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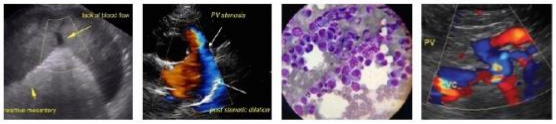


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Louie Fleming

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7 Years

WEIGHT

9.25 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Grand River VH

REFERRING VET

Day/Robinson

INVOICE

23001

DATE

6/20/23

PRESENTING CLINICAL SIGNS

History: Newer patient to hospital. Strictly indoors, 2 cats in home. Has been on Iams weight and hairball food for about 5 years. No meds. Has been vomiting fairly regularly and has lost weight without trying to. No hair seen in vomit, still eating and drinking and normal litter box habits. Abnormal PE/Chem/CBC/UA Results: CBC non responsive anemia, chem NSF and fPL normal.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses or inflammatory changes are observed. There is a 1.7 cm long shadowing dependent mineral density that could represent a dependent pile of small urinary bladder cystoliths or mineral sand/debris, however, one large cystolith is suspected. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (4.62 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.

Right kidney is normal is size (4.53 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

Left adrenal gland is normal in size 0.52 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.49 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.

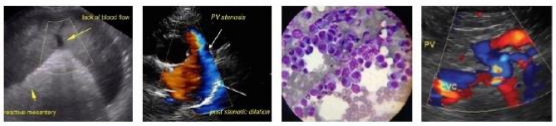
Liver

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 wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. Given the gas artifact, a gastric foreign body or gastric foreign material can't be definitively ruled out, but there is no obvious visible evidence of gastric foreign material. Pyloric outflow tract appears patent.



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The visible small intestines are normal in wall thickness and layering. 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. *See note under large bowel section.

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

*In the mid cranial abdomen, there is a focal loop of bowel with a thick hypoechoic wall, measuring 0.73 cm thick and emerging loss of layering that is believed to be near or adjacent to the ileocecocolic junction. A fluid distended cecum vs infiltrative thick bowel can't be definitively ruled out.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free fluid. A 1.0 cm x 1.2 cm rounded, hypoechoic lymph node is noted in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- The prominent abnormal appearing part of the GI tract in the cranial abdomen appears to be a thickened loop of ileum, however, the location is not definitive for small bowel, and a mildly fluid distended cecum can't be definitively ruled out. The structure is difficult to trace, and therefore difficult to definitively identify.
- Adjacent lymphadenopathy is noted, both reactive lymphadenopathy, as well as infiltrative neoplasia are differentials and cannot be differentiated without tissue sampling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

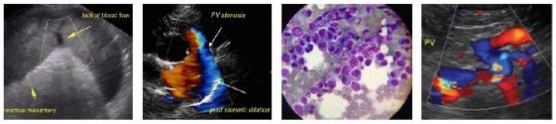
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

In the meantime, empirical supportive/symptomatic medical management of the vomiting and possible emerging infiltrative or infectious or parasitic bowel disease is recommended in the form of antiemetics and gastroprotectants, empirical deworming with a 5-day course of Panacur, as well as, if tolerated, a transition in diet, beginning potentially with a hydrolyzed protein diet. Some patients respond better to one brand or version of hydrolyzed protein diet better than another, so, sometimes several trials are warranted.

Pending results, if clinical signs persist, recheck imaging of the focal bowel loop in question being sure to maximally zoom in on the structure, as well as trace it both cranially and caudally (if possible), could be considered or alternatively, upper and lower GI endoscopy/colonoscopy for further visualization and biopsies, could be considered, and may ultimately be necessary.

Finally, while of unknown clinical significance, given the vomiting, given the urinary bladder changes, if not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is



