



PATIENT

Booper Ferguson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9.5 Years

WEIGHT

11.3 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Tam Mengine

INVOICE

34214

DATE

1/13/22

PRESENTING CLINICAL SIGNS

Three pound weight loss over the last year, with 0,7# of that loss occurring in the last 2 months. Vomits right after meals once or twice a week, but seems to be associated with rapidly eating his food. CBC / Chem / T4 / U/A all within normal limits.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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 (3.98 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 (3.92 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. 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 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



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with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.27 cm. Jejunum wall measures 0.34 cm. Visualized peristalsis appears appropriate. There is a focal area of bowel thickening with loss of layering involving the ileocecal junction. The bowel in this area has a width of 0.64 cm. Additionally, the duodenum appears focally corrugated and irritated.

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The ileocecal junction was visualized and adjacent bowel appears thickened with loss of layering. The ileum measures 0.64 cm in thickness. There are clusters of lymph nodes surrounding the ileocecal junction measuring 0.4, 0.41, 0.45 cm with hyperechoic mesentery. The distal colon appears relatively normal with normal wall thickness of 0.12 cm.

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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.

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Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mesenteric lymphadenopathy particularly surrounding the ileocecal junction with lymph nodes measuring 0.4, 0.41, 0.45 cm. The mesentery surrounding the ileocecal junction is hyperechoic.

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ULTRASONOGRAPHIC FINDINGS

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- Focal bowel thickening with reduced distinction of layering at the ileocecal junction – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. A reduction in the detail of wall layering favors either severe intestinal disease or neoplastic infiltration. Biopsy is recommended.
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Duodenal corrugation – The duodenum appears inflamed, prominent and corrugated.
- Diffusely 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.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The majority of the small bowel appears to have changes consistent with inflammation /IBD, etc., but there is a focal area, which I believe is the ileocecal junction, which appears focally inflamed and thickened with loss of distinct layering. I am concerned that this represents an emerging neoplastic change. Recommend a fine needle aspirate of the bowel wall in this area. If an answer cannot be obtained through cytology, then recommend surgical biopsies. Recommend 3-view thoracic radiographs.

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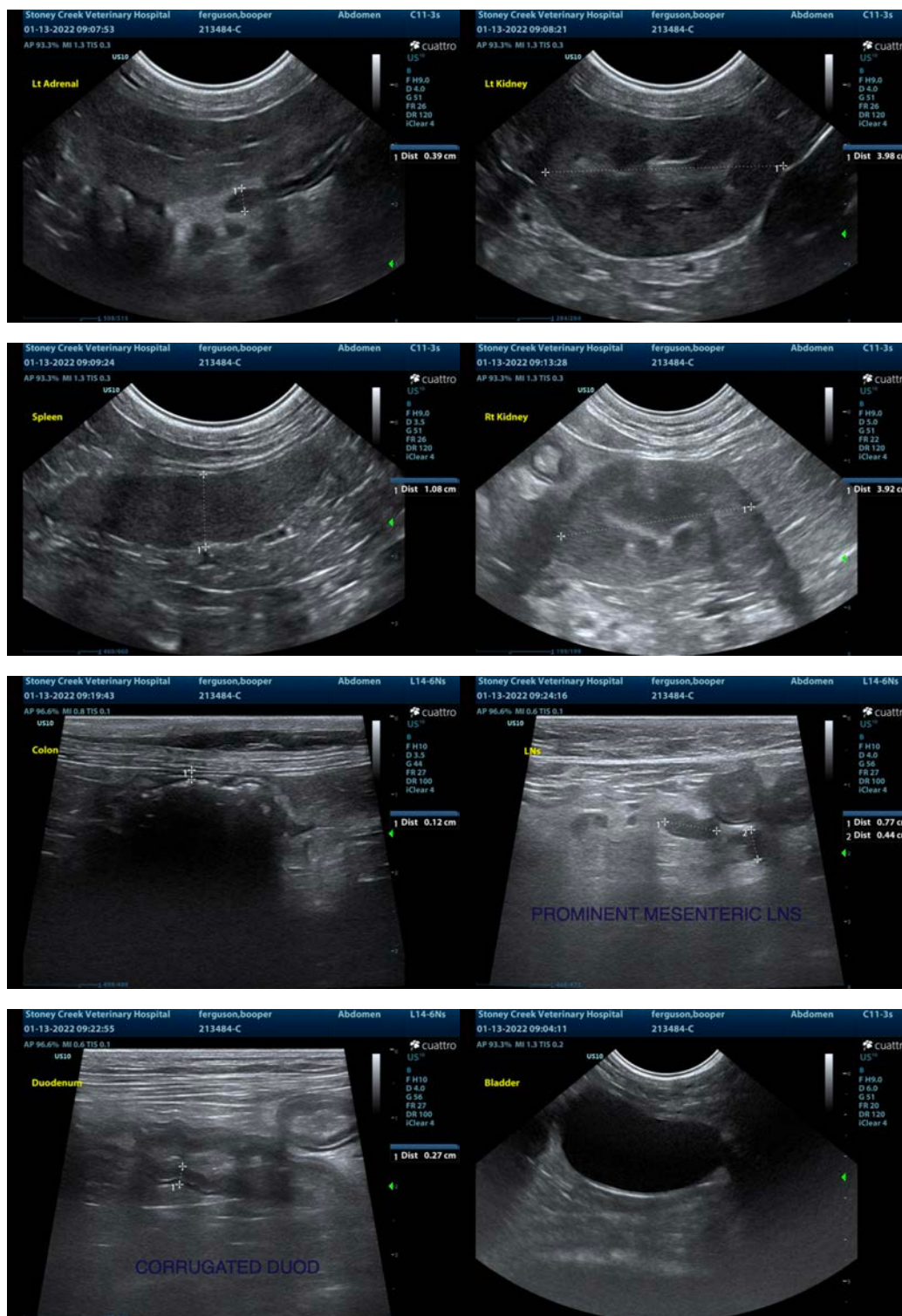
Dr. Tam Mengine

