

**DATE PRESENTING CLINICAL SIGNS**

7.12.2023 Weight loss; inappropriate defecations outside litterbox (chronic issue).

**PATIENT**

Go Go Deuber

Current Medications: RC multifunction diet (renal/hydrolyzed) due to other cat eating the diet  
 Fortiflora, Dasuquin, vit B12 injections

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Rachel Brillhart, RDMS.

**SPECIES**

Feline

**BREED**

Ragdoll

**SEX**

Neutered Male

**AGE**

12/23/2012

**WEIGHT**

9.56 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**HOSPITAL NAME**

Frederick Road VH

**REFERRING VET**

Dr. Beyer

**INVOICE**

13665

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

Urinary bladder is adequately 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.

Left kidney is normal in size (3.64 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 in size (3.57 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 (0.40 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.37 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 moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

**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 mildly 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 of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is mildly thick cranially into the proximal descending colon. The thickness ranges between 0.29 and 0.34 cm, with normal intact layering (but for a slightly prominent mucosal layer). Distally, the colon returns to normal thickness. Contents are consistent with normal formed feces and gas.

#### ***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 peritoneal effusion. There is no apparent lymphadenopathy.

### **ULTRASONOGRAPHIC FINDINGS**

#### **Findings**

- Mild 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.
- Mildly thick proximal descending colon – differentials for which are similar to above and include benign inflammatory colitis, secondary to parasitic or infectious disease, potentially dietary sensitivity, versus other inflammation. While there are no criteria of malignancy visible, infiltrative neoplasia cannot be definitively ruled out.
- Moderate gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

### **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

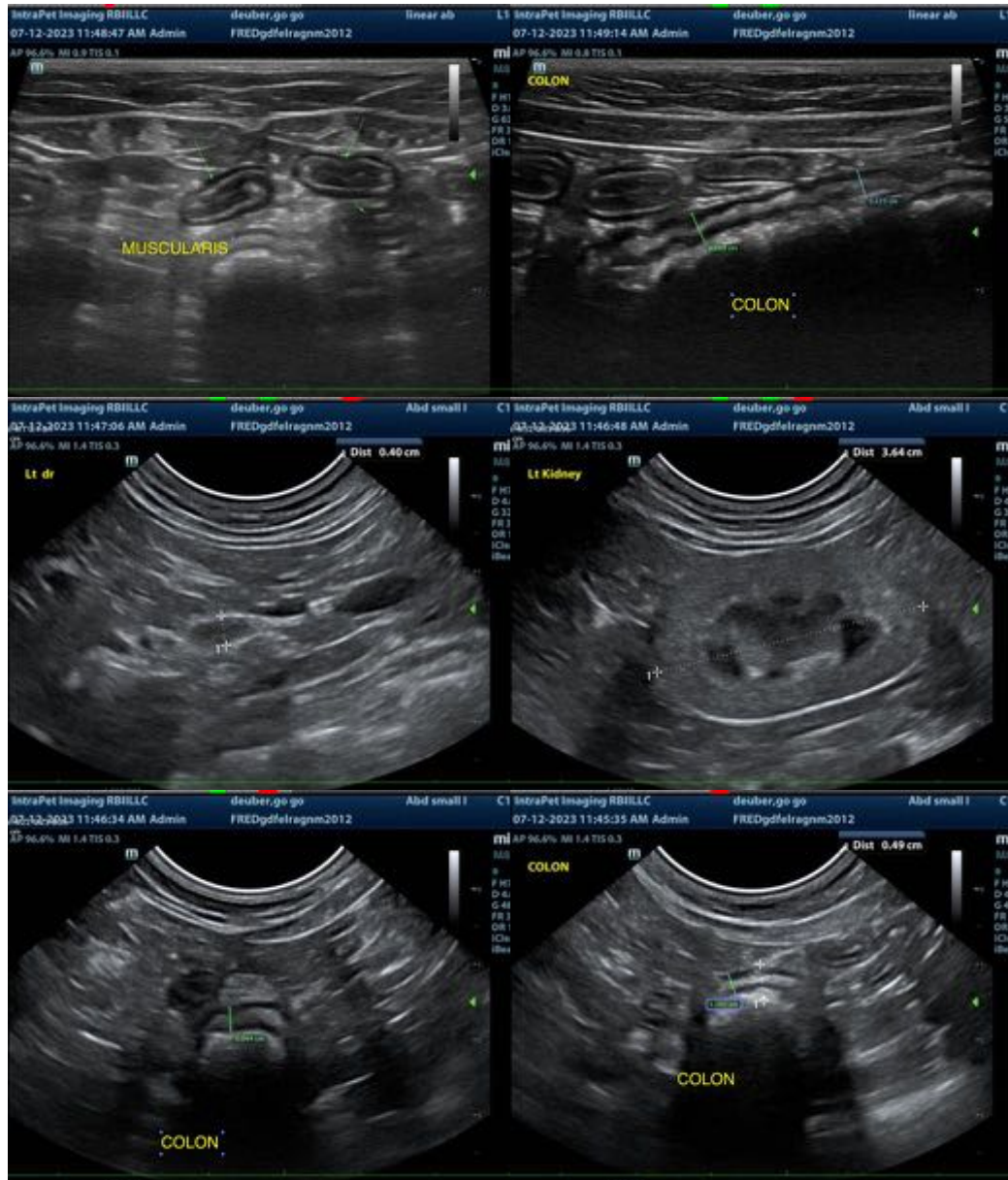
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

