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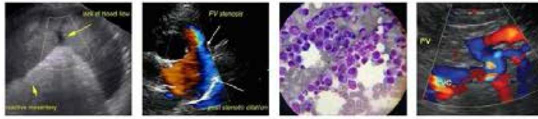


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Bubbah Bujeaux

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

5 Years

WEIGHT

3.95 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Incline Vet Hospital

REFERRING VET

Dr. Kris Moger

INVOICE

26716

DATE

10/28/21

PRESENTING CLINICAL SIGNS

Current Diet: z/d canned How much is fed daily? Any treats? 10-15 times feeding 1 can total a day. otherwise will vomit- not doing great, not feeling well.for months now diarrhea 10 minutes after he eats, racing to his litterbox. farts and gassy often. Been on prednisolone 5mg long term BID, started metronidazole recently Chronic diarrhea Chronic vomiting Fluctuating weight - downward trend r/o IBD vs GI lymphoma vs EPI vs pancreatitis vs other neoplasia vs SIBO vs infectious vs other. All teeth extracted-
Abnormal PE/Chem/CBC/UA Results: chem/cbc WNL- sent out GI panel today

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.6 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 (3.8 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.35 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.

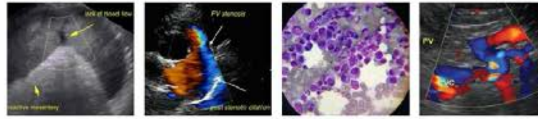
Spleen

The spleen is subjectively normal in size, 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 is hypoehoic with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. 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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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 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 0.19 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 liquid fecal material and gas shadowing distally. In the distal colon, the wall appears slightly more prominent at 0.28 cm, but maintains intact wall 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

No free fluid. Prominent mesenteric lymph nodes noted, measuring 0.32, 0.37, and 0.39 cm. The omentum is generally of normal echogenicity, but mildly increased around the ileocecal junction.

PRIMARY FINDINGS

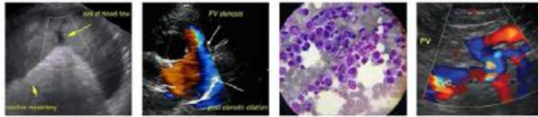
- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Hypoechoic, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The hypoechoic echogenicity favors a possible inflammatory or infiltrative process. If liver enzymes are normal, this could be within normal limits.
- Subjectively thickened colon wall – could be consistent with inflammation, infection, edema, or less likely neoplasia.
- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

SECONDARY FINDINGS

- Echogenic debris in the urinary bladder

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ultrasonographic lesions are relatively mild for such a chronic condition. Provided metabolic disease including hyperthyroidism, Addison's disease, and underlying liver disease is thought unlikely, then a primary gastrointestinal cause is considered most likely. Consider GI parasitism, mild