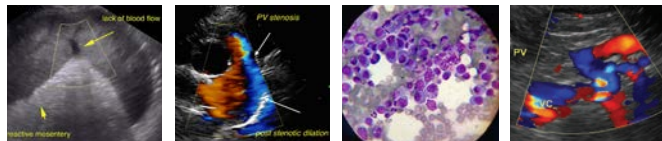
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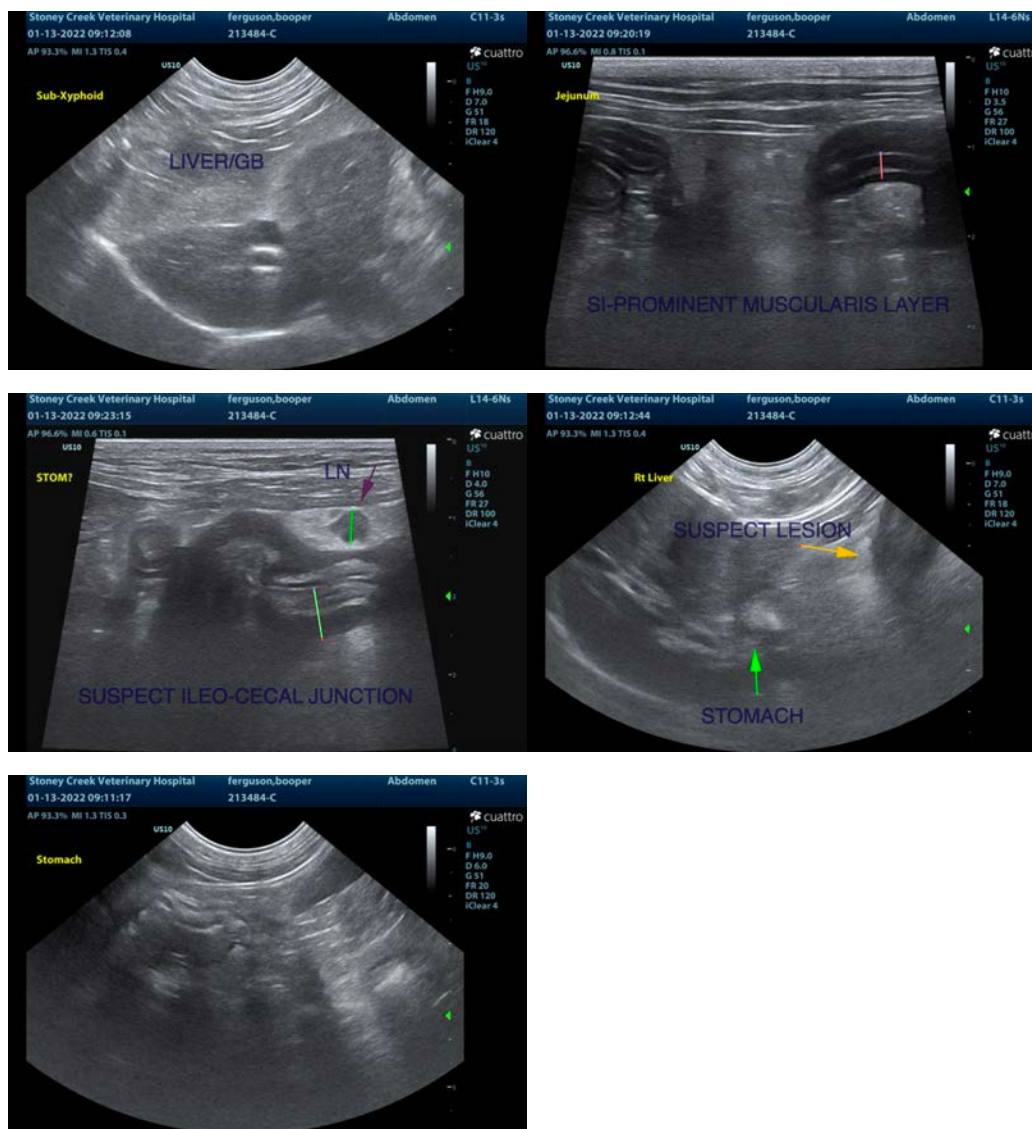
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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