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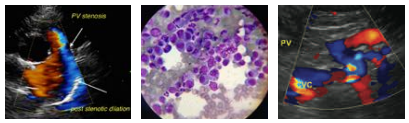

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DATE
10/27/21

PATIENT
Eddie Khalaf

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
1/1/08

WEIGHT
9 lbs

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

HOSPITAL NAME
Mount Airy AH

REFERRING VET
Dr. Riley

INVOICE
92708

PRESENTING CLINICAL SIGNS

History: lack of appetite, chronic vomiting, weight loss, bloody diarrhea.
Current Medications: Metoclopramide 1/2 Tab PO BID, Cerenia, Convenia, Metronidazole, Proviable, Gabapentin.
Lab Results: Not provided by the veterinarian.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: not needed
Stat Report: not requested by the veterinarian.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with echogenic 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 (3.49 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 (3.71 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 0.29 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.

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 echogenicity 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. There is a 0.68 cm hyperechoic nodule with a cystic center visualized within the parenchyma. The gallbladder lumen is moderately distended. The wall of the gallbladder 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 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. The jejunum measured 0.26 cm with a severely increased muscularis layer. 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 hypoechoic as compared to the surrounding isoechoic mesentery. The pancreatic duct was prominent and measured 0.22 cm. 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 moderate mesenteric lymphadenomegaly present. The mesenteric lymph nodes measured 0.67 cm, 0.82 cm, 0.73 cm and 0.7 cm. A large, cystic sublumbar lymph node measured 1.5 cm. These lymph nodes are surrounded by hyperechoic omentum and seem to be clustered around the mesenteric root and ileocecal junction.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

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

- Subjectively thickened small intestine with very prominent muscularis layer and reduced detail of layering in some areas. The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. A reduction in the detail of wall layering favors either severe intestinal disease or neoplastic infiltration. Biopsy is recommended.

- Hypoechoic prominent pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

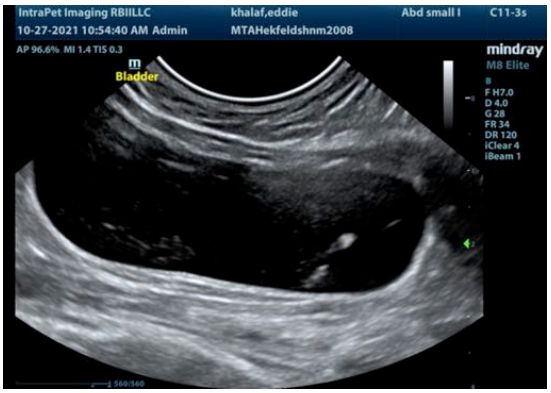
SECONDARY FINDINGS:

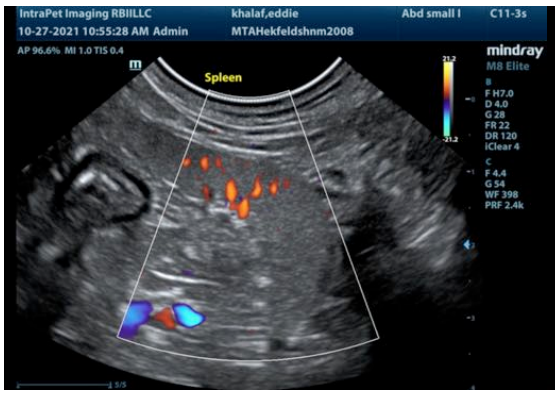
- Mildly heterogenous liver with small cystic nodule. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The small cystic nodule favors a possible benign lesion (cystadenoma?), but should be monitored with ultrasound.

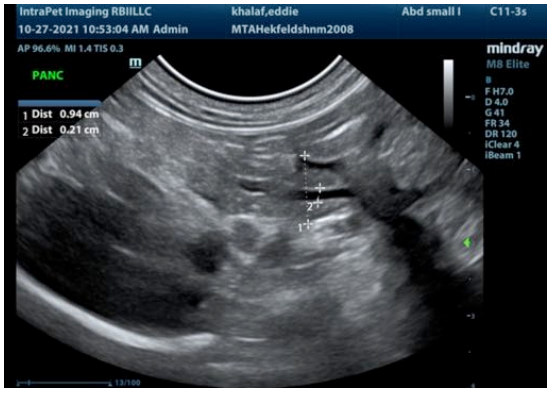
- Echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient has prominent and thickened small intestinal loops with a very prominent muscularis layer and clusters of inflamed and enlarged mesenteric lymph nodes. This is supportive of a small intestinal issue, which could be inflammatory or neoplastic in nature. Biopsy would be necessary to differentiate. You can consider a FNA of a mesenteric lymph node and GI panel to obtain further information regarding the pancreas and looking for evidence of concurrent B12 deficiency, etc. If biopsies are desired then options would include surgical biopsies, which would obtain full thickness samples and biopsy of the mesenteric lymph node could also be included or endoscopic small and large bowel endoscopy, which would not obtain the same thickness or obtain mesenteric lymph node samples, but could further evaluate the colon if that is a major concern. I recommend three view thoracic radiographs to evaluate for concurrent intrathoracic disease and full blood work to look for any metabolic abnormalities.



