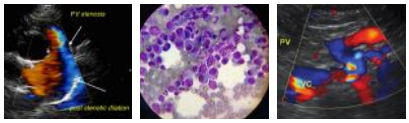
IMAGING PERFORMED BY

IntraPet.com



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DATE
6/29/22

PATIENT
Ronan Lowery

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
4/24/17

WEIGHT
14 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

HOSPITAL NAME
Jacksonville AH

REFERRING VET
Dr. Burk

INVOICE
16391

PRESENTING CLINICAL SIGNS

History: Decreased appetite, eating small amounts at a time since 6/3/22. In the past he would eat larger amounts at a time and then vocalize after eating. Now he eats small amounts. No vomiting or diarrhea. 14 pounds BCS 6/9 Dental tarter gingivitis, missing some teeth.

Current Medications: Hill's I/D.
Lab Results: CBC platelets 144, Chem WNL, FPL Normal, BIL 553, Folate 13.8.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV Torb.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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.

Left kidney is normal is size (4.58 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 (4.69 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 (0.36 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.5 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a coarse/heterogenous echotexture. 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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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 visible colon is normal in wall thickness 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 peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Chronic active pancreatitis
- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis (leave amyloidosis out if canine) as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Inflammatory bowel disease pattern-This finding has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No concurrent lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probably, but lymphoma cannot be definitively ruled out without tissue sampling.

Secondary Findings

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

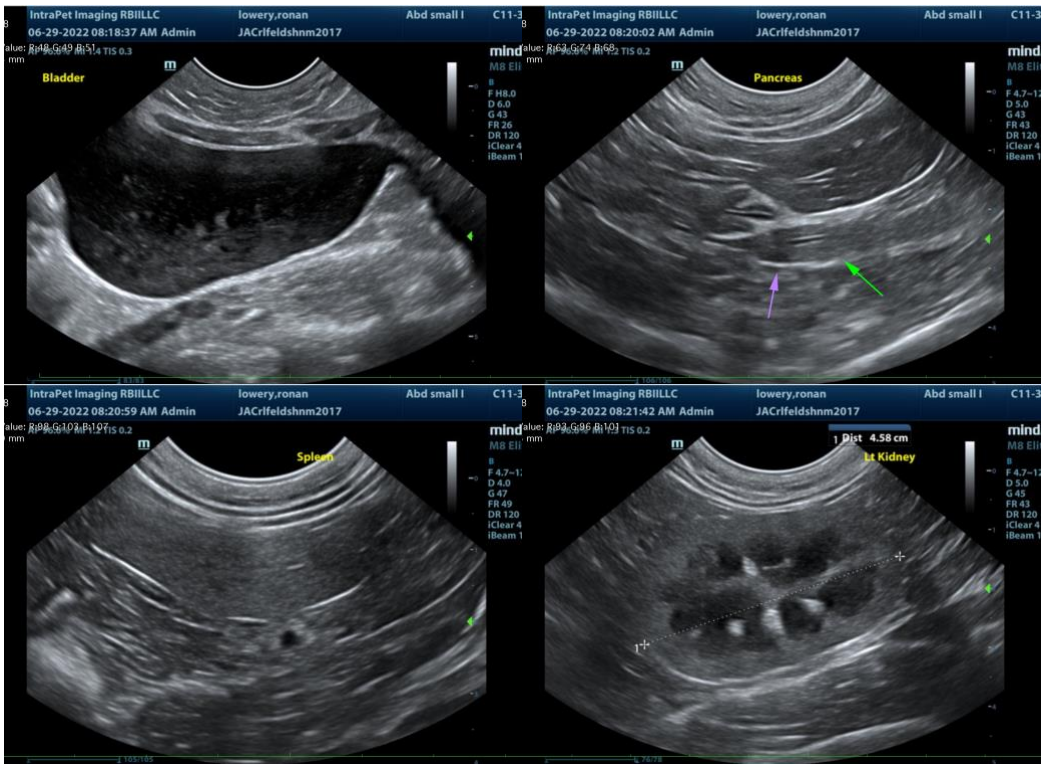
Recommendation for this patient:

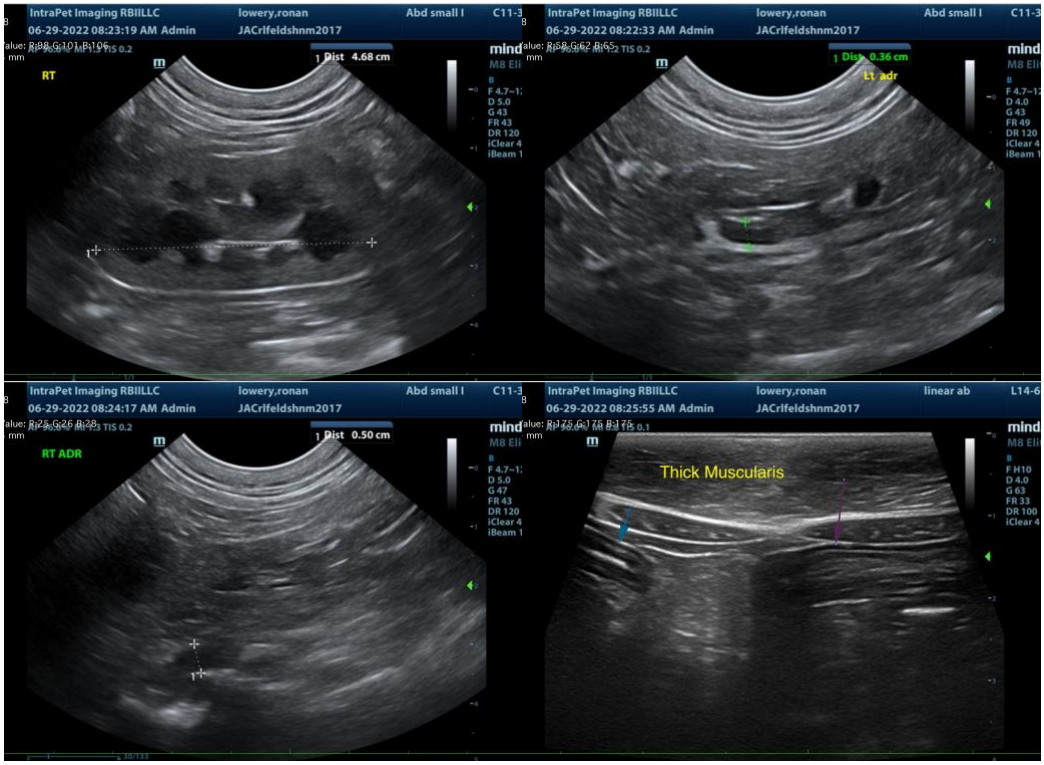
1. Given the pancreatic changes, combined with the patients history of decreased appetite, a quantitative PLI is recommended for further evaluation of suspect pancreatitis.
2. A fine needle aspirate of the spleen could be considered if patient coagulation status is appropriate.
3. Given the mildly thick muscularis, inflammatory bowel disease is also a differential, therefore

Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease. If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5-day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Other supportive therapeutic considerations could include fiber supplementation, especially with large bowel diarrhea and/or a probiotic.

4. 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, closer evaluation and management of suspected dental disease is warranted in case oral pain is contributing to decreased appetite, given the lack of other clinical signs of inflammatory bowel disease, such as vomiting, diarrhea and/or weight loss. In the meantime, pending the response to dental care, transition to a novel or hydrolyzed diet with monitoring of improvement and using diet on a trial and error basis could be considered.





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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