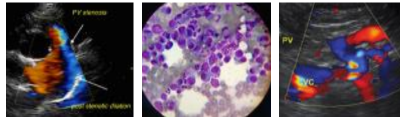
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

1-800-838-4268 info@sonopath.com SonoPath.com

DATE
1/14/22

PATIENT
Keith Moon Shonborn

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
4/4/11

WEIGHT
16.6 Lbs.

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

HOSPITAL NAME
Timonium AH

REFERRING VET
Dr. Kauder

INVOICE
13425

PRESENTING CLINICAL SIGNS

History: Chronic soft stool. Has been on 2.5mg prednisolone twice weekly for 6+ years for ibd (diagnosed at prior vet in another state). Past few months have had to change foods & struggling to get stool back to normal even with higher pred. Metronidazole trial did not help. Probiotic helped for a while. Eating fine, acting fine, no vomiting.

Current Medications: Prednisolone 7.5mg every other day past month.
Proviable -1 capsule daily for the past 2 months.
Lab Results: Low phosphorus 1.5-10/19/21, Rest of chem/cbc/t4 ok, GI panel : fpl 12.1 (0-3.5), Folate >24 (8.9-19.9). Attached separately.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson RDMS.

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 2 cm) 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 is irregular in shape (4.22 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 pyelectasia, measuring 0.25 cm. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.81 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 region of left adrenal (Cranial to left renal artery) is unremarkable, but the adrenal is not distinctly visualized. 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 gall bladder 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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The jejunum measured as normal (0.21 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 mild/moderate pancreatitis.

Free Abdomen
There is no free fluid. Occasional prominent mesenteric lymph nodes are visualized, measuring 0.31cm, 0.3 cm, and the omentum is of increased echogenicity, particularly cranial to the left kidney near the left limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Prominent hypoechoic pancreas with surrounding hyperechoic mesentery. The pancreatic changes are most consistent with mild/moderate pancreatitis/pancreatic infiltration. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

- Decreased corticomedullary distinction in both kidneys with left sided mild pyelectasia. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Hyperechoic mesentery and mildy prominent mesenteric lymph nodes. The changes are most consistent with reactive mesentery and lymph nodes. Underlying neoplastic change seems less likely.

Secondary Findings

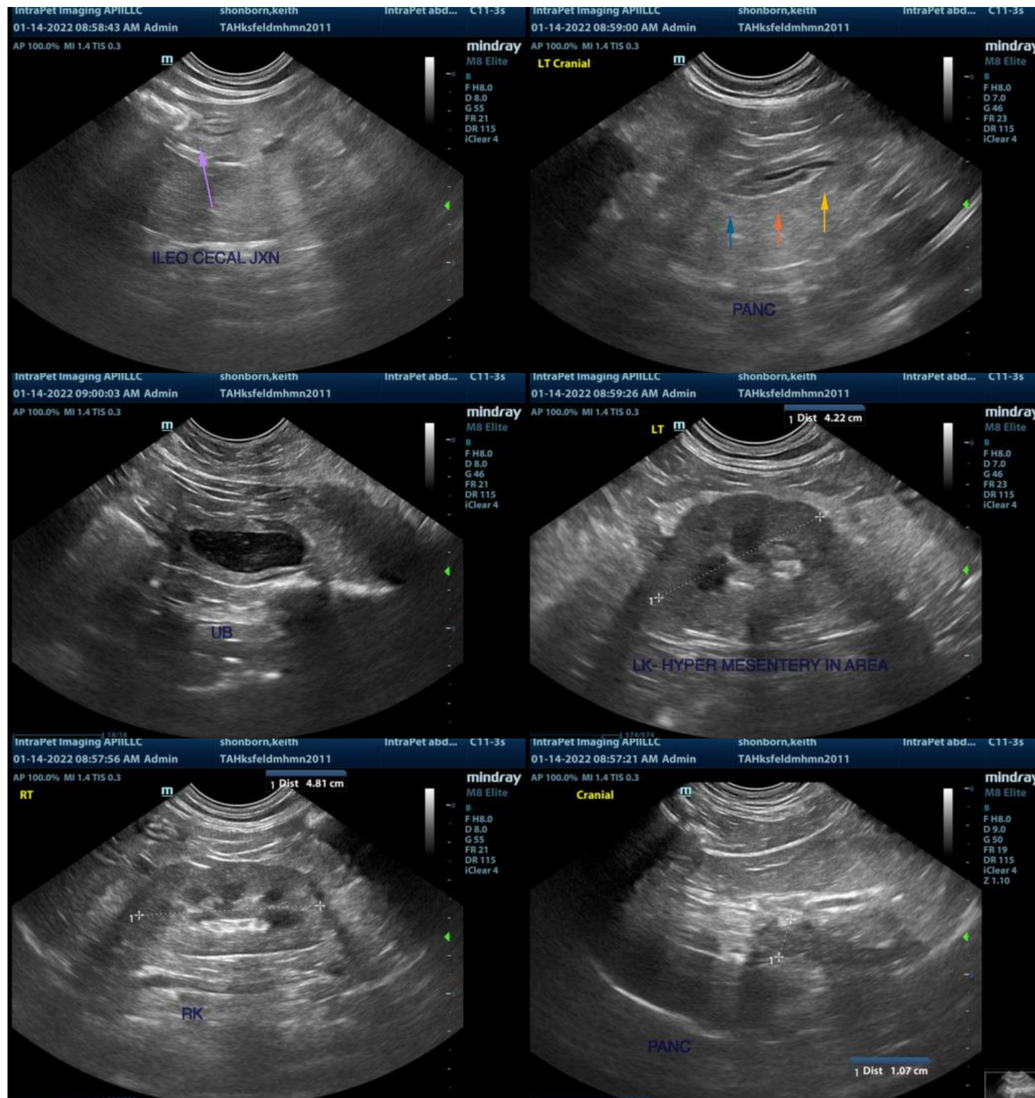
- Echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.