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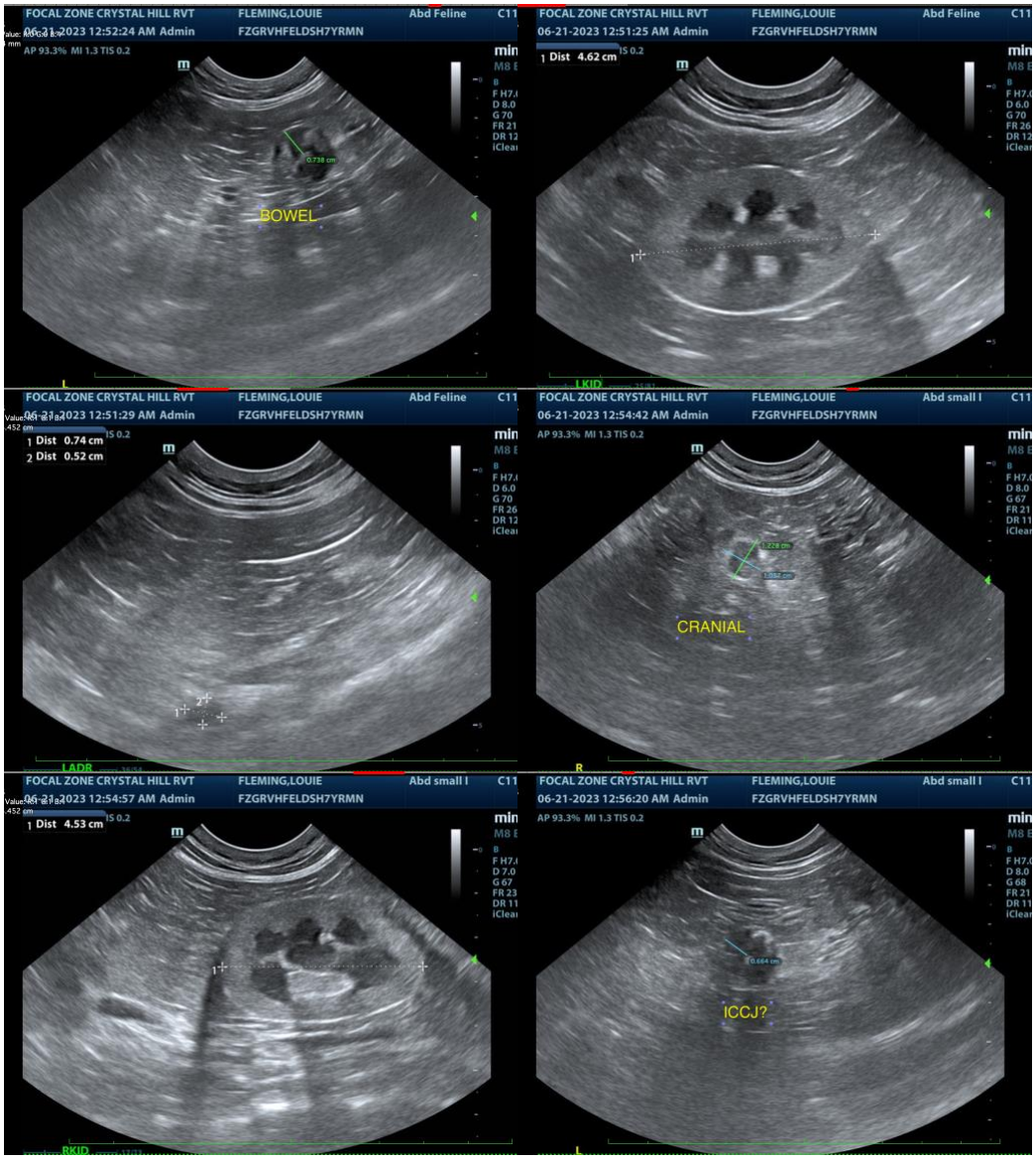
recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.



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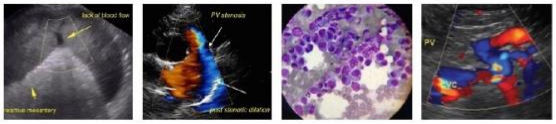

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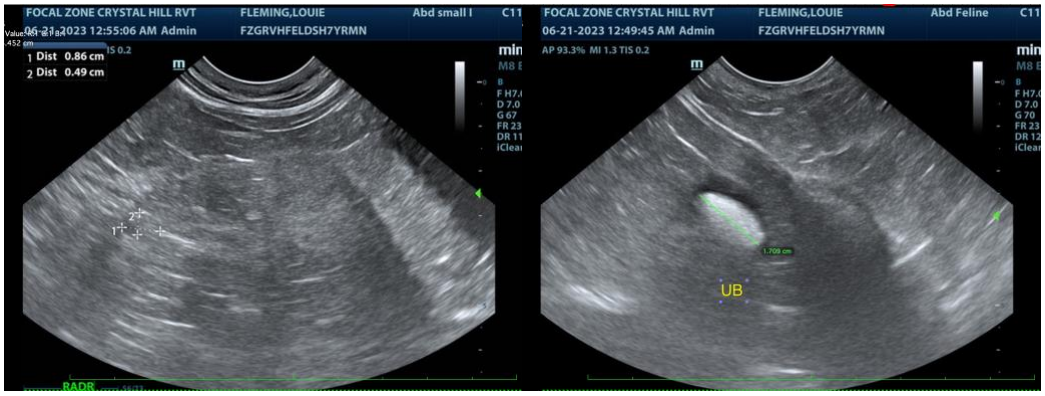

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

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