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khalaf,eddie
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mindray
M8 Elite
PANC
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2 Dist 0.21 cm


IntraPet Imaging RBIILLC
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linear ab
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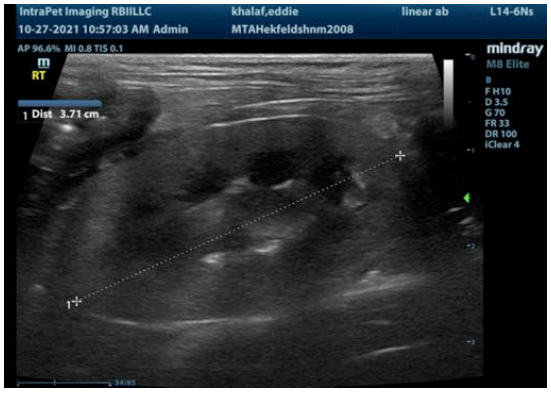
L
1 Dist 3.49 cm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linear ab
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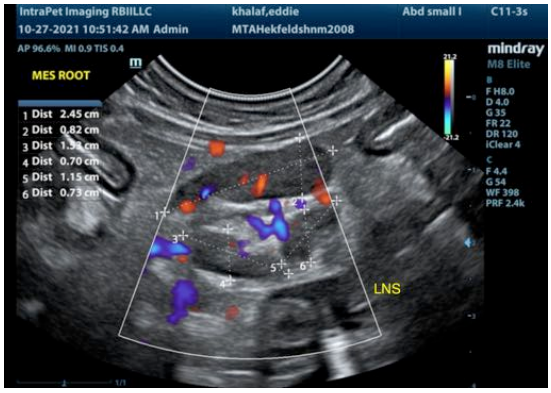
mindray
M8 Elite
RT
1 Dist 3.71 cm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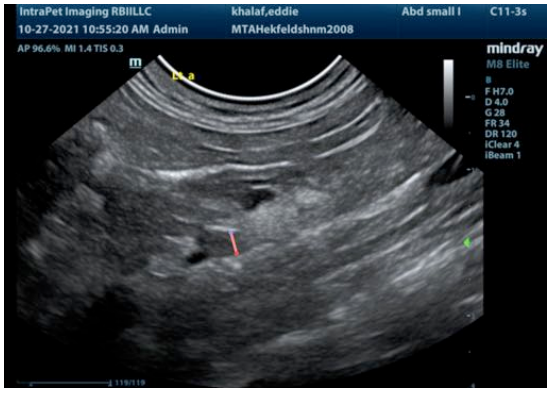
AP 96.6% MI 0.9 TIS 0.4
mindray
M8 Elite
MES ROOT
1 Dist 2.45 cm
2 Dist 0.82 cm
3 Dist 1.53 cm
4 Dist 0.70 cm
5 Dist 1.15 cm
6 Dist 0.73 cm
LNS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khalaf,eddie
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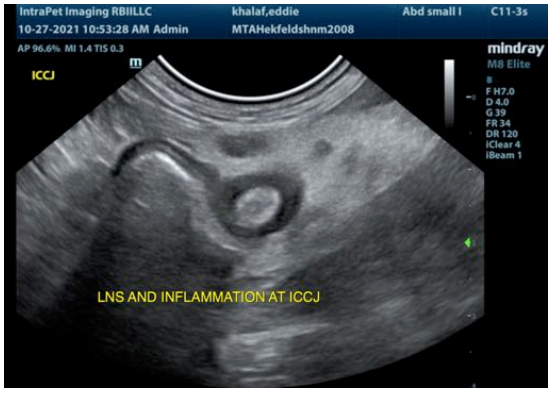
AP 96.6% MI 1.4 TIS 0.3
mindray
M8 Elite
L1-a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khalaf,eddie
Abd small I
C11-3s
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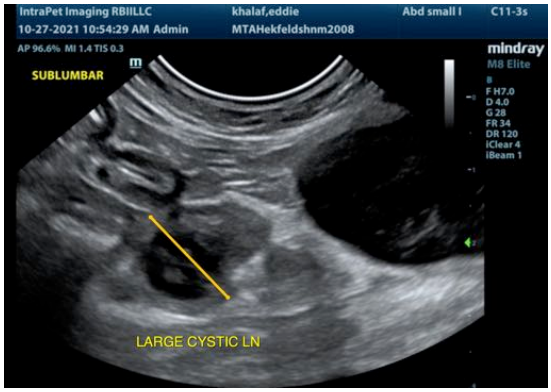
mindray
M8 Elite
ICCJ
LNS AND INFLAMMATION AT ICCJ



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)
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