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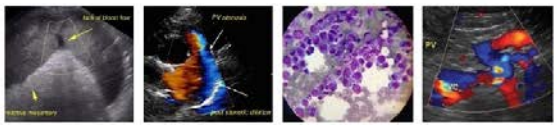

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Bastian Gaudet

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

12 Years

WEIGHT

3.7 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hespeler AH

REFERRING VET

Dr. Bhinder

INVOICE

34192

DATE

1/12/22

PRESENTING CLINICAL SIGNS

Continued diarrhea, weight loss. Bloodwork normal. Feline GI panel negative. Very little response to Prednisolone and Anallergic foods. Concerned re: Lymphoma vs IBD. NO meds.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.38 cm) with non-obstructive nephrolith measuring 0.35 cm. Overall echogenicity is slightly hyperechoic with poor 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.07 cm). Overall echogenicity is slightly hyperechoic with poor 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 0.29 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 0.28 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, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the biliary tract show hyperechoic shadowing material within the intrahepatic bile ducts. No severe dilation is noted. The gallbladder does not appear dilated. 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, but there is some hyperechoic shadowing debris, consistent with small stones. The cystic and common bile ducts appear prominent and slightly dilated and tortuous, measuring 0.37 cm.

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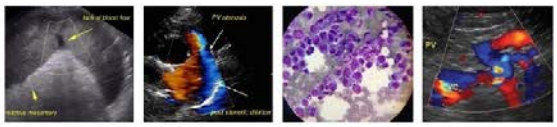

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Gastrointestinal

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 0.20 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 normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a significant mesenteric lymphadenopathy visualized with irregular hypoechoic lymph nodes measuring 0.81, 0.67, and 0.65 cm. The omentum is of increased echogenicity around these enlarged lymph nodes.

PRIMARY FINDINGS

- 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.
- Mild/moderate mesenteric lymphadenopathy – Possible differentials include inflammation, infection, or underlying neoplasia.
- Mineralizations within the intrahepatic bile ducts, gallbladder, and dilation of the common bile duct. While stones are visible in the biliary tree, no obvious obstruction is noted.

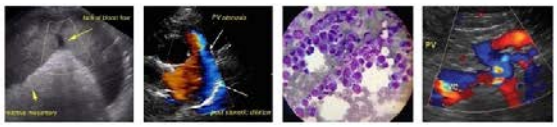
SECONDARY FINDINGS

- Decreased corticomedullary distinction in the kidneys – The bilateral renal findings are consistent with age-related change.
- Echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The prominent muscularis layer to the small intestine and the prominent mesenteric lymph nodes are likely indicators of the chronic small intestinal signs observed. No large focal mass effects were visualized. I would recommend starting with a fine needle aspirate of a mesenteric lymph node. If this is not helpful/diagnostic, I think you would likely need GI biopsies to obtain more information.

- Recommend a novel protein/hydrolyzed protein prescription diet (if not already done).
- Recommend probiotic therapy chronically.
- If these things have already been done with no effect, then consider trying a different



