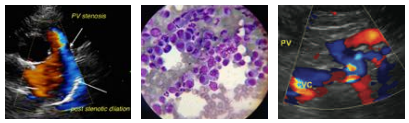
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE
10/8/21

PATIENT
Oatmeal Poley

SPECIES
Feline

BREED
Domestic Longhair

SEX
Neutered male

AGE
2013

WEIGHT
15.1 lbs

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

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Thompson

INVOICE
92275

PRESENTING CLINICAL SIGNS

Vomiting. History: Date: 10-07-2021 Notes: Oatmeal is a 7 y/o MN DLH who presents for vomiting - vomiting since 10 am approximately 10 times - food at first and progressed to clear liquid and white foam - some projectile vomiting - unable to keep food and water down - no seen to use the litterbox today - No know FB ingestion, history of FB Sx - No known toxin exposure - chronic skin condition on abdomen - indoor only - history of hairballs, was on Miralax, not currently on Medications: - none - no preventatives
Current Medications: Ampicillin 125mg/vial Injection (Per mL), Buprenorphine 0.6mg/mL, Acepromazine 10mg/mL Injection (Per mL), Pantoprazole (Protonix) 40mg/vial Injection (Per mL)
Lab Results: Attached
Radiographs: Abdomen 2 View- Stomach small, uniform gas dilation of small intestine, no overt FB seen, multifocal suspicious gas bubbles, cloth FB cannot be ruled out
Date of Previous IntraPet Ultrasound: No previous
Sedation: not needed
Stat Report: not requested

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 (4.12 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 (4.37 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 0.4 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 0.49 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 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

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 0.24 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 hypoechoic as compared to the surrounding isoechoic mesentery. The pancreatic duct is prominent at 0.21 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, 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, hypoechoic pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

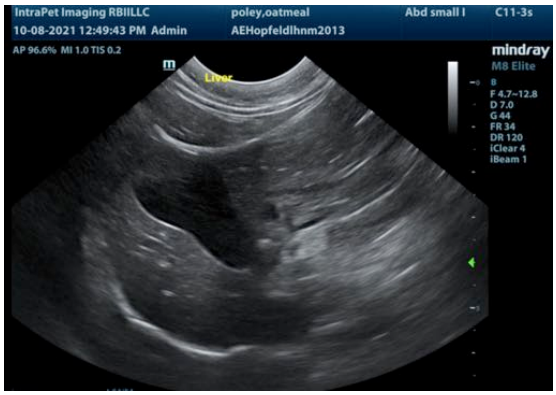
- Prominent muscularis layer to the small intestine. The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ultrasound findings are relatively mild and most consistent with mild pancreatitis with possible underlying gastrointestinal disease such as inflammatory bowel disease. I recommend ruling out metabolic causes for vomiting (including a T4 level). Additionally, many causes for vomiting cannot be diagnosed by ultrasound along including GI parasitism, dietary indiscretion, dysbiosis, food allergy, IBD and less likely neoplasia. A foreign body cannot be definitively ruled out, but none is observed.

I recommend symptomatic therapy for pancreatitis, acute gastroenteritis and close monitoring. If symptoms persist reevaluate and consider serial radiographs, recheck ultrasound or exploratory surgery to obtain GI biopsies and evaluate for foreign material. I recommend a GI panel with PLI, quantitative fPLI, TLI, cobalamin and folate to further evaluate for pancreatic and small intestinal disease.


