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DATE PRESENTING CLINICAL SIGNS

1/11/22 History: Abdominal discomfort, decreased appetite and weight loss. Has been vomiting. Bloodwork shows pancreatitis and small intestinal disease. We have started Mirataz and vit b12 injections.

PATIENT

Tinley Cianelli

Current Medications: Mirataz and vit b12 injections.

Lab Results: Attached separately.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Gabapentin, Torbugesic and low dose Dexdomitor.

Stat Report: Not requested.

SPECIES

Feline

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

BREED

DSH

SEX

Neutered Male

AGE

4/13/11

WEIGHT

17.9 Pounds

INTERPRETED BY

Kathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)

IMAGING PERFORMED BY

Stephanie Pearce
RDMS, RVT

HOSPITAL NAME

Festival Vet Clinic

REFERRING VET

Dr. Cianelli

INVOICE

34123

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.06 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.12 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.39 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.40 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size. The spleen echotexture is heterogenous and mildly mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There are at least two ill-defined, hyperechoic areas within the splenic parenchyma, measuring 0.5 and 0.51 cm. These do not deform the splenic capsule. Appearance favors a benign process, but underlying neoplasia cannot be excluded.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measured 0.23 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with moderate pancreatitis.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mild mesenteric lymphadenopathy with a cluster of lymph nodes at the mesenteric root measuring 0.48 cm and 0.49 cm. The omentum is hyperechoic in the area around the prominent lymph nodes.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mildly hypoechoic pancreas with surrounding hyperechoic pancreas – The pancreatic changes are most consistent with moderate pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Hyperechoic foci within the splenic parenchyma – These lesions are most consistent with a benign process, but cytologic evaluation would be necessary to know for sure.
- Prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

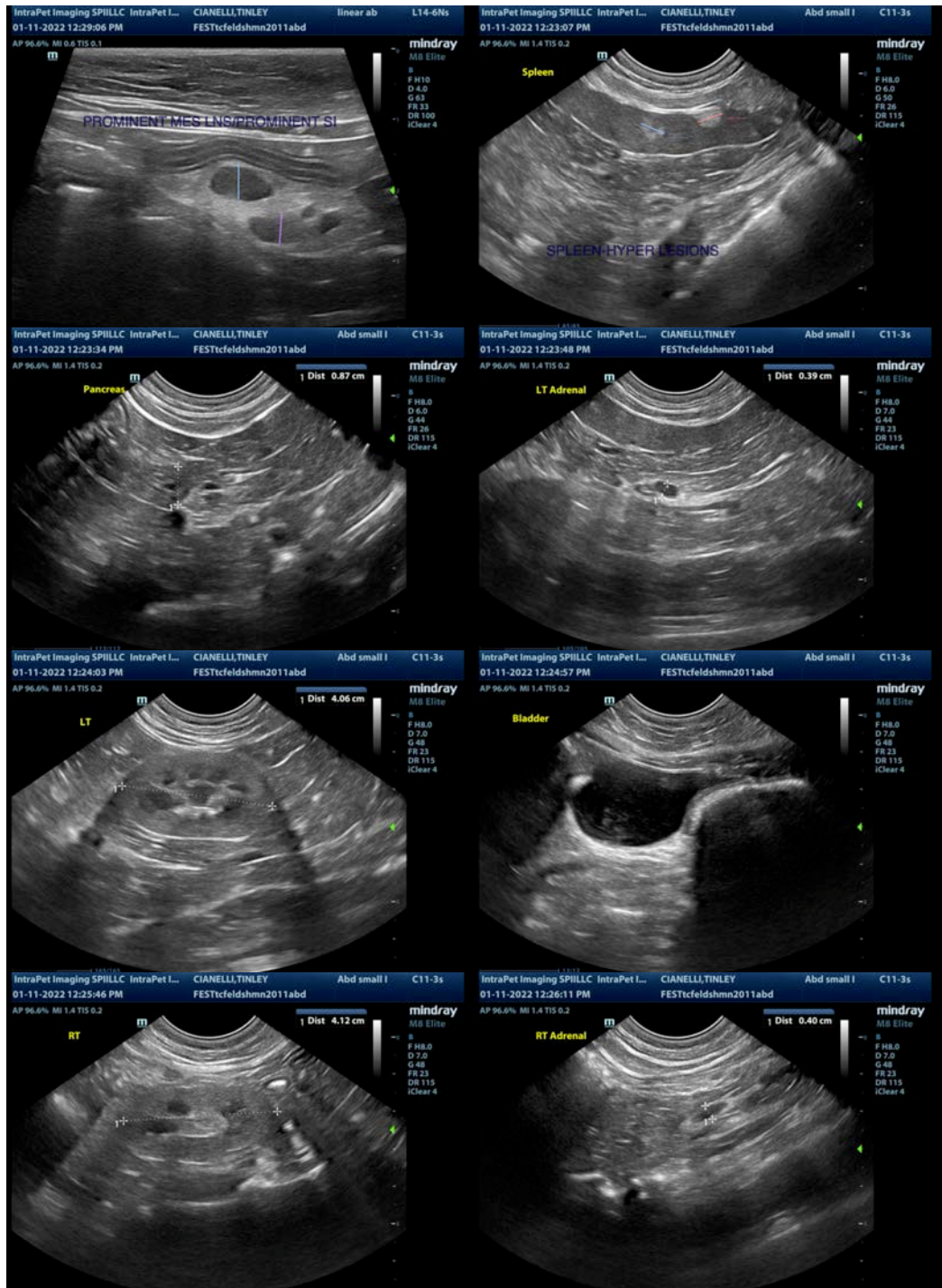
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

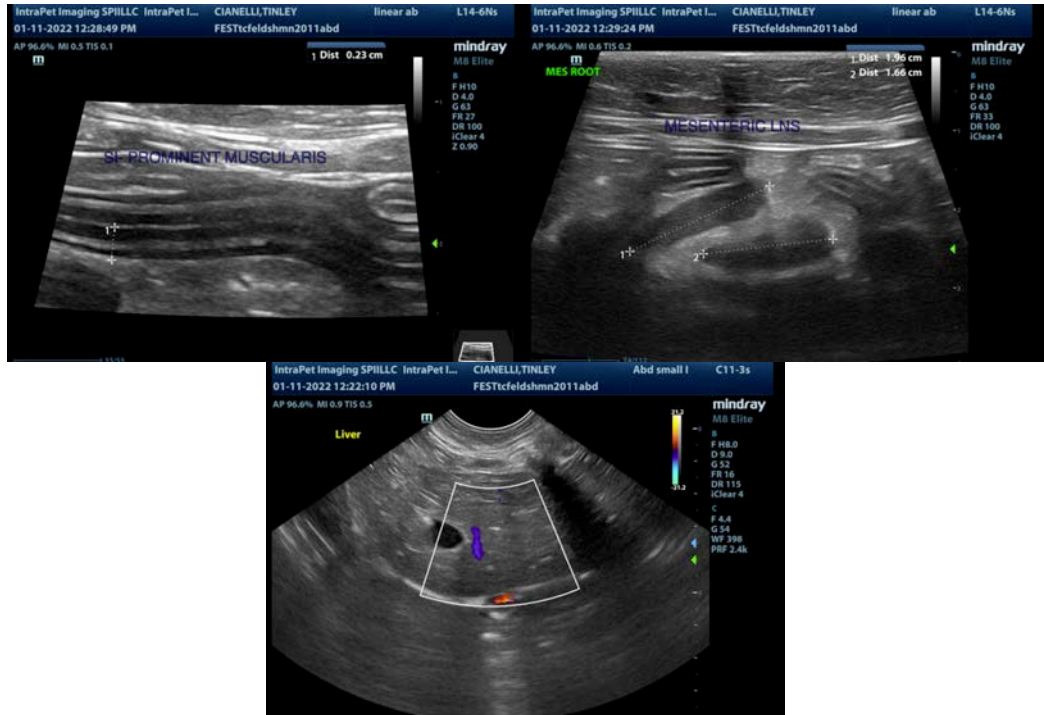
I feel the ultrasonographic findings confirm your suspicions of pancreatitis and small intestinal disease. No focal bowel lesions were observed. Possible differentials would include acute enteritis, dietary indiscretion, GI parasitism, food intolerance, IBD, or less likely intestinal neoplasia.

- Recommend a novel protein/hydrolyzed protein diet.
- Recommend supportive care for pancreatitis/enteritis with nausea medications, pain medications, etc.
- Recommend probiotic therapy.
- If symptoms are persisting, consider obtaining GI biopsies and biopsies of the mesenteric lymph nodes if a fine needle aspirate is not possible.

Additionally, there are some ill-defined, hyperechoic lesions within the spleen. In general, hyperechoic lesions are less concerning than hypoechoic lesions, but cytology would be necessary to determine the true nature.

Recommend 3-view thoracic radiographs to rule out concurrent intrathoracic disease.





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.

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