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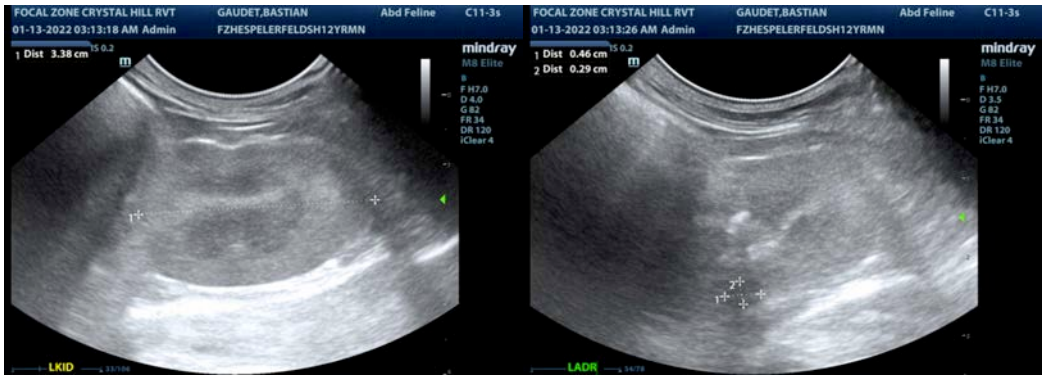
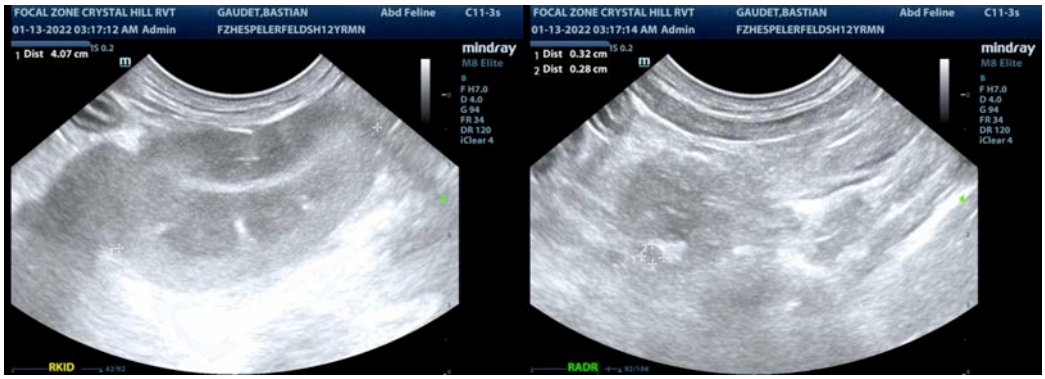
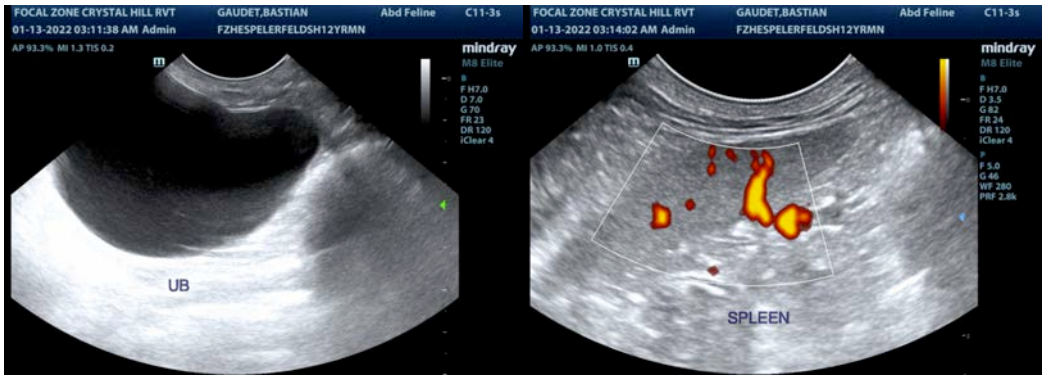
- If dysbiosis is considered likely due to recent systemic antibiotic therapy, etc., you could consider a fecal transplant.
- Recommend 3-view thoracic radiographs to look for evidence of concurrent intrathoracic disease.
- Recommend continued monitoring of the gallbladder and liver for a biliary obstruction occurring.