IntraPet Imaging RBIILLC
poley,oatmeal
Abd small I
C11-3s
10-08-2021 12:49:29 PM Admin
AEHopfeldlhnm2013
AP 96.6% MI 1.1 TIS 0.2
1 Dist 0.80 cm
2 Dist 0.21 cm
Pancreas
mindray
M8 Elite
F 4.7~12.8
D 5.0
G 44
FR 43
DR 120
iClear 4
iBeam 1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poley,oatmeal
Abd small I
C11-3s
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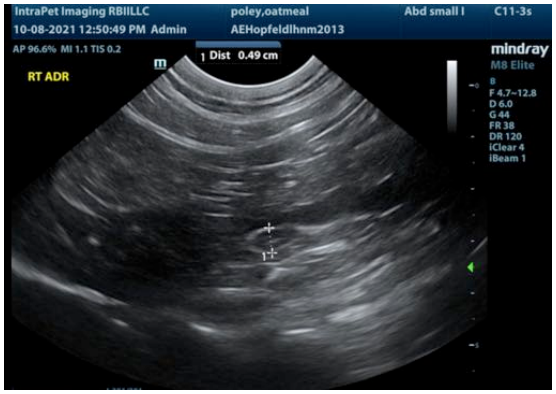
AEHopfeldlhnm2013
AP 96.6% MI 1.0 TIS 0.2
Liver
mindray
M8 Elite
F 4.7~12.8
D 7.0
G 44
FR 34
DR 120
iClear 4
iBeam 1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poley,oatmeal
Abd small I
C11-3s
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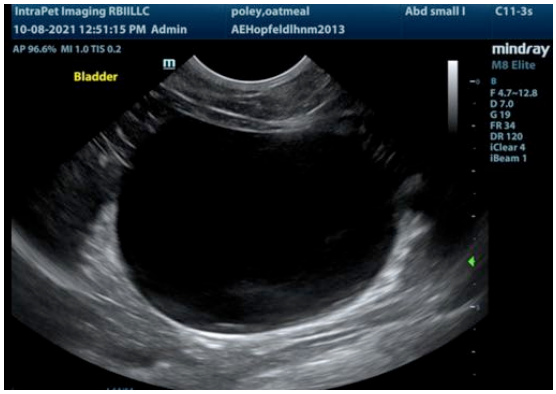
AEHopfeldlhnm2013
AP 96.6% MI 1.1 TIS 0.2
1 Dist 0.49 cm
RT ADR
mindray
M8 Elite
F 4.7~12.8
D 6.0
G 44
FR 38
DR 120
iClear 4
iBeam 1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poley,oatmeal
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Bladder
