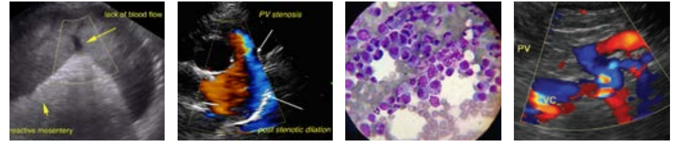
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™

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

PATIENT

Boya Hall

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

12 Years

WEIGHT

11.5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Judy Schroeder

HOSPITAL NAME

Animal Health Associates

REFERRING VET

Dr. Ashley N. Fadden

INVOICE

42155

DATE

10/18/22

PRESENTING CLINICAL SIGNS

History of vomiting hairballs. Recently vomiting has increased to every other day, sometimes with hair. Patient has thickened intestines on PE. Patient previously had diarrhea which resolved on GI Biome diet. Patient has not lost weight other than prescribed/intended. Patient has heart murmur, no evidence of LA dilation, pro BNP is normal

Abnormal PE/Chem/CBC/UA Results: Thickened intestines on palpation. Heart murmur, II/VI Spec fPL mild elevation 3.6 ug/l. USG 1.020, UPC 0.1 creatinine 2.0 mg/dl Mild neutropenia 2456/ul Normal albumin Previous anemia, resolved.

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 (3.71 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is mild corticomedullary rim sign present. 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 (3.93 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is mild corticomedullary rim sign present. 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 0.33 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 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. (See notes under other)

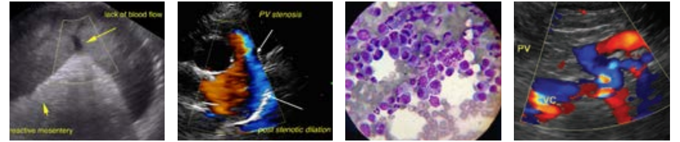
Spleen

The spleen is subjectively normal in size (0.72 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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.



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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 meaures 0.32 cm. Jejunum wall measures 0.26 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. (See notes under other)

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are prominent mesenteric lymph nodes visualized. Examples measure 0.32 cm and 0.33 cm. The omentum is generally of normal echogenicity.

Other

There is a somewhat ill-defined, focal hypoechoic structure caudal to the tail of the spleen, measuring 1.6 cm x 0.65 cm. This could represent a prominent mesenteric lymph node or an area of focal pancreatic mottling. Recommend continued monitoring.

It is challenging to definitively see the right adrenal gland in this patient. There is a structure in the area of the right adrenal gland measuring approximately 0.69 x 1.0 cm. This could represent a prominent/slightly enlarged right adrenal gland or a relatively subtle lymph node in the region. Recommend continued monitoring of this region.

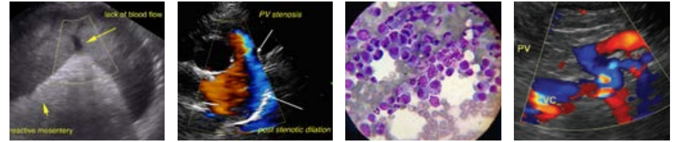
ULTRASONOGRAPHIC FINDINGS

- Corticomedullary rim sign visualized in both kidneys – Clinical significance uncertain, can be seen in normal patients and in cases of ethylene glycol toxicity, FIP, chronic interstitial nephritis, and leptospirosis.

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

- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

- 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



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seen in normal older cats. Correlate with clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

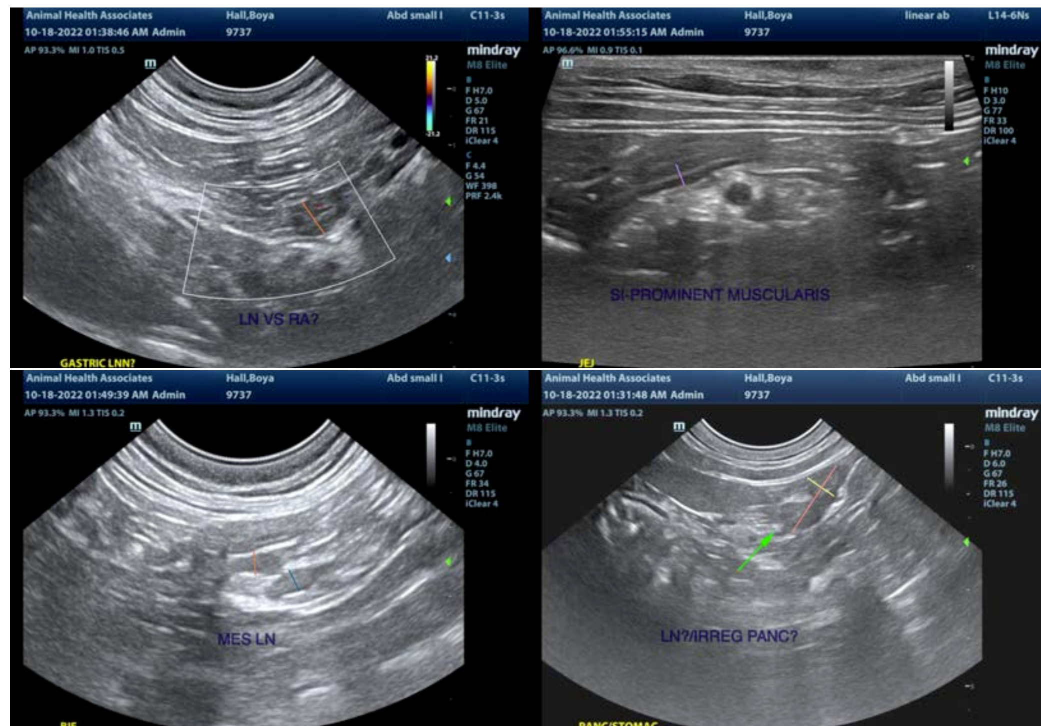
No focal GI lesions are visualized to explain the intermittent vomiting observed. Generally, the small intestine appears somewhat "ropey" with a prominent muscularis layer. This can be seen with underlying gastrointestinal disease, but also can be seen in normal older cats.

