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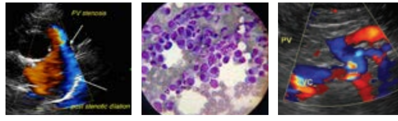

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE
1/25/23

PATIENT
Gus Gus Dement

SPECIES
Feline

BREED
DMH

SEX
Neutered Male

AGE
11/8/10

WEIGHT
8.94 Pounds

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

HOSPITAL NAME
Frederick Road VH

REFERRING VET
Dr. Beyer

INVOICE
44485

PRESENTING CLINICAL SIGNS

Weight loss (has been slowly losing weight since 2018 (was 13.2 lbs that time), ravenous appetite- begging for canned food; increased energy level; persistently elevated Ca. Tried Hills w/d in past for hypercalcemia pet wouldn't eat it well and owner went back to previous diet (since other cat eats it and is easier for her) eating RC limited ingredient rabbit and pea; presented 12/8/2022 for not eating and ADR, hiding
bw to IDEXX

Current Medications: None.
Lab Results: 12/8/22: **this is the first time Free T4 elevated since losing weight** T4 4.7 ug/dL 0.8 - 4.7. FREE T4 (ng/dL) 3.4 ng/dL 0.7 - 2.6, FREE T4 (pmol/L) 43.8 pmol/L 9.0 - 33.5, SDMA 13 ug/dL 0 – 14, CREA 1.3 mg/dL 0.9 - 2.3, BUN/UREA 26 mg/dL 16 – 37, PHOS 6.4 mg/dL 2.9 - 6.3, Ca 12.4 mg/dL 8.2 - 11.2. URINALYSIS: SP GRAVITY 1.055, WBC UAM 10-15 HPF 0 – 5, RBC UAM 30-50 HPF, BACTERIA NONE SEEN

-in-house urine culture NEGATIVE/no growth, FeLV/FIV negative
SPEC fPL 17.0 ug/L 0.0 - 3.5. did have elevated P last time bw checked (now wnl) (1/16/2023) Ca 12.3 mg/dL 8.2 - 11.2. FREE T4 (ng/dL) 3.0 ng/dL 0.7 - 2.6, FREE T4 (pmol/L) 38.6 pmol/L 9.0 - 33.5, T4 4.2 ug/dL 0.8 - 4.7, SDMA 12 ug/dL 0 – 14, CREA 1.2 mg/dL 0.9 - 2.3, BUN/UREA 26 mg/dL 16 – 37; have NOT done Gi panel
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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, or masses. In the dependent portion of the urinary bladder, there is a very small amount of hyperechoic dependent debris, most consistent with sandy debris.

The left kidney has a normal shape and size (4.28 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (4.35 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 0.40 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 0.48 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 (1.0 cm), 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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal
The stomach contains minimal luminal contents. The majority of the wall measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. In these areas, the distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. In the region of the pylorus and proximal duodenum, the wall appears somewhat thickened with decreased detail of wall layering. In this region, the wall measures up to 0.64 cm. Another measurement is 0.40 cm.

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 measures 0.23 cm. Duodenum wall measures 0.33 cm. Visualized peristalsis appears appropriate. The region of the proximal duodenum/pylorus appears somewhat thickened with reduced detail of wall layering. In this region, the duodenal wall varies from 0.40-0.64 cm in thickness.

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 prominent and mottled compared to the surrounding isoechoic 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, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Diffusely prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

- Prominent pyloric region of the stomach with some wall thickening and reduced detail of wall layering – Findings could be consistent with edema, gastritis, or infiltrative disease (round cell neoplasia, carcinoma, etc.).

SECONDARY FINDINGS

- Small amount of sandy debris in the dependent portion of the urinary bladder – The echogenic

debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

- Decreased corticomedullary distinction in the kidneys – The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

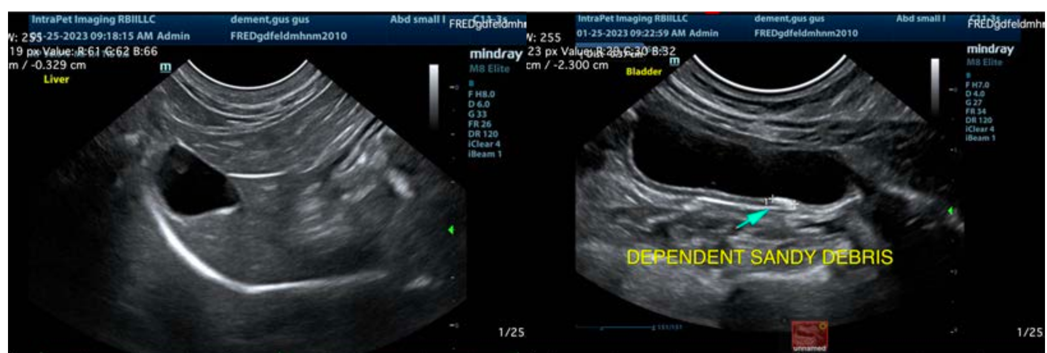
The pyloric region of the stomach appears somewhat prominent on today's study with some thickening and reduced detail of wall layering. Typically, you would expect a history of vomiting in this situation, so the significance of this thickening is unclear. You could consider a fine needle aspirate of the thickened area of pyloric wall to try and look for any evidence of round cell neoplasia.

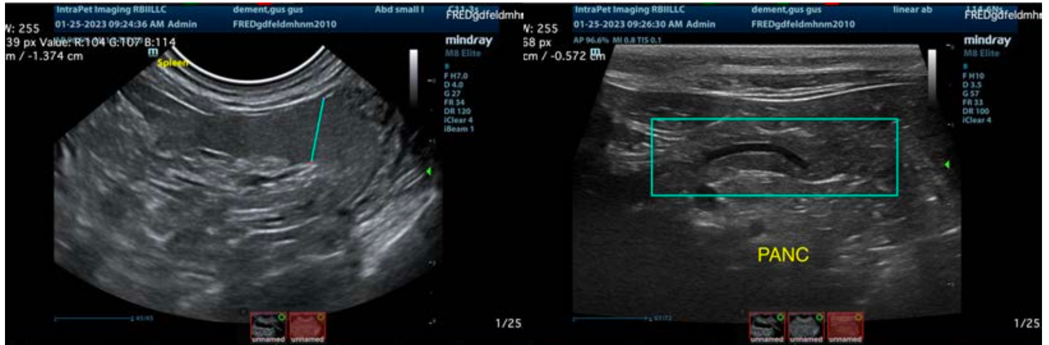
Additionally, the pancreas is diffusely prominent and hypoechoic. The surrounding inflammation is somewhat minimal, so these changes could be consistent with chronic mild pancreatitis or previous episodes of pancreatitis. Correlate these findings with quantitative fPLI level. Consider symptomatic treatment for pancreatitis.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

The changes observed in the kidneys are most consistent with age related progressive renal changes. Consider a blood pressure, urinalysis and culture as a baseline. Additionally, there is some sandy debris in the urinary bladder. A urinalysis and culture could be considered.

Additionally, because of the concerns for malabsorptive disease, you could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, looking for evidence of exocrine pancreatic insufficiency, B12 deficiency, etc. Additionally, you could consider a novel protein or hydrolyzed protein prescription diet. If symptoms are persistent and you are unable to obtain a cytologic sample of the thickened area of pylorus, then GI biopsies may need to be considered (likely surgical would be necessary). Additionally, you could consider reimaging to see if lesions have progressed.





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FREDgdfeldmhnm2010
mindray
Spleen
1/25
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PANC
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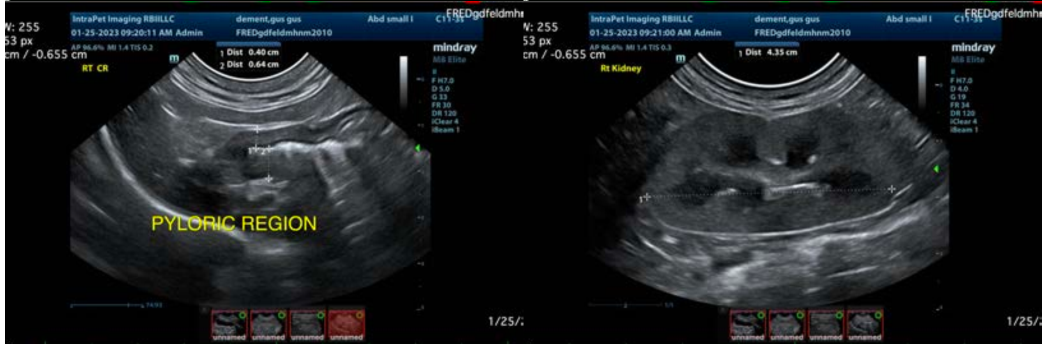

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FREDgdfeldmhnm2010
1 Dist 0.40 cm
2 Dist 0.64 cm
mindray
RT CR
PYLORIC REGION
IntraPet Imaging RBIILLC
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1 Dist 4.35 cm
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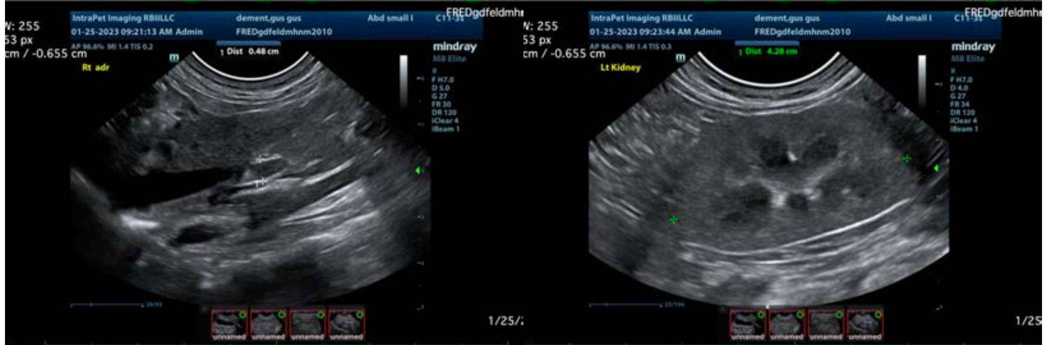
Rt Kidney



IntraPet Imaging RBIILLC
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FREDgdfeldmhnm2010
1 Dist 0.48 cm
mindray
Rt adr
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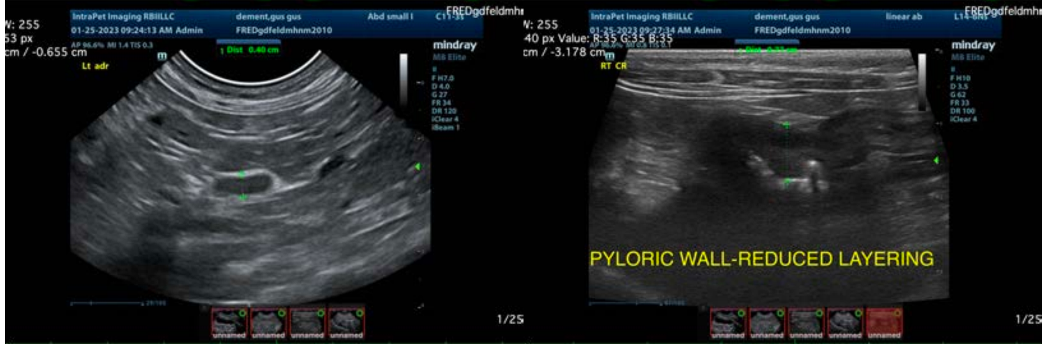
1 Dist 4.28 cm
mindray
Lt Kidney



IntraPet Imaging RBIILLC
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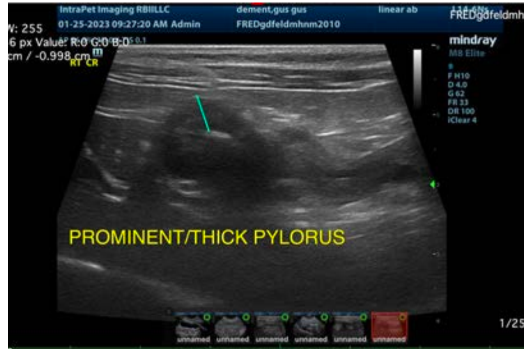
01-25-2023 09:24:13 AM Admin
FREDgdfeldmhnm2010
1 Dist 0.40 cm
mindray
Lt adr
1/25
IntraPet Imaging RBIILLC
dement,gus gus
FREDgdfeldmhnm2010
mindray
RT CR
PYLORIC WALL-REDUCED LAYERING



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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com