mindray
M8 Elite
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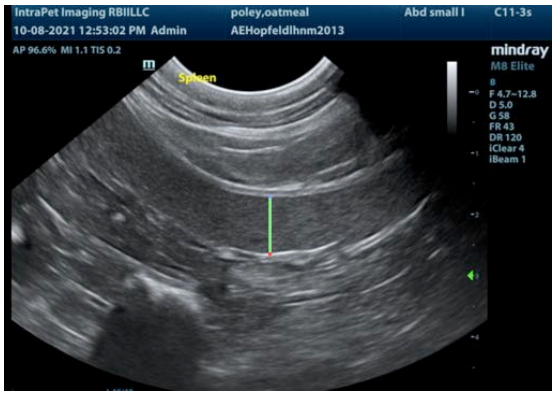
D 7.0
G 19
FR 34
DR 120
iClear 4
iBeam 1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poley,oatmeal
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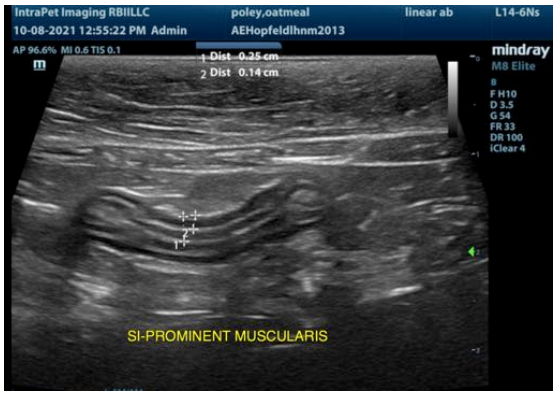
AP 96.6% MI 1.1 TIS 0.2
Spleen
mindray
M8 Elite
F 4.7~12.8
D 5.0
G 58
FR 43
DR 120
iClear 4
iBeam 1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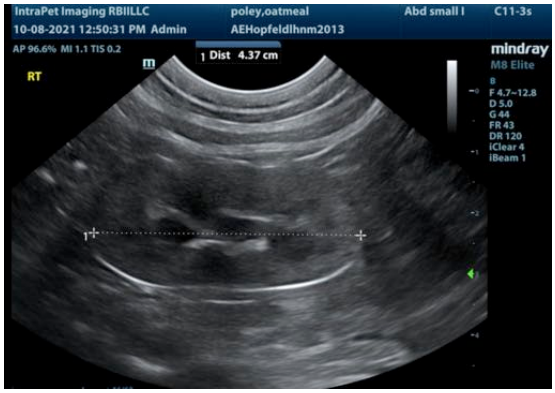
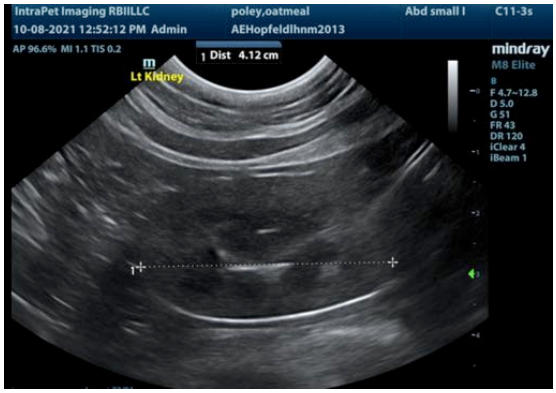
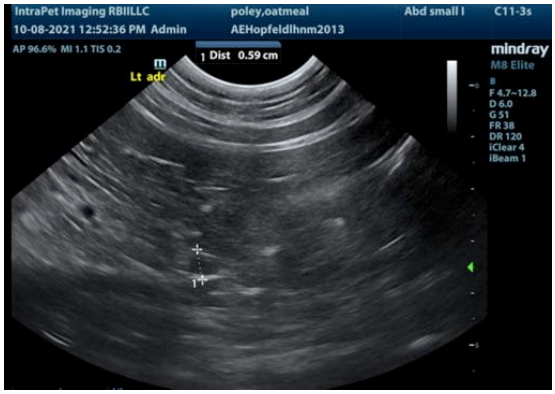
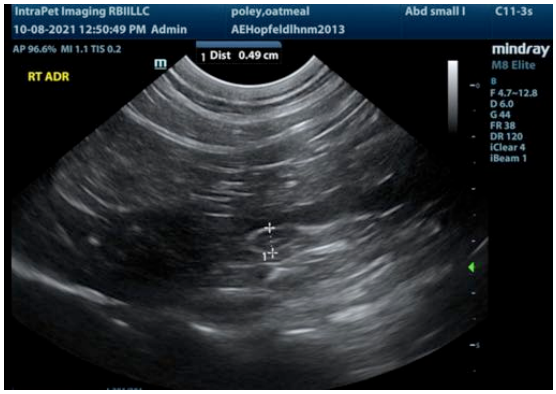
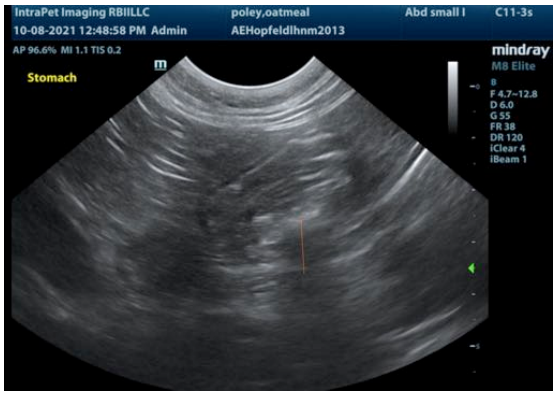
poley,oatmeal
linear ab
L14-6Ns
10-08-2021 12:55:22 PM Admin
AEHopfeldlhnm2013
AP 96.6% MI 0.6 TIS 0.1
1 Dist 0.25 cm
2 Dist 0.14 cm
SI-PROMINENT MUSCULARIS
mindray
M8 Elite
F H10
D 3.5
G 54
FR 33
DR 100
iClear 4











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