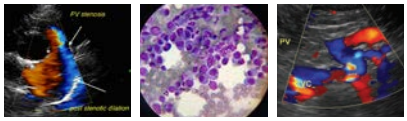
IMAGING PERFORMED BY

IntraPet.com



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DATE

11/2/22

PATIENT

Gypsy Allen

SPECIES

Feline

BREED

English Tabby

SEX

Spayed Female

AGE

1/18/17

WEIGHT

17.52 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Stephanie Warga RDCS, RVT

HOSPITAL NAME

Northwind AH

REFERRING VET

Dr. Cross

INVOICE

42496

PRESENTING CLINICAL SIGNS

P seen 10/19/22 for 3 day history of not eating and some vomiting. PE revealed tense abdomen. P started on Mirtaz paste to help appetite. P also given convenia and cerenia on 10/26/22. Admitted for IV fluids. p still not eating but is no longer vomiting. p is being syringe fed RC Recovery in slurry 12ml po every 3 hrs

Current Medications: None.
Lab Results: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 (4.09 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. 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 (4.17 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. 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 0.44 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 0.56 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 (0.65 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 mildly 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 mild and 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. The pylorus appears somewhat irregular and thickened. Some of this could be normal rugal folding, but in the cross sectional view the irregularity persists with wall layering reaching up to 0.88 cm in regions.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with moderate fluid dilation of the proximal duodenum and small intestine. 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. Jejunum wall measures 0.26 cm. Visualized peristalsis appears appropriate. There is a focal area of bowel in the mid abdomen that appears irregular, somewhat hypoechoic, with reduced detail of wall layering. In this region, wall thickness measures 0.35 cm.

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 normal and isoechoic to surrounding 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. There are prominent mesenteric lymph nodes visualized measuring 0.32 cm and 0.28 cm. Additionally, there is a hypoechoic round structure visualized in the right cranial abdomen, which has the appearance of either an enlarged lymph node or less likely a pancreatic lesion, measuring 0.91 cm. The omentum is of increased echogenicity around the abnormal bowel.

ULTRASONOGRAPHIC FINDINGS

- Echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Mildly heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Irregular, thickened pyloric wall – This could reflect irregular rugal folding, inflammation, or infiltrative disease.
- Focally thickened area of small intestine with reduced detail of wall layering – Findings are concerning for possible infiltrative disease.
- Prominent mesenteric lymph nodes and possible enlarged cranial abdominal lymph node – Differentials include inflammation, infection, or neoplastic disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

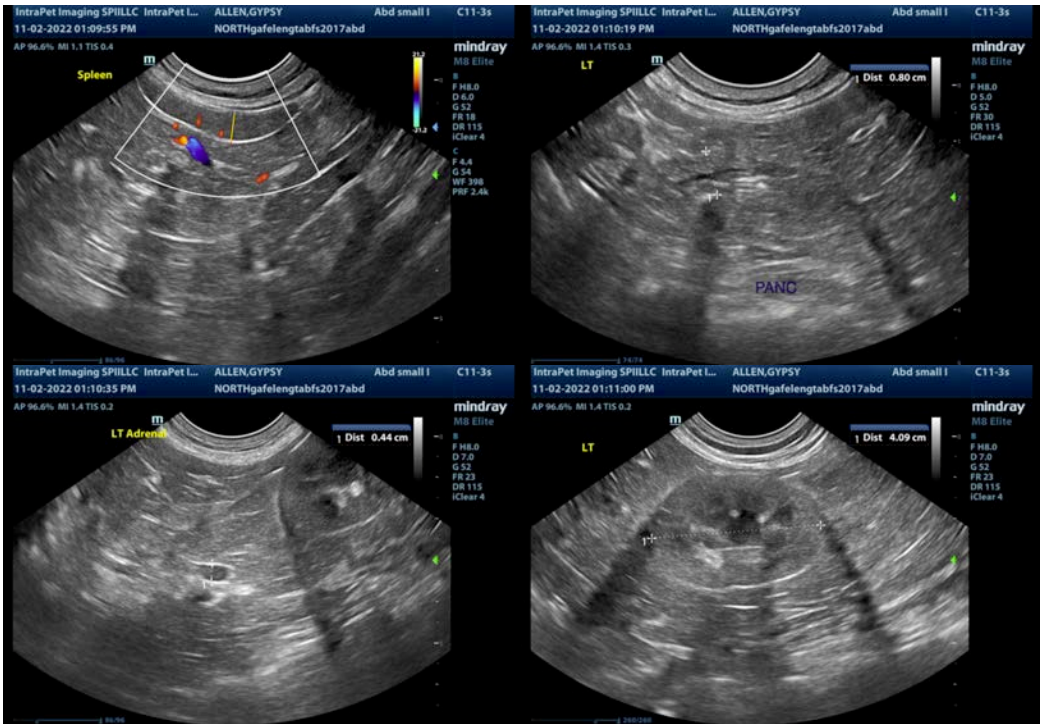
Surprisingly, the changes observed in the liver are relatively mild. Unfortunately, there are many primary hepatopathies that can elevate liver enzymes with minimal changes ultrasonographically. Consider a fine needle aspirate of the liver, provided coagulation parameters are normal.

