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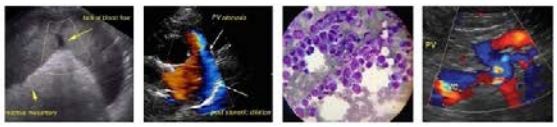


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Vince Rode

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

13 Years

WEIGHT

4.05 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Haldimand AH

REFERRING VET

Dr. Rode

INVOICE

44631

DATE

1/31/23

PRESENTING CLINICAL SIGNS

History of Eosinophilic granuloma complex, lesions as a kitten and young adult. Neg FELV/FIV tested multiple times as a young cat. Chronic vomiting of food and hairballs almost daily for the past several weeks. Dec 22/Jan 23 visible thinning of pinnae, hind end, tailcoat. Not obviously itchy. Intermittent diarrhea which resolved with diet change and Fortiflora. Decreased appetite for 2 to 3 weeks. Offering anything he will eat at this point. No interest in any dry food. Will not eat the hypo diets that have been offered. Weight changes and fluctuations - highest was May 2021 at 4.8kg. History of URTI or tooth root infection which resolved with Clavaseptin. No palpable masses but intestines feel ropey. Has been on Gabapentin.

Abnormal PE/Chem/CBC/UA Results: Barium study done showed delayed stomach emptying otherwise NSF.

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 (4.02 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 (4.23 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 0.39 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.

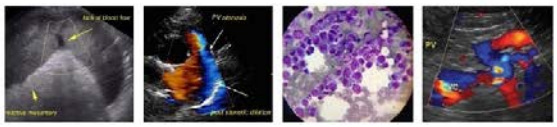
The right adrenal gland is normal in size measuring 0.34 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.97 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.



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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 mild fluid. 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 measures 0.24 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

There is a scant amount of free abdominal fluid. There are occasional prominent mesenteric lymph nodes, examples measure 0.40 cm and 0.34 cm. The omentum is generally of normal echogenicity.

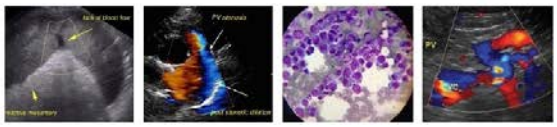
ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Prominent muscularis layer to the small intestine – The small intestinal wall changes could be consistent with an underlying inflammatory process. These types of changes can sometimes be seen in normal older cats. Correlate with clinical signs.
- 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

No focal lesions are visualized to explain the chronic vomiting and inappetence reported. Many of changes observed could be considered normal in an older cat, but given the clinical symptoms, I do feel that the small intestine appears somewhat “ropey”, and there are occasional interspersed prominent mesenteric lymph nodes. These findings could be point to underlying gastrointestinal disease, but close continued monitoring is warranted, as complete anorexia is concerning and could be due to a different concurrent issue.

Consider such differentials as food allergy/dietary intolerance, GI parasitism, chronic pancreatitis, IBD and less likely neoplasia, etc.. .



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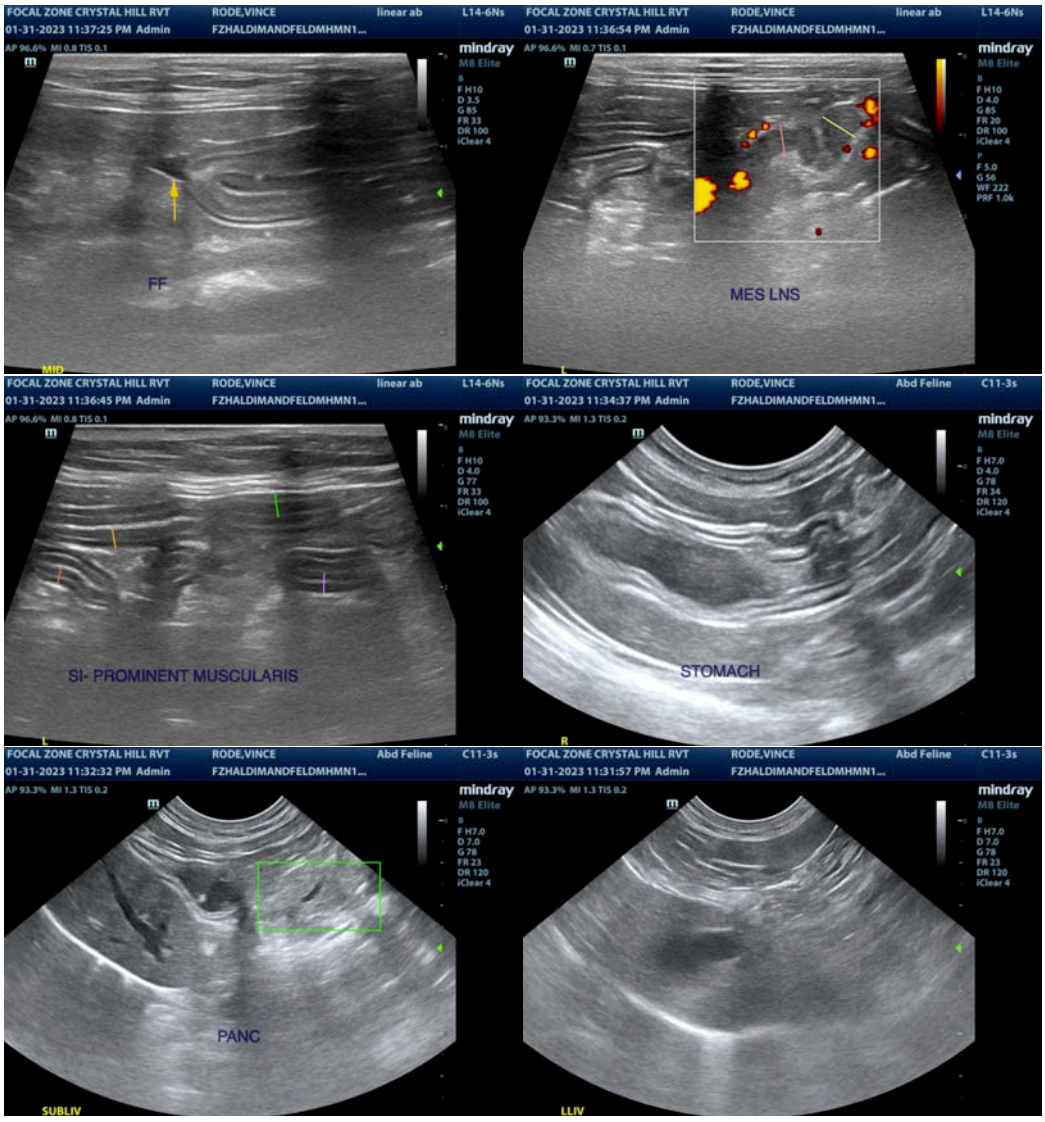
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

I know these recommendations are challenging for a patient that is not eating at all. Consider in-hospital symptomatic treatment for acute gastroenteritis/pancreatitis despite the relatively abnormal appearing pancreas on today's exam and recommend continued monitoring for any concerns about ingested foreign material, etc., as this cannot always be visualized on ultrasound. If symptoms persist and underlying GI disease seems likely, consider obtaining GI biopsies. A feeding tube may need to be considered fi the patient's appetite does not improve shortly.



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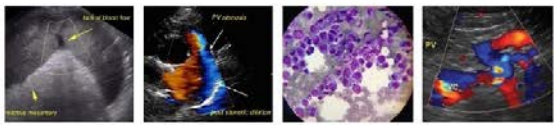

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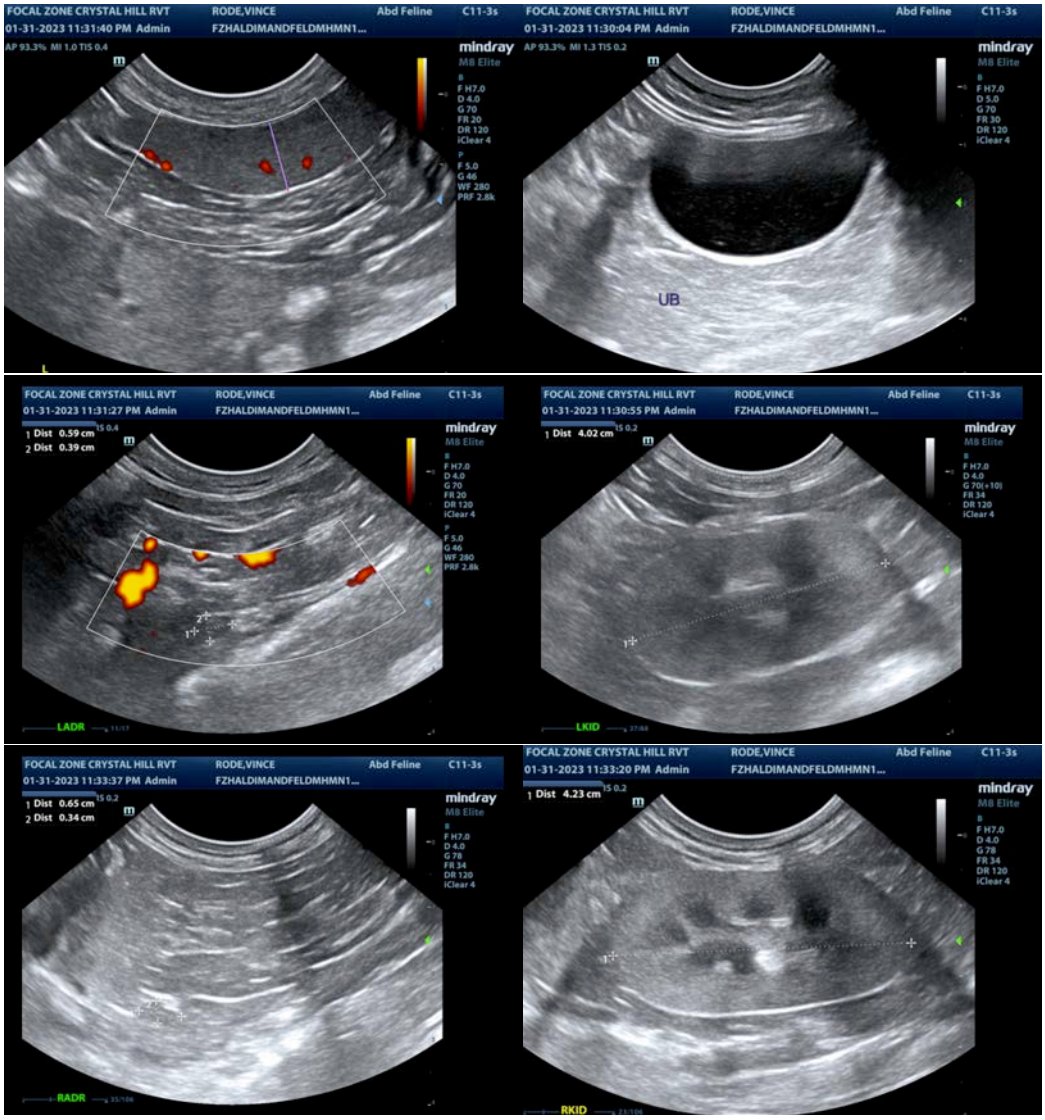

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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