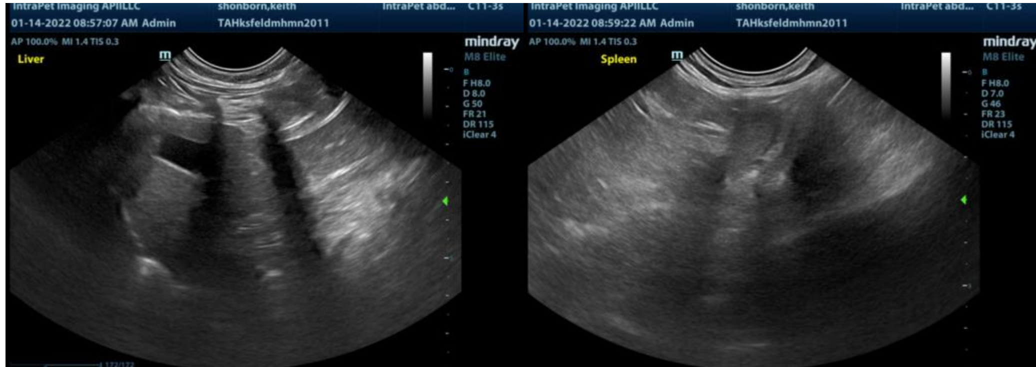
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is the impression of overall inflammatory change in the cranial abdomen. This seems to be centered around the pancreas primarily with a focus of inflammation cranial to the left kidney near the left limb of

the pancreas. Additionally, both kidneys are somewhat irregular with decreased corticomedullary distinction and there is pyelectasia in the left kidney. I recommended urine culture and sensitivity both due to the pyelectasia and due to the echogenic debris visualized in the urinary bladder.

No focal bowel lesions are observed to explain the chronic diarrhea. Sometimes it can be difficult to interpret diagnostics on pets on steroids for their disease, as this can suppress some of the typical lesions. Primary concern would be either transformation of the IBD (if diagnosed based off of biopsies) to lymphoma or just worsening of the IBD itself. Additionally, you can have concurrent illness, such as dysbiosis, developing pancreatitis, exocrine pancreatic insufficiency, etc. It does appear that there is some degree of pancreatitis going on, so continued symptomatic therapy with pain medication, antinausea medications, ensuring adequate hydration, etc., is warranted. If this pet is not already on a hydrolyzed protein or novel protein diet, this should be strongly considered. If symptoms persist, I would recommended considering repeat endoscopic biopsies to try and determine what the status of the GI disease is at this point.





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