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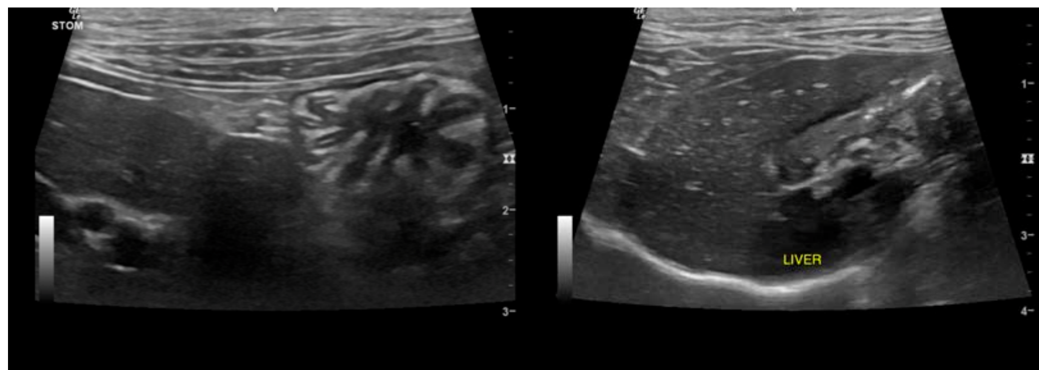
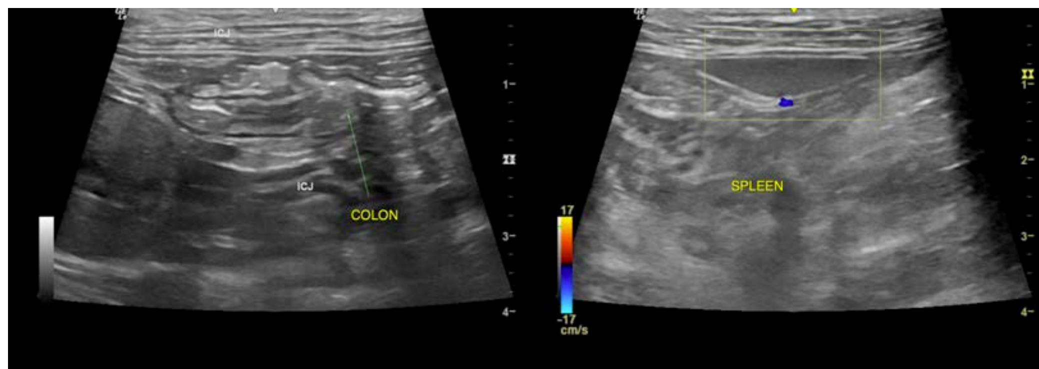
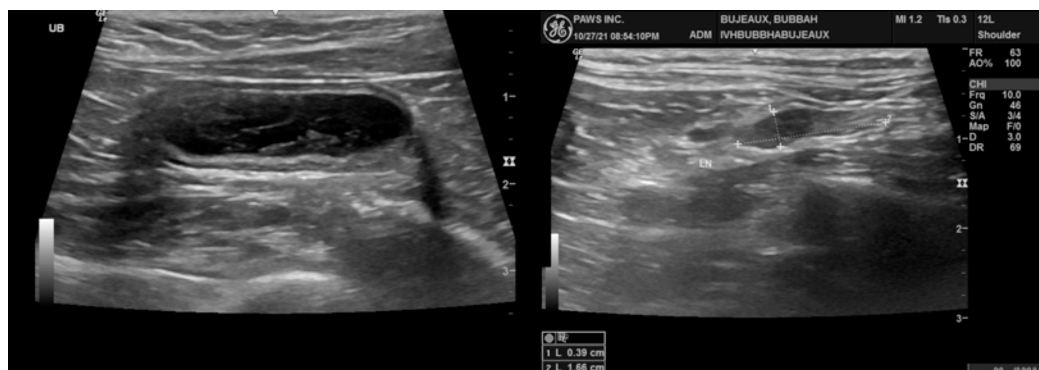
pancreatitis, bacterial dysbiosis, food allergy, IBD, and less likely intestinal neoplasia.

- Recommend empirical deworming and testing for protozoal parasites (giardia, tritrichomonas, etc).
- Recommend a GI panel to look for evidence of dysbiosis, cobalamin deficiency, and underlying pancreatitis (this is pending, which is excellent).
- If not already done, recommend a diet trial with a novel protein/hydrolyzed prescription diet.
- Recommend screening for exocrine pancreatic insufficiency (this should be on your GI panel).
- Recommend chronic probiotic therapy.
- If these steps have been takena and are not helping, recommend tapering down or off on the Prednisolone (particularly if it is not helping) and referral to a veterinary internal medicine specialist for endoscopy (likely upper and lower endoscopy).