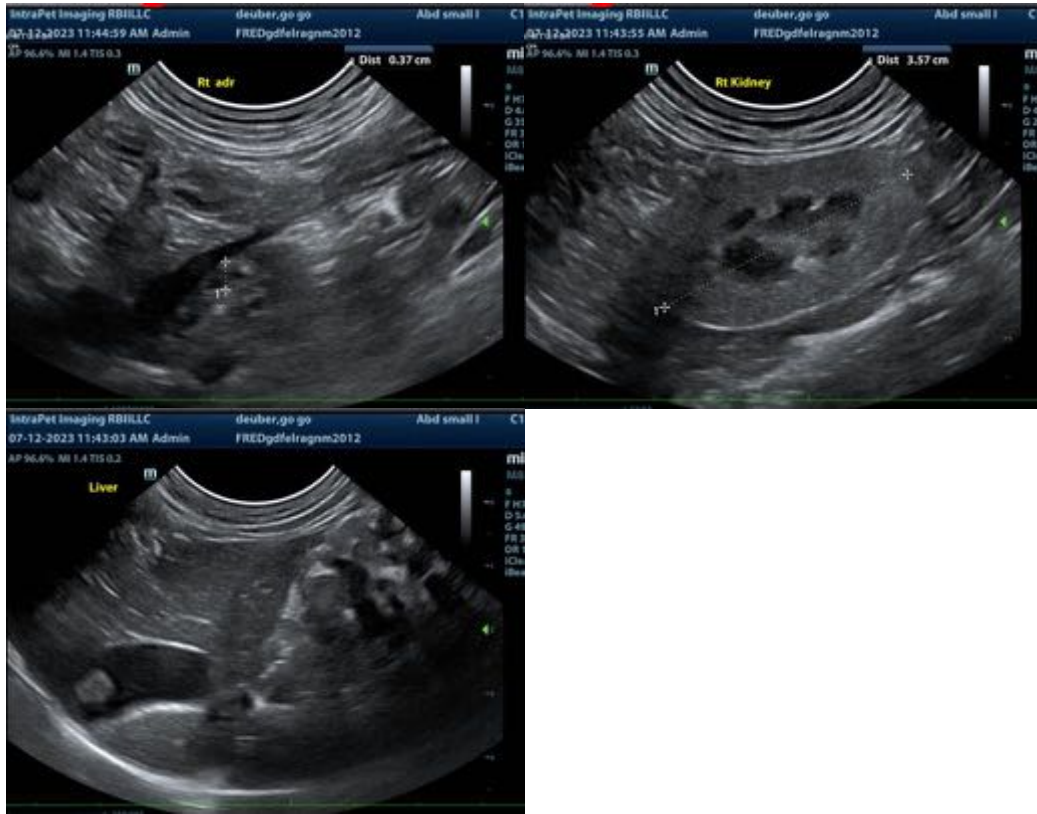
Additionally, a fecal examination is recommended (if not recently evaluated), as is a fecal PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

Ideally, biopsies of the GI tract (both upper and lower), being sure to include ileum and the thick portion of the colon, 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.





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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