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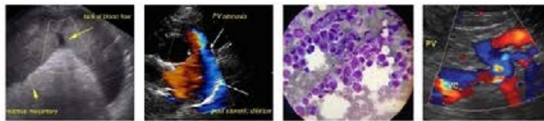


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Suzie Kress

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8 Years

WEIGHT

4.92 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Buck Animal Hospital

REFERRING VET

Dr. Yenssen

INVOICE

42930

DATE

11/22/22

PRESENTING CLINICAL SIGNS

- chronic vomiting cat, tried on hypo diet but vomiting continues - started on Pred Nov 2,2022: vomiting stopped for 5 days but then returned. not sure if it started again because we switched from tablets to liquid prednisolone. - PE is normal except for the vomiting. Only meds Prednisolone.

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 (3.47 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 (4.05 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 0.35 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 0.36 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.

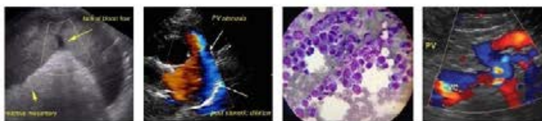
Liver

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 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. No masses or focal lesions were observed.



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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 measures 0.20 cm. Visualized peristalsis appears appropriate. There is a section of bowel visualized in the right cranial abdomen that appears to have some isoechoic mobile material within the lumen. I cannot definitively determine what area of bowel this is, as there is no obstructive pattern to accompany it. It is in the region of the duodenum.

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 is a focal area of inflammation in the right cranial abdomen in the region of the stomach/pylorus. There is a prominent lymph node in this region measuring 0.67 cm, most consistent with a gastric lymph node.

ULTRASONOGRAPHIC FINDINGS

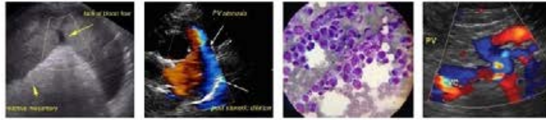
- Isoechoic intraluminal structure that is mobile and appears to be within the small bowel – Findings are concerning for intraluminal material within the small bowel. This could represent an ingesta ball, a tissue mass, etc., as this does not appear to shadow. Positionally, this appears to be in the duodenum, but I cannot confirm this. The structure measures larger than 3.22 cm x 1.99 cm. Recommend evaluation with color doppler.

- Cranial abdominal inflammation and a prominent gastric lymph node – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach appears relatively empty as does most of the small bowel, but there is an area of somewhat mobile isoechoic, non-shadowing material visualized within a bowel loop. There is no accompanying obstructive pattern. This could be consistent with soft tissue, an ingesta ball, etc. Consider discontinuing the Prednisone and either reimaging this area in 24 hours after fluid therapy and symptomatic treatment, or you could consider exploratory with the intention of obtaining GI biopsies and gastric biopsies to further investigate this area.

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



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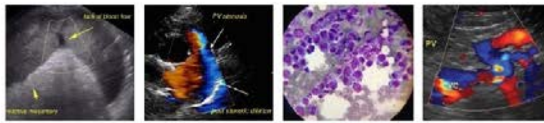

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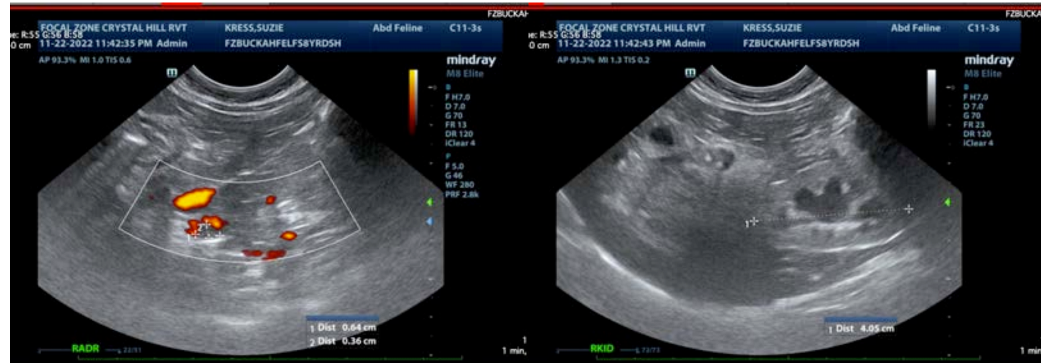

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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