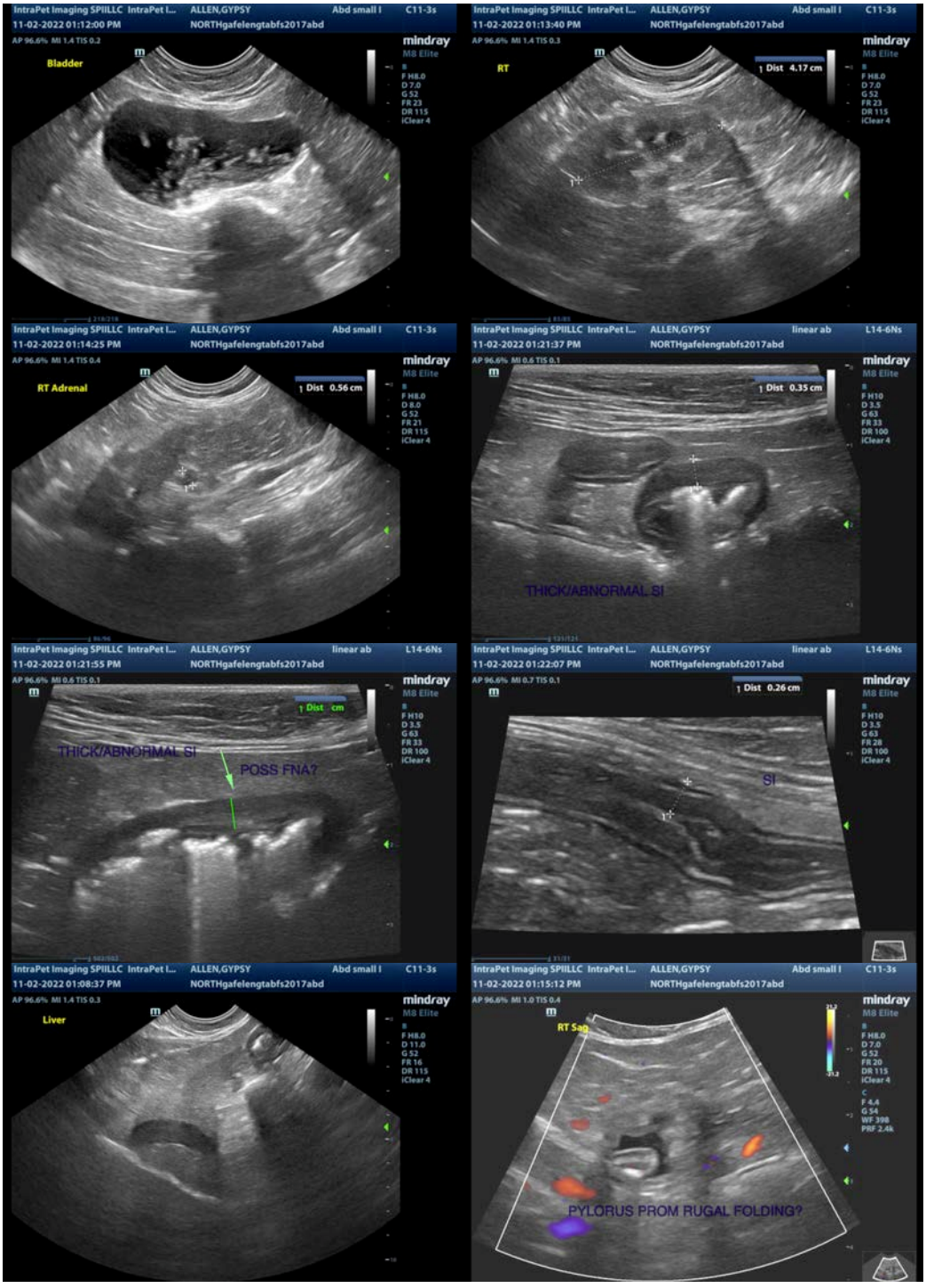
There is moderate irregularity toward the pylorus. The significance of this is unclear, as it could represent irregular rugal folding, but there is a concern that some of the irregularity could be significant. Additionally, the proximal duodenum and small intestine are fluid dilated. This could be due to the frequent liquid feedings provided in the hospital. Of more concern is a focal area of small intestine that has irregularity to the wall with thickening and reduced detail of wall layering. The appearance of this area is concerning for possible infiltrative disease, round cell neoplasia, etc. A fine needle aspirate of the bowel wall could be considered (see images).

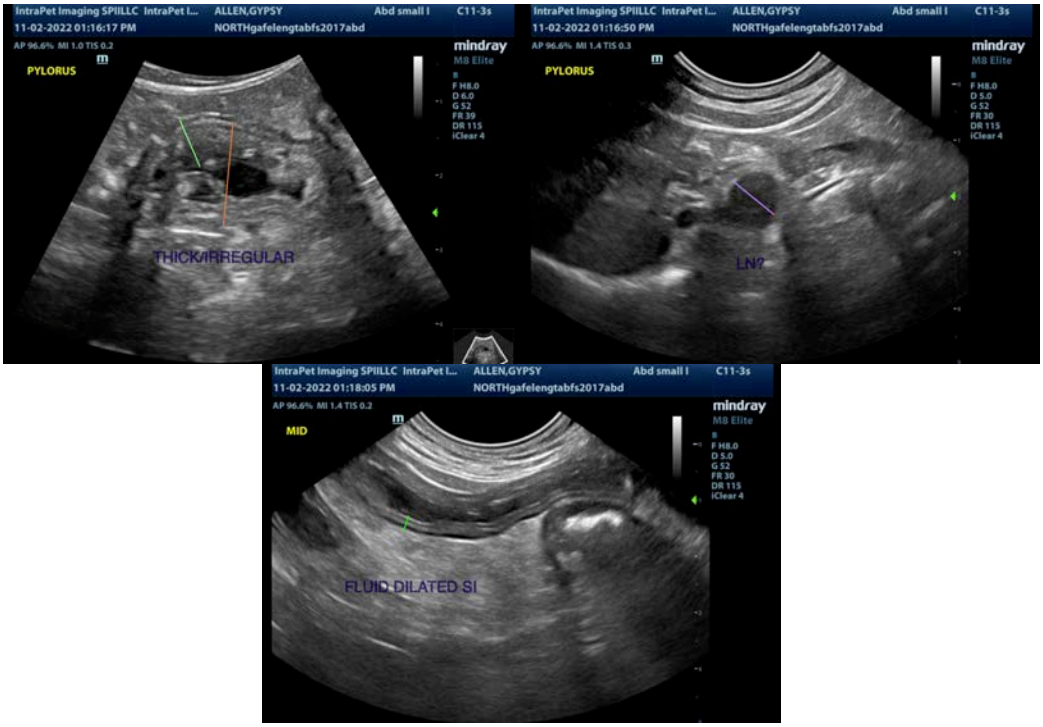
There is a diffuse mild lymphadenopathy present and a prominent hypoechoic round structure in the right cranial abdomen, which is most consistent with a lymph node, although another lesion such as a pancreatic nodule, etc. cannot be ruled out.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

If a fine needle aspirate of the liver and bowel wall does not provide a cytologic diagnosis, then consider the possibility of obtaining surgical biopsies.




Bladder
RT
Dist 4.17 cm
RT Adrenal
Dist 0.56 cm
Dist 0.35 cm
THICK/ABNORMAL SI
Dist cm
THICK/ABNORMAL SI
POSS FNA?
Dist 0.26 cm
SI
Liver
RT Sag
PYLORUS PROM RUGAL FOLDING?



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.

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