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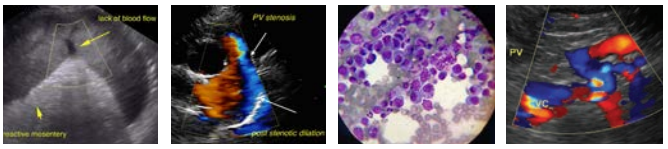

PATIENT

Taco Hogan

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

11.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sheldon

HOSPITAL NAME

Advanced PetCare of Oakland

REFERRING VET

Dr. Jill Sheldon

INVOICE

33160

DATE

12/1/21

PRESENTING CLINICAL SIGNS

Has a history of occasional vomiting(twice a month). 10/25 owner noted inappropriate urination and defecation. Was treated with some gabapentin for pain. Has been on RC hydrolyzed dry diet, and recently a few weeks ago started on canned urinary S/O(11/5). He hasn't had any inappropriate urination that the owner knows of in the last 2 weeks since starting the new canned food. Abnormal PE/Chem/CBC/UA Results: CBC/Chem/T4 : high SDMA 18 10/25 Urinalysis: SG 1.054, 3 + hematuria, 6-10 WBC/hpf, 2+ protein. 11/5 urinalysis: SG 1.052, 2 + protein, >50 struvites/hpf Urine culture: negative49

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 is normal in size and slightly rounded in shape with questionable pyelectasia at 0.46 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 (3.57 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 0.38 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 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 primarily anechoic. The cystic and common bile ducts are normal/not visible.

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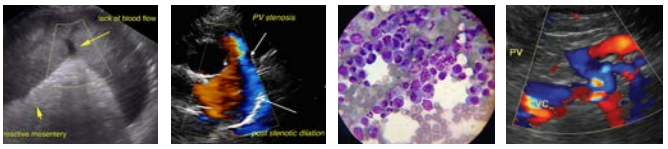

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Gastrointestinal

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 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. Jejunum wall measured 0.21, 0.29 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The area of the ileocecal junction is visualized. There is an area of proximal colon right at the ileocecal junction that appears to have loss of layering, is focal and hypoechoic. This area measures 0.26 cm in thickness. More distal sections of colon appear normal with fecal material and gas shadowing distally. There is a lymphadenopathy and hyperechoic mesentery surrounding this area.

Pancreas

The pancreas is prominent and hypoechoic as 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. Prominent pancreatic duct noted at 0.18 cm.

Free Abdomen

No free fluid. There is an enlarged lymph node visualized adjacent to the ileocecal junction, measuring 0.4 cm. The omentum appears hyperechoic in the area around the ileocecal junction.

PRIMARY FINDINGS

- Focal loss of layering and thickening of proximal bowel wall at the level of the ileocecal junction. This lesion could be consistent with inflammation, infection, or neoplasia. Sampling would be necessary to differentiate.
- Mildly 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.
- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

SECONDARY FINDINGS

- Possible pyelectasia of the left kidney – Pyelectasia of the left kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The lower urinary tract appears relatively normal. An obvious source for the hematuria is not noted. There is questionable pyelectasia of the left kidney visualized at 0.46 cm. Recommend urinalysis and culture to look for evidence of UTI or pyelonephritis. There is a focal hypoechoic area of thickened wall with loss of layering in the area of the ileocecal junction. There is an enlarged mesenteric lymph node in this area, and omental inflammation. This is suspicious for a possible very focal mass in this area.

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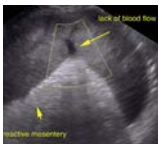
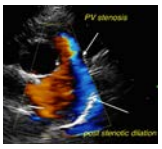
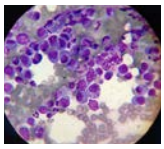
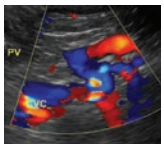

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