

**DATE**

7/25/22

PRESENTING CLINICAL SIGNS

History: Patient was presented for continued weight loss and was dehydrated, labs suggested renal disease, but did not explain weight loss or dehydration.

PATIENT

Mac Scriba

Current Medications: None.

Lab Results: See attached.

Date of Previous IntraPet Ultrasound: No previous.

SPECIES

Feline

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Stephanie Pearce RDCS, RVT.

BREED

DSH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**SEX**

Neutered Male

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.

AGE

8/24/11

Kidneys revealed irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Marked pyelectasia of the left kidney is noted, including a dilated proximal ureter that tapers down at the level of an echogenic structure with acoustic shadowing, consistent with a ureterolith and the right kidney has mild pyelectasia. The left kidney is large, measuring 4.36 cm, caused by marked pyelectasia. The right kidney is normal in size, measuring 3.68 cm.

WEIGHT

6.58 Pounds

Adrenal Glands

Left adrenal gland is normal in size (0.42 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

INTERPRETED BYBeth Johnson, DVM
DACVIM

Right adrenal gland is normal in size (0.43 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.

HOSPITAL NAMEAnimal Hospital at
Southgate**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.

REFERRING VET

Dr. Jones

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.

INVOICE

16545

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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.

The visible colon is normal in wall thickness 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

A very scant amount of free fluid is noted. There is no apparent lymphadenopathy.

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 acute pancreatitis is suspected.
- Chronic kidney disease with bilateral pyelectasia and a suspected left ureterolith, resulting in at least partial obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's presenting complaint of weight loss, combined with the ultrasound images here, infiltrative bowel disease is considered the most likely differential. Given the concurrent reported eosinophilia, food allergy or insensitivity or eosinophilic inflammatory disease are top differentials.

Therefore, recommendations include:

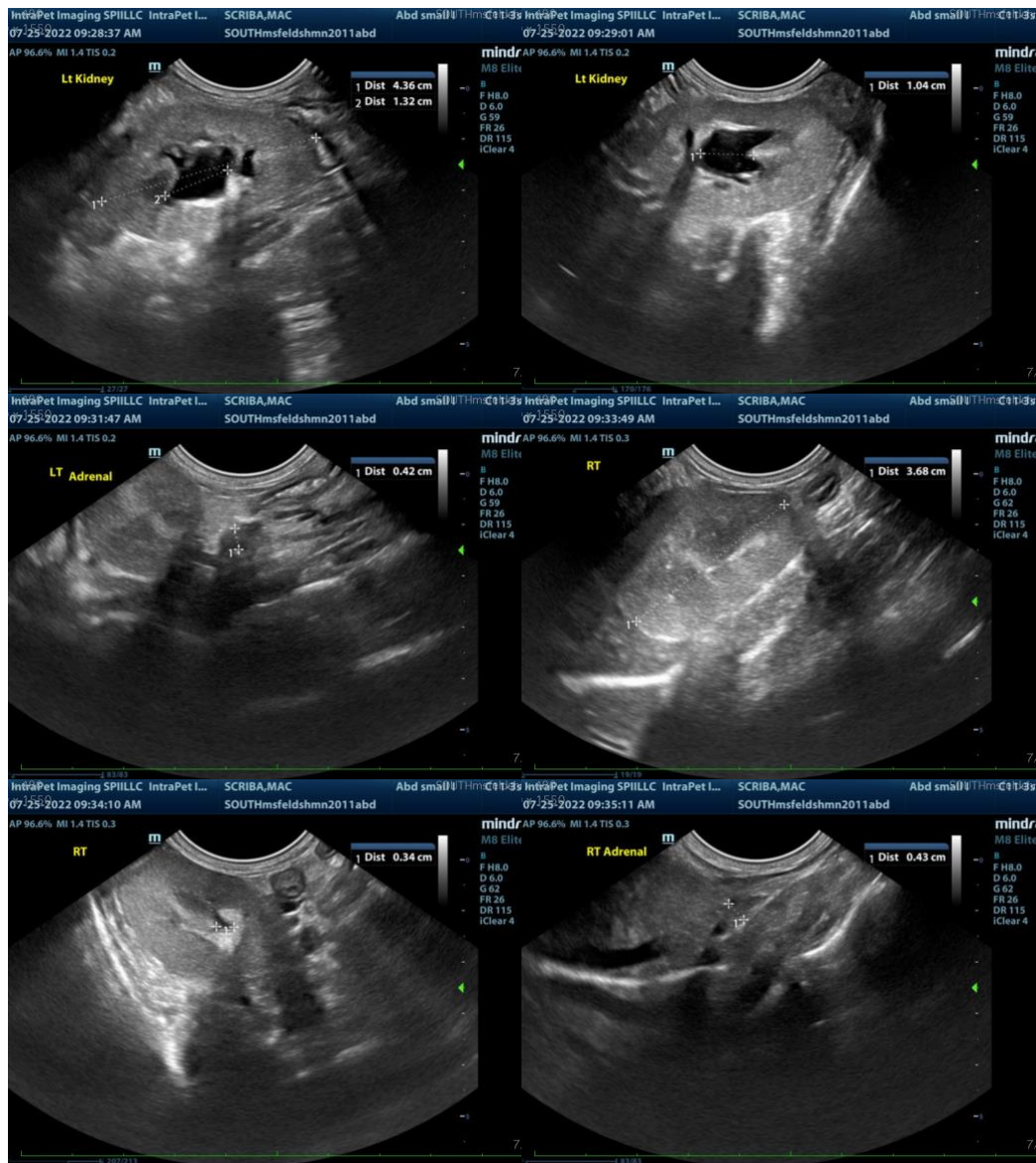
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- Ideally, biopsies of the GI tract, being sure to include ileum (if possible) would be recommended to definitively diagnose, and therefore manage the infiltrative bowel disease. However, given the concurrent kidney changes, biopsies may need to be postponed until further patient stabilization.
- In the meantime, a urine culture is recommended to rule out an occult urinary tract infection or potential pyelonephritis contributing to the patient's kidney changes.

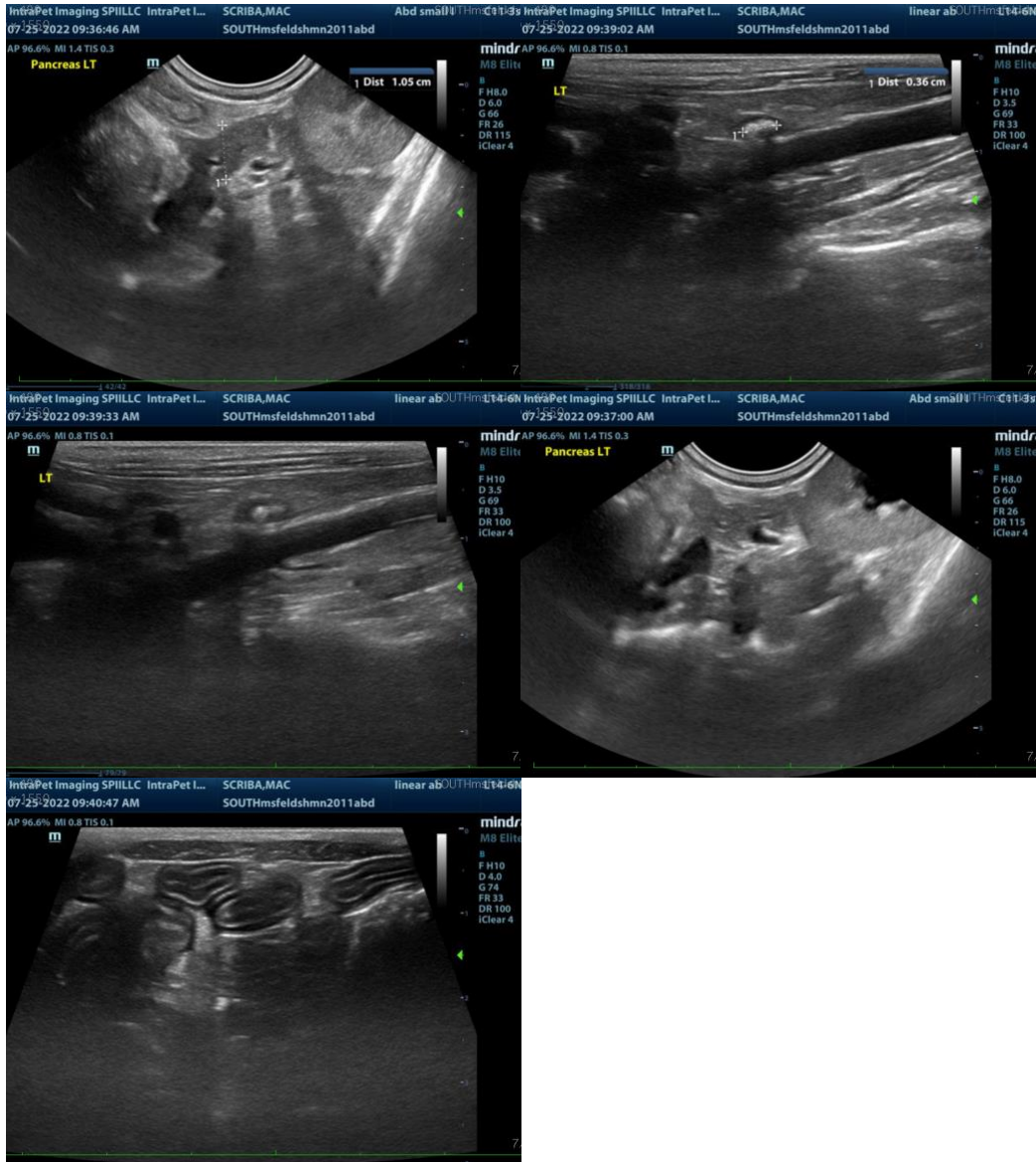
Therapeutic recommendations include:

- Symptomatic supportive care of the gastrointestinal signs, including potentially deworming with a 5-day course of Panacur, given the eosinophilia, as well as a diet transition to a novel or hydrolyzed

protein diet, combined with diuresis and a broad-spectrum antibiotic to see if the ureterolith will pass, and the kidney values will improve.

While considered an incidental finding and likely not related to weight loss as the GI disease, if the ureterolith doesn't pass, more invasive intervention, such as surgical consultation for stent placement, stone removal and/or sub placement may need to 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
Beth.Johnson@SonoPath.com