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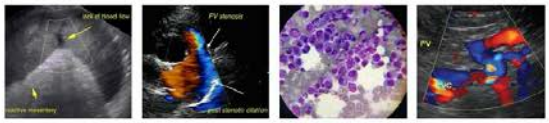

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Pounce Lawrence

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

12 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Brighton Greens VH

REFERRING VET

Dr. Robin Janeway

INVOICE

34013

DATE

1/5/22

PRESENTING CLINICAL SIGNS

Vomiting, gas noted on palpation, Blood panel 11/16/21- PSL 29, mild thrombocytopenia but clumping. 11/16/21 Radiographic Findings Images of the abdomen. There is gas identified within the stomach which is mildly enlarged. Liver size and kidney size appear normal. There is a gas pattern within the small intestine which does not appear to be distended. The urinary bladder is moderately enlarged. Conclusion The gas pattern within the stomach and small intestine is excessive and likely inflammatory without distinct evidence of gastrointestinal obstruction. Ascites is not noted. The urinary bladder is enlarged without evidence of visible calculi Eric Herrgesell, DVM, DACVR

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 (3.9 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 (3.74 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 0.36 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 0.44 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 (0.85 cm in width at the level of the hilus), 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.

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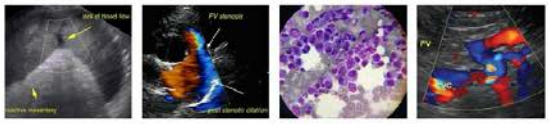

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Gastrointestinal

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. Duodenum wall measured 0.38 cm. Jejunum wall measured 0.30 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 present with mesenteric lymph nodes clustered, measuring 0.78, 0.64, 0.66 cm. The omentum is of increased echogenicity around the prominent lymph nodes.

Other

A brief view of the heart was submitted. No pericardial effusion was seen.

ULTRASONOGRAPHIC FINDINGS

- Diffusely thickened small intestine with very prominent muscularis layer – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.
- Mild to moderate mesenteric lymph node enlargement – Changes are most likely inflammatory, but neoplasia cannot be excluded as a possibility.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small bowel appears prominent and thickened with a very prominent muscularis layer. These changes are most consistent with inflammatory disease, although an underlying neoplastic process cannot be ruled out. Biopsies of the GI tract and lymph nodes would be necessary to obtain a definitive diagnosis.

- Consider a novel protein/hydrolyzed protein diet.
- It is possible that the gas seen on radiographs is due to either aerophagia or hypomotility. You could consider a Metoclopramide trial to see if it helps.
- Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to look for evidence of dysbiosis, B12 deficiency, etc.
- Recommend obtaining GI biopsies.
- Recommend 3-view thoracic radiographs to rule out concurrent intrathoracic disease.

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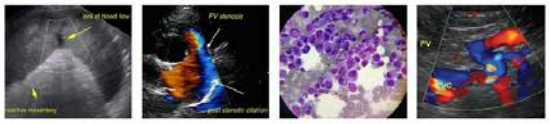

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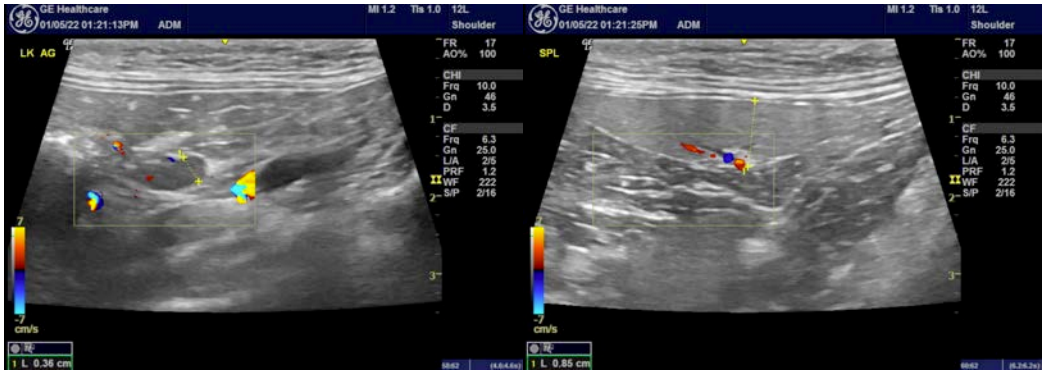

