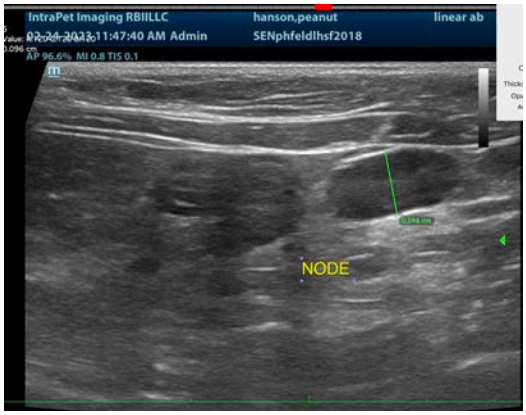
SENphfeldlhsf2018
AP 96.6% MI 1.4 TIS 0.3
Pancreas



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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