

**DATE PRESENTING CLINICAL SIGNS**

10/1/21 History: Inappetence since 9/25/21 after acute vomiting. Cause for persistent vomiting (despite administration of anti-nausea medications) not apparent on radiographs, blood panel or previous abdominal ultrasound.

PATIENT

Herman Mathis Current Medications: Cerenia, Ondansetron, Famotidine, Midazolam, 1 dose Dex SP 9/29, 1 dose budesonide 1mg 9/30.

SPECIES

Feline

Lab Results: No significant abnormalities. Attached separately.

Radiographs: No significant abnormalities.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Sedation not required for scan.

Stat Report: STAT report not requested by the veterinarian.

BREED

DSH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**SEX**

Neutered Male

Urinary System

The urinary bladder is minimally 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.

AGE

9/28/07

The left 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.

WEIGHT

7.3 Pounds

The right kidney has a normal shape and size (3.57 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.

INTERPRETED BY

Kathleen Sennello DVM,
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Adrenal Glands

The left adrenal gland is normal in size measuring 0.35 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.

HOSPITAL NAME

Timonium AH

The right adrenal gland is normal in size measuring 0.46 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.

REFERRING VET

Drs. Stephens/Kauder

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.

INVOICE

26030

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 is moderately dilated with fluid and air. 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 layering 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. Jejunum wall measured 0.3 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 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.

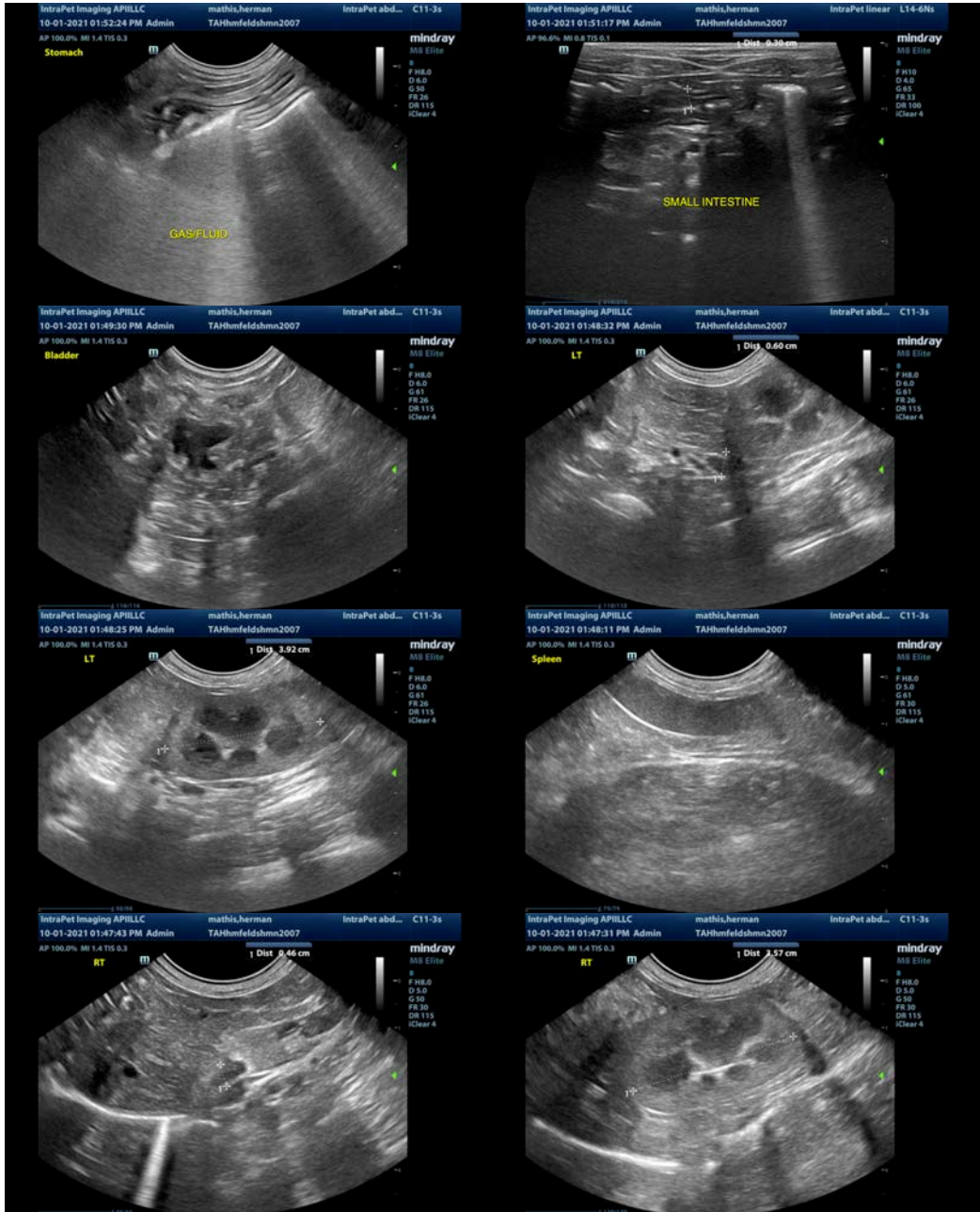
ULTRASONOGRAPHIC FINDINGS

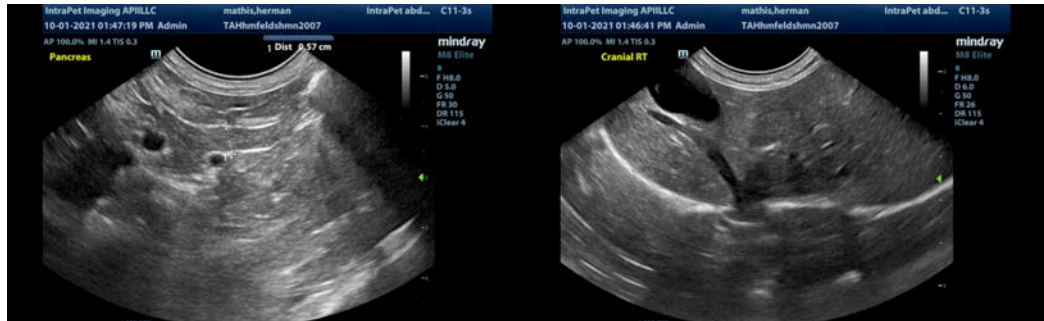
- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mildly distended stomach with primarily air and a little fluid – This makes full evaluation of the stomach and gastric contents difficult.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No significant lesions were observed on today's scan. The stomach is difficult to evaluate due to some likely aerophagia. Correlate with radiographic findings, etc. If metabolic causes have been largely ruled out (as I believe they have been), consider primary GI causes, as it is possible to have significant GI disease without significant ultrasonographic lesions.

- Consider primary GI causes such as GI parasitism, dietary indiscretion, mild pancreatitis, food allergy, IBD, and less likely intestinal neoplasia.
- If truly not eating, and vomiting for the last week approximately, it can be difficult to implement a diet trial, etc. If possible, consider novel protein/hydrolyzed prescription diet.
- Recommend a GI panel with TLI, PLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- You may need to consider either abdominal explore to obtain GI biopsies, further evaluate abdominal contents, and place a feeding tube, or endoscopy with placement of a feeding tube.
- Recommend 3-view thoracic radiographs to evaluate the esophagus and for intrathoracic disease.
- Additionally, consider other causes for anorexia such as inability to smell, stress, behavior, etc.
- If the vomiting is persistent, concern for primary GI disease is higher.





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.

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