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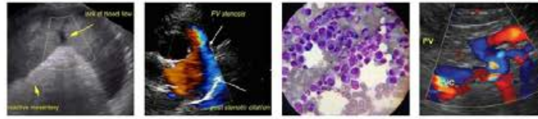

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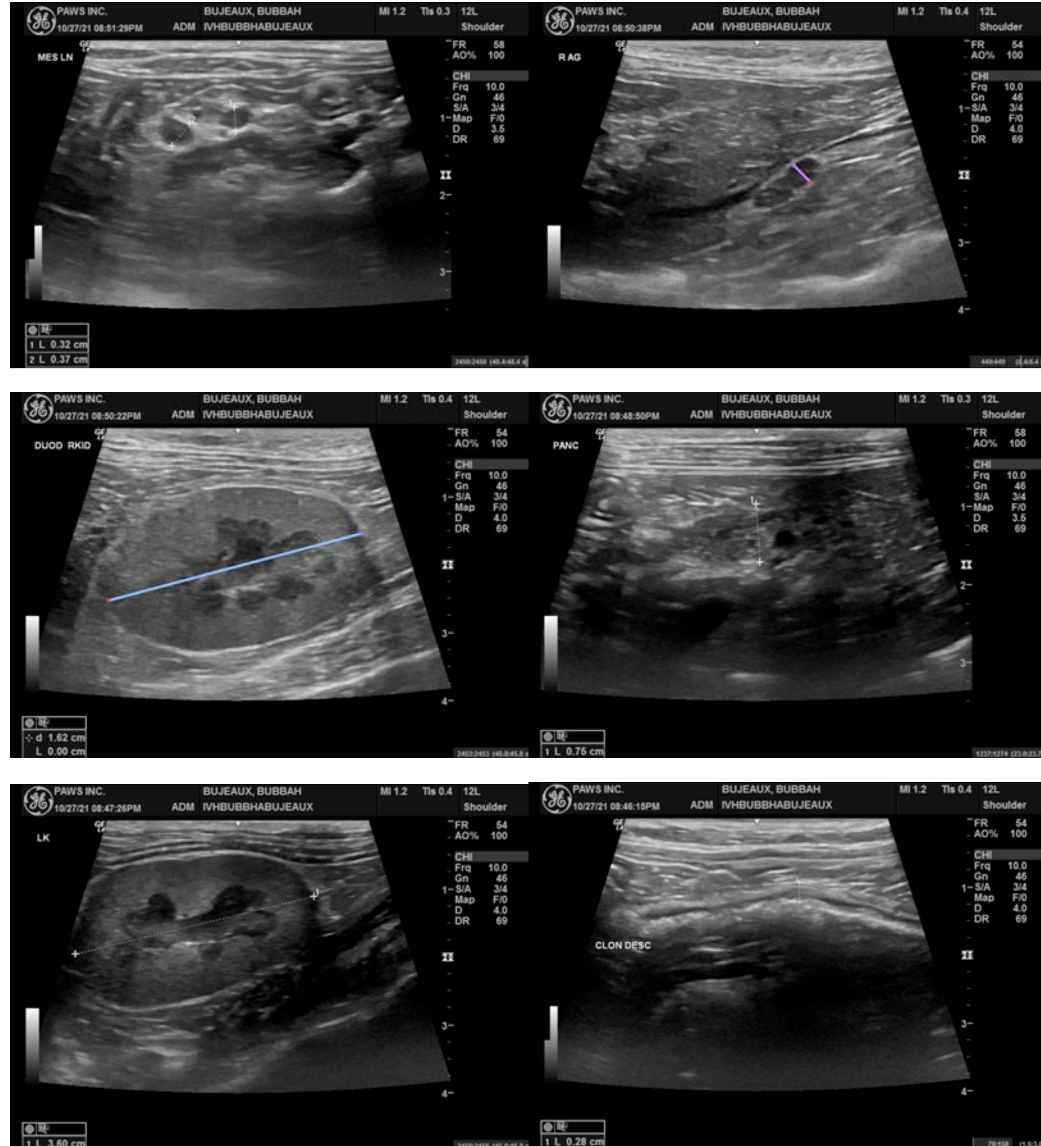

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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