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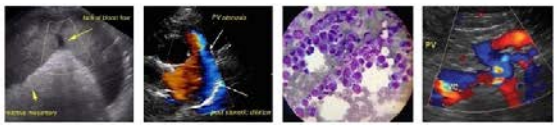

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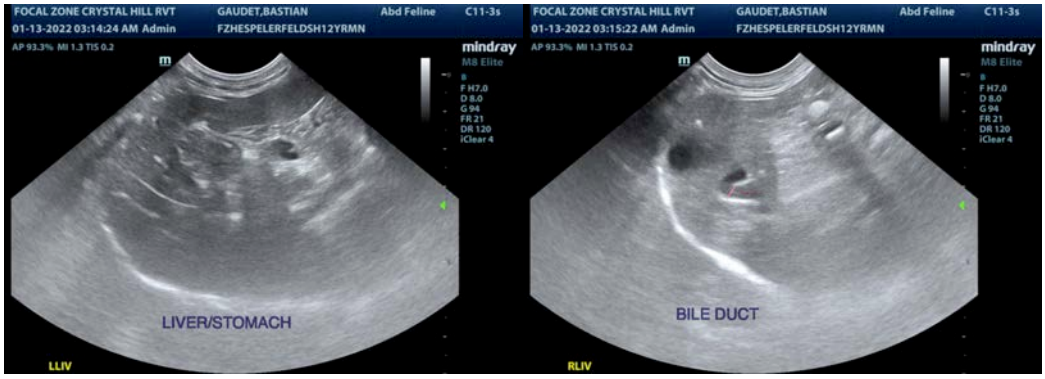

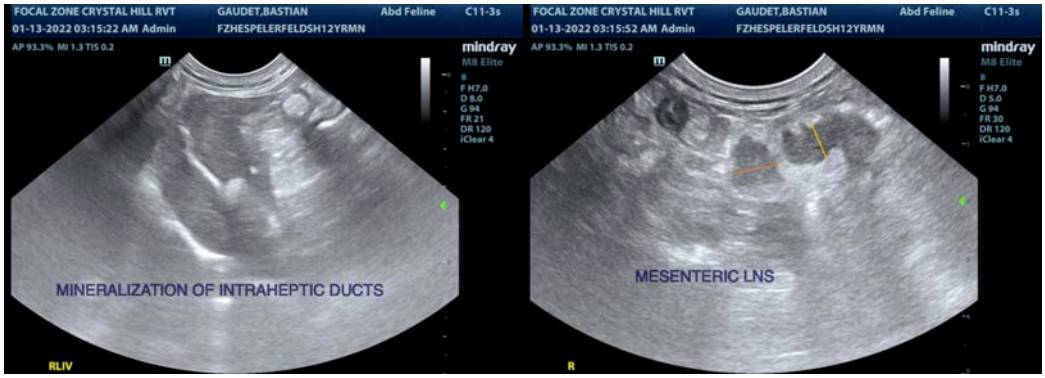

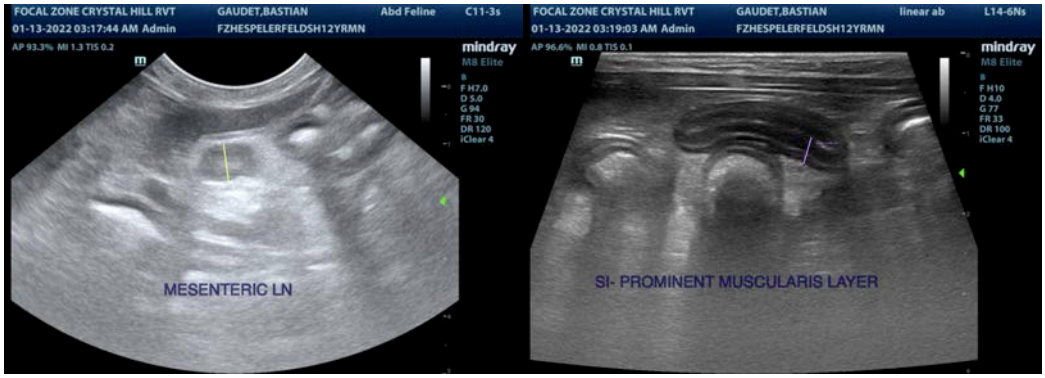

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com