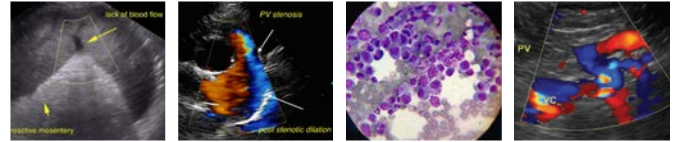
Additionally, the pancreas is somewhat prominent and mottled with minimal surrounding inflammation, making this most consistent with very mild pancreatitis or a previous episode of pancreatitis with pancreatic remodeling.

There is an irregular, somewhat ill-defined structure caudal to the tail of the spleen, which could be a lymph node, an irregular mottled area of pancreas, etc. Recommend continued monitoring of this region with ultrasound. If desired, it is a relatively superficial structure, and a fine needle aspirate could be considered.

Additionally, it is difficult to clearly see the right adrenal gland. There is a structure in this region that could represent a mildly enlarged right adrenal gland or a lymph node. Consider reevaluation of this area in 2-3 months, sooner if you have concerns.

- 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 hairball therapy.
- If symptoms persist, consider obtaining GI biopsies.





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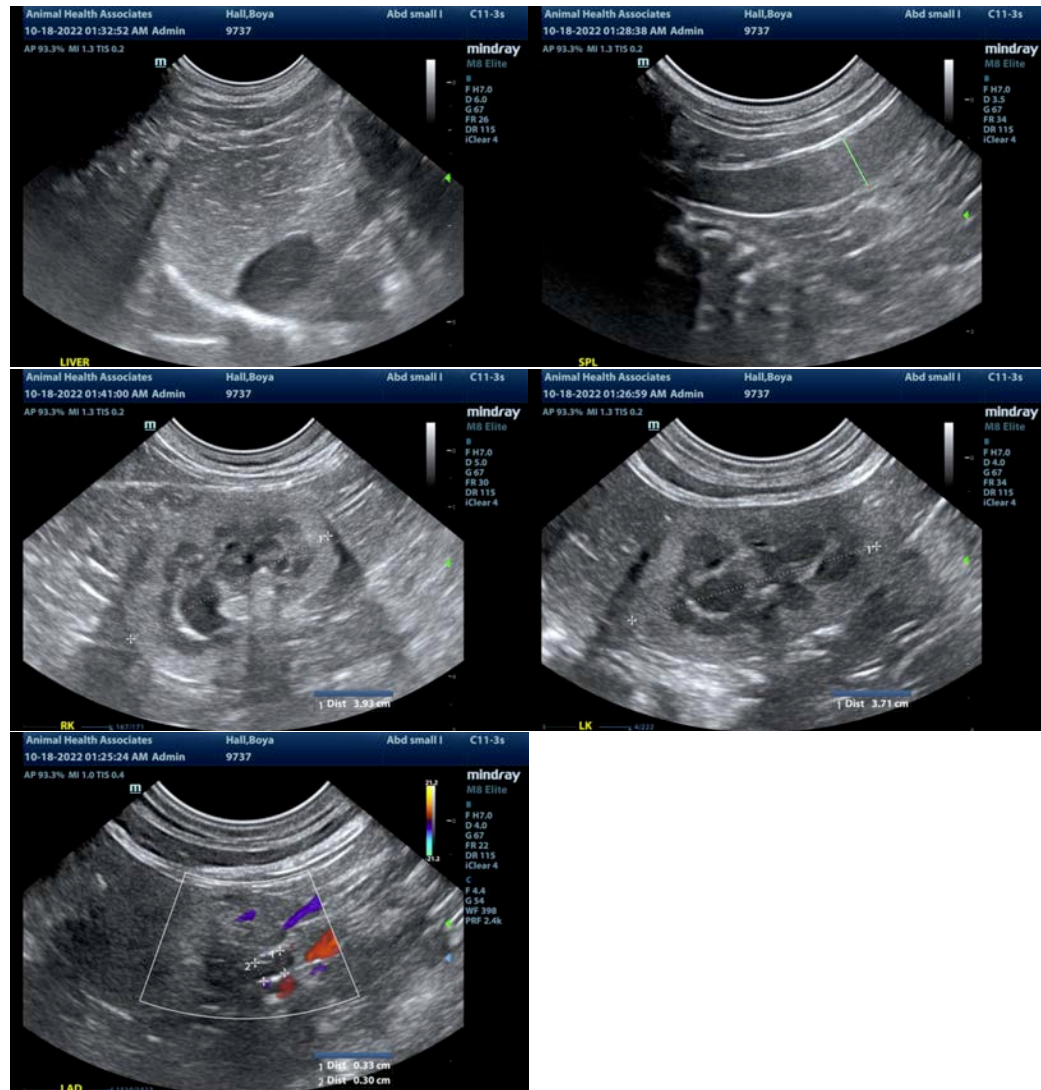

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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