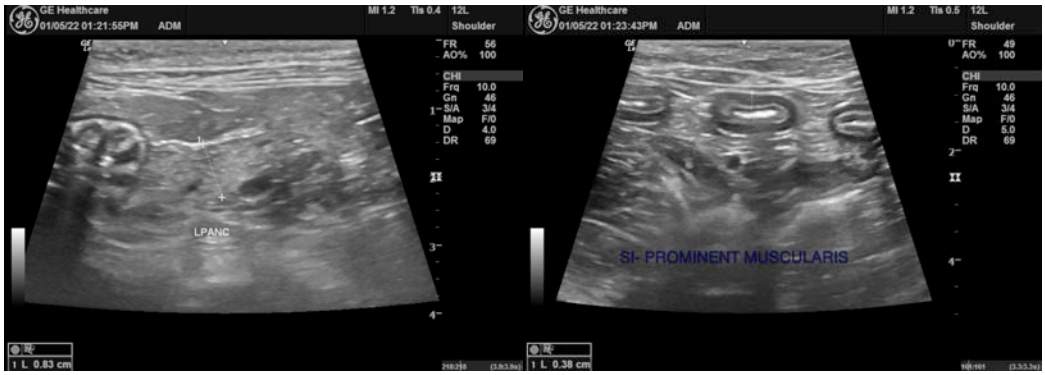

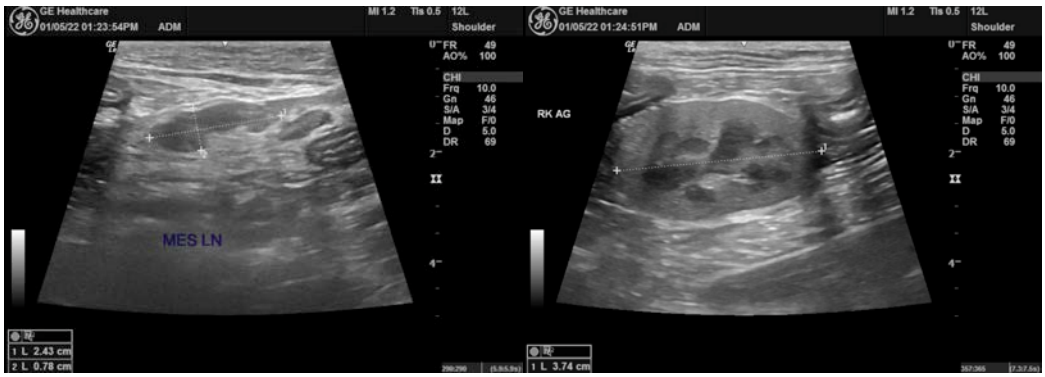

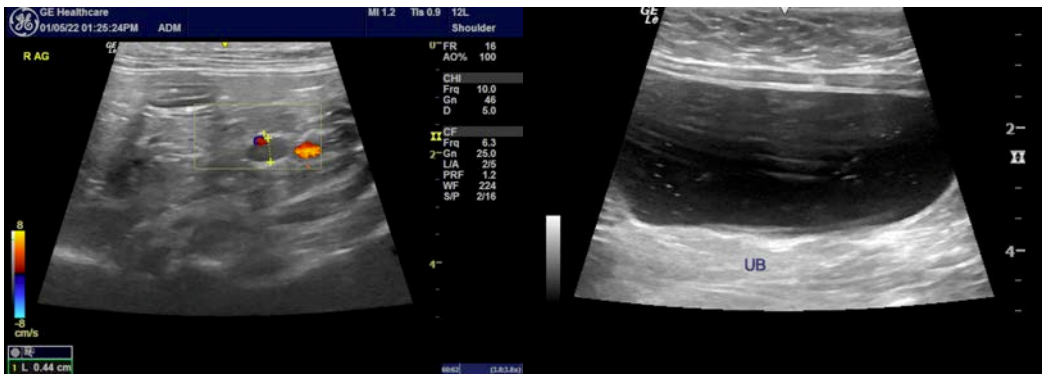

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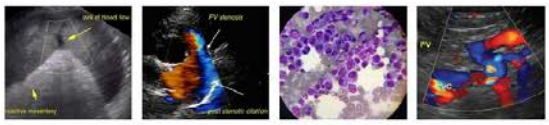

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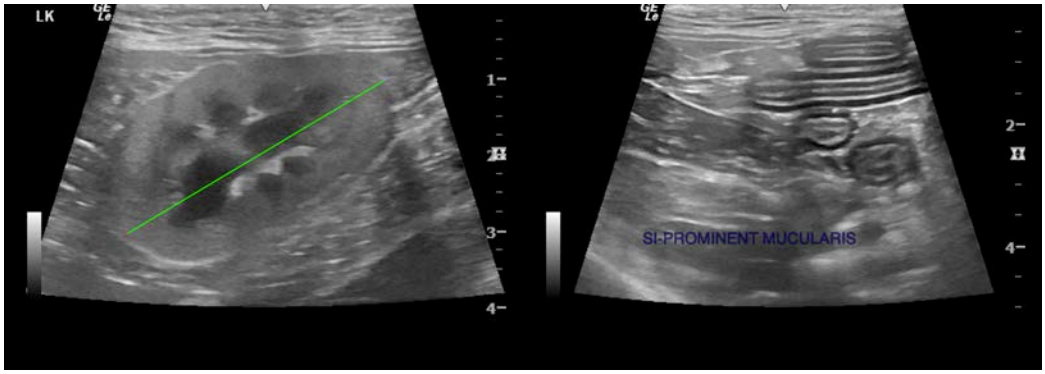

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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