

**DATE PRESENTING CLINICAL SIGNS**

9/28/22 History of chronic diarrhea. Was diagnosed with hyperthyroidism but had a negative reaction to methimazole. Is in the process of a work-up prior to I-131 therapy. On exam at the referral center on 9/1/22, she had a BCS of 4/9. A sinus tachycardia was present, as was a palpable thyroid nodule

PATIENT

Ladyfist Mertz

Current Medications: Adequan (chronic), Glyde (chronic), Purina HA diet

Lab Results: 6/22/22: CBC: Decreased retic HGB. Chem: Mildly decreased BUN and CK, Mildly elevated Na+. T4: Elevated at 5.9 ug/dL. BPs: 240-260

SPECIES

Feline

Date of Previous IntraPet Ultrasound: 8/5/21. See attached.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

BREED

Siberian

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**SEX**

Spayed Female

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.

AGE

7/8/10

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 or infarcts observed. The left kidney measures 3.49 cm. The right kidney measures 3.54 cm. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted in both kidneys.

WEIGHT

6.58 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**Adrenal Glands**

The right adrenal gland is normal in size (0.41 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

IMAGING PERFORMED BYStephanie Warga
RDMS, RVT

The left adrenal gland is normal in size (0.41 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

HOSPITAL NAME

Paradise AH

Spleen

The 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.

REFERRING VET

Dr. Twardzik

Liver

The 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.

INVOICE

41722

The 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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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 visible colon is normal in wall thickness (< 0.2 cm) 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 free peritoneal effusion noted in these images.

The mesenteric and medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

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. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- **Reactive mesenteric and medial iliac lymph nodes** – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Chronic active pancreatitis

SECONDARY FINDINGS

- Age related kidney change
- Urinary bladder debris

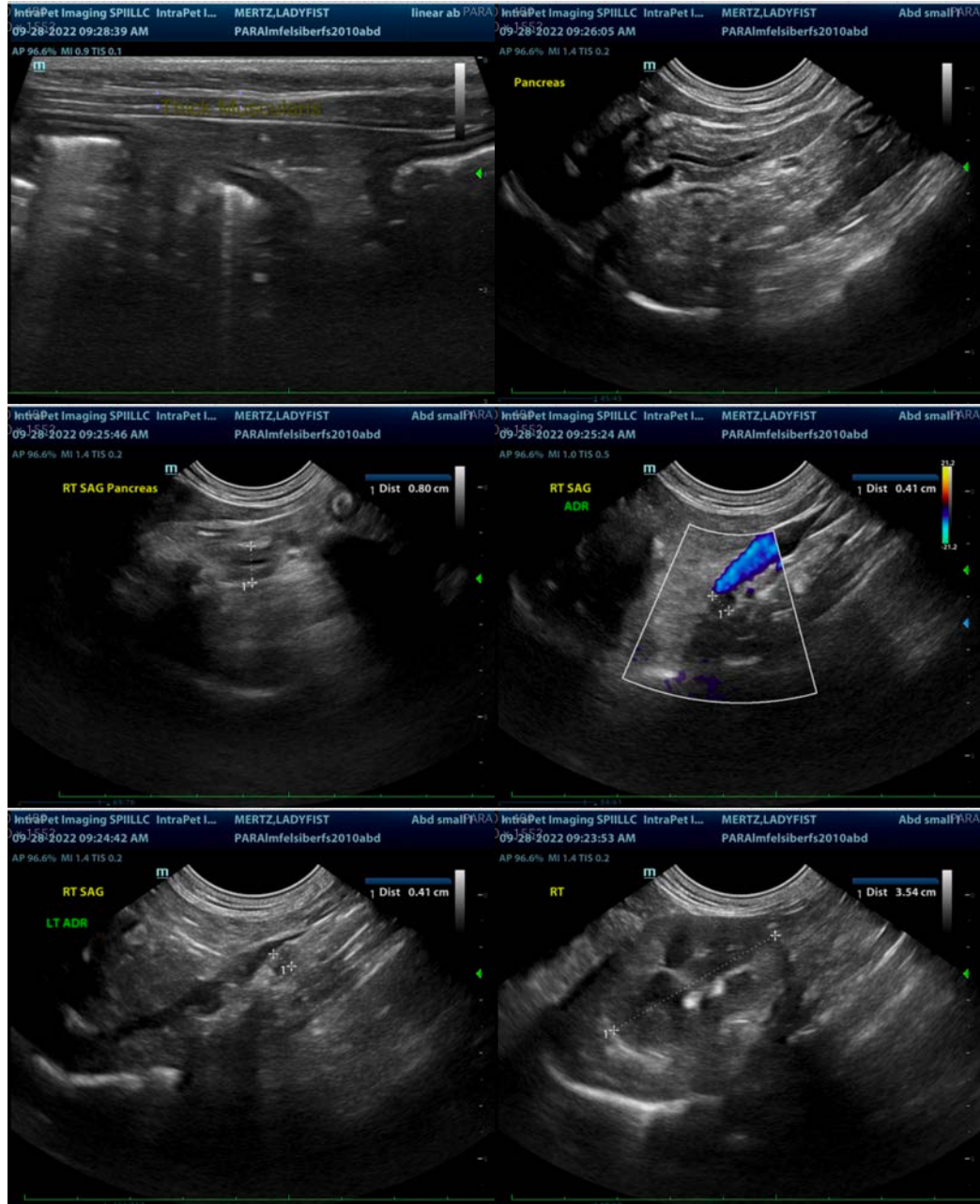
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

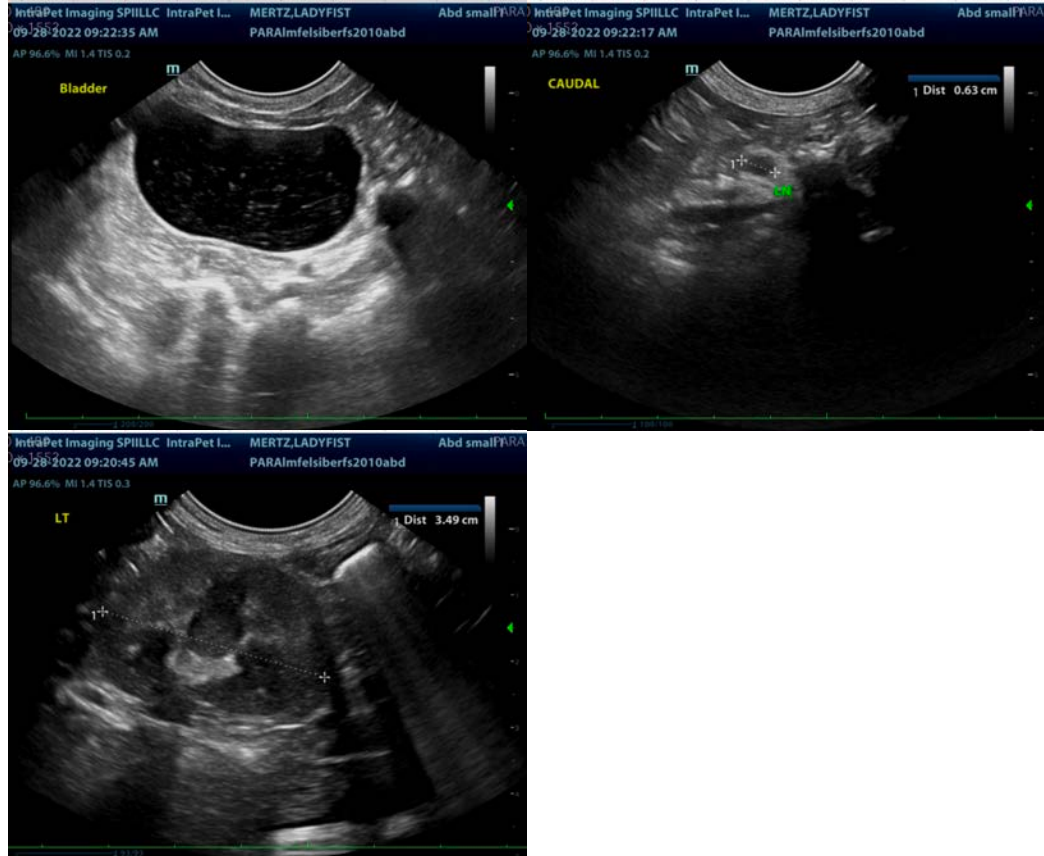
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Given the reported chronic diarrhea and enlarged medial iliac lymph nodes, additional testing in the form of a fecal exam (if not recently evaluated), and a fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

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, in addition to the reportedly already in place hydrolyzed diet, empirical deworming with a 5-day course of Panacur is recommended, and ultimately biopsies of the gastrointestinal tract may be warranted to definitively diagnose and therefore manage the suspected infiltrative bowel disease. However, managing the hyperthyroidism is recommended first.





The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. 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.

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