

**DATE**

7/25/22

PRESENTING CLINICAL SIGNS

History: Weight loss, decreased appetite, increased vomiting.

PATIENT

Current Medications: None.

Lab Results: NSF on senior panel.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Stephanie Pearce RDCS, RVT.

Illya Ojanen

SPECIES

Feline

BREED

Color Point

SEX

Neutered Male

AGE

7/5/10

WEIGHT

12 Pounds

INTERPRETED BY

Beth Johnson, DVM

DACVIM

HOSPITAL NAME

Everhart VH

REFERRING VET

Dr. Hess

INVOICE

16544

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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measured 4.05 cm. The right kidney measures 3.6 cm.

Adrenal Glands

Adrenal glands are bilaterally uniformly plump egg-shaped adrenals, hypoechoic in echogenicity with bilateral dystrophic mineralization noted. This is most likely a benign age-related change. This change can be caused by chronic stress/disease, so investigation for/management of other disease (chronic kidney disease, hyperthyroidism, etc.) is recommended. The left adrenal gland measures 0.44 cm. The right adrenal gland measures 0.46 cm.

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. Multifocal, primarily hyperechoic but cystic nodules are noted, measuring approximately 1.0 cm in diameter. 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 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.

Right at the ileocecolic junction, there is a focal area of colon with hypoechoic emerging loss of layering that is concentrically thick, measuring 0.7 cm.

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 a scant amount of free fluid around the left pancreas. No appreciable lymphadenopathy is noted in these images.

ULTRASONOGRAPHIC FINDINGS

Primary 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.
- A focal colonic thickening with loss of layering, concerning for infiltrative neoplasia, such as lymphoma versus other.
- Mild acute pancreatitis is suspected
- Feline biliary cystadenoma – In a senior cat, this liver lesion is most consistent with a/multiple benign biliary cystadenoma(s). Malignancy cannot be ruled out but is considered less likely given lack of clinical signs and/or laboratory changes.

Secondary Findings

- Age-related kidney and adrenal changes
- 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.

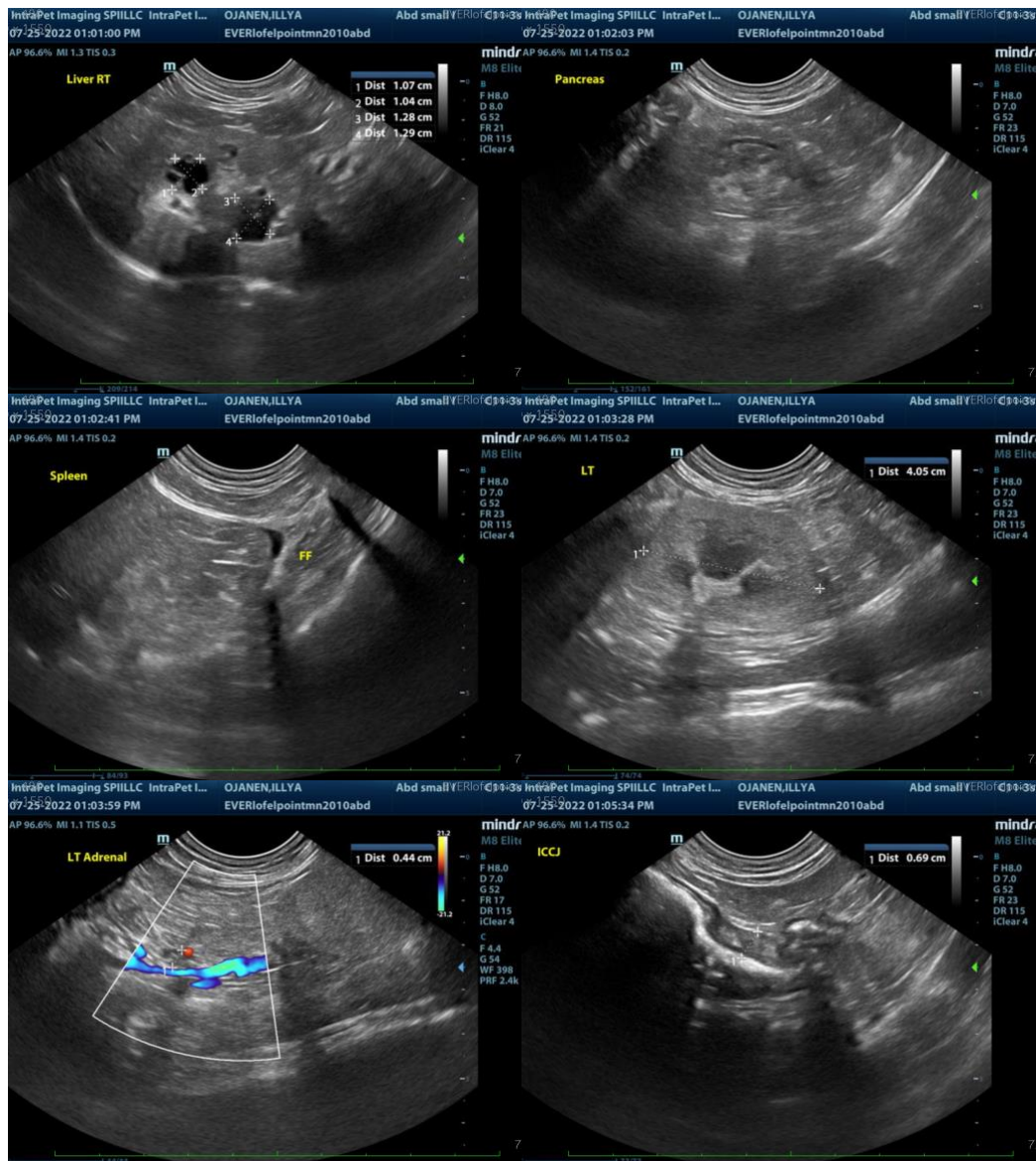
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

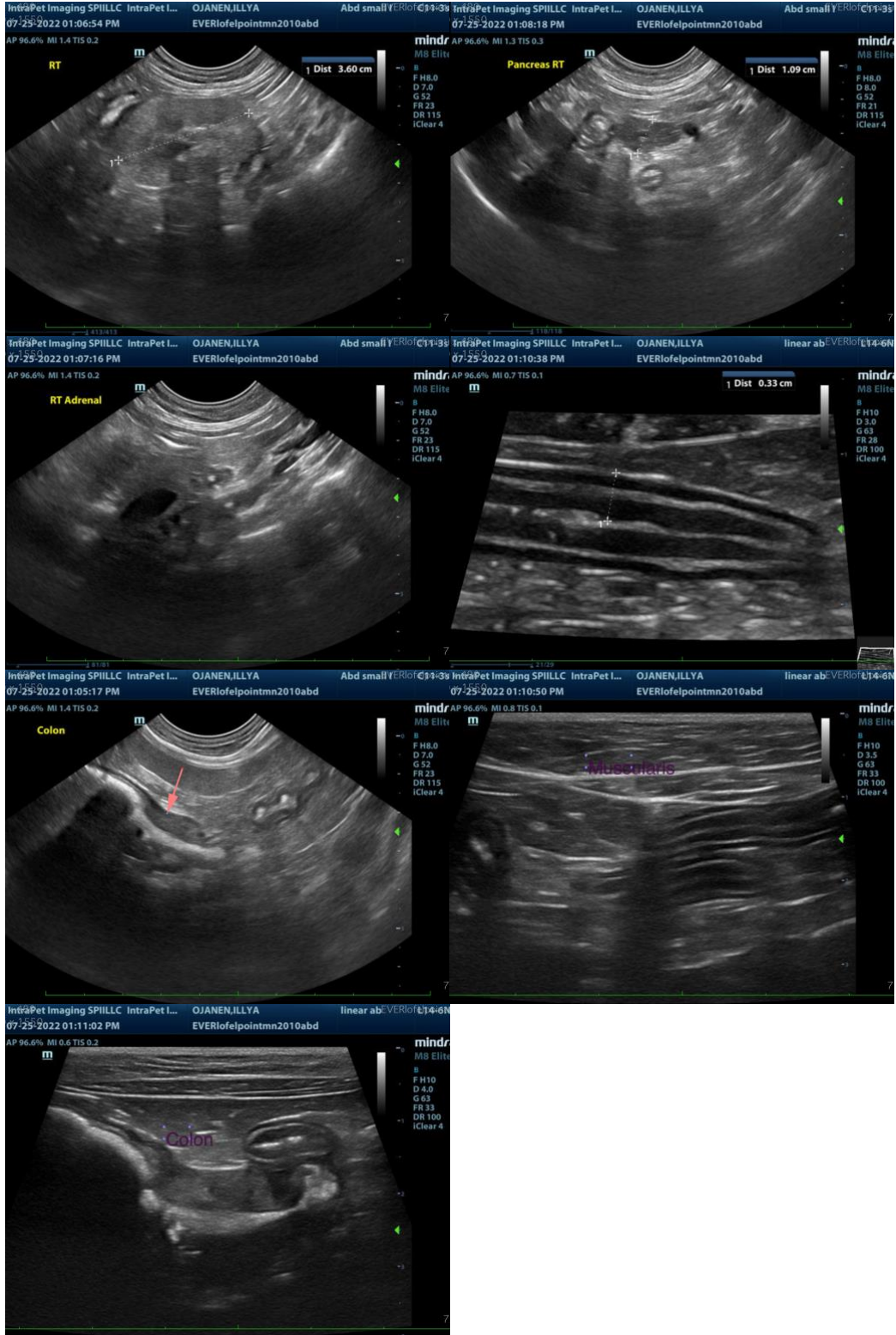
Further diagnostic recommendation include:

- 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 fine needle aspirate of the focally thick colon could be considered, if patient's coagulation status

is appropriate and it's deemed possible to reach it in a safe manner. Otherwise, if not possible, biopsies of the GI tract, being sure to include colon, ileum and small bowel, if possible, are recommended to definitively diagnose, and therefore, manage the infiltrative bowel disease.

In the meantime, symptomatic supportive care of suspected mild acute pancreatitis, on top of the infiltrative bowel disease is recommended in the form of antiemetics, gastroprotectants, appetite stimulants or nutritional support (if needed), pain management (as indicated) and fluid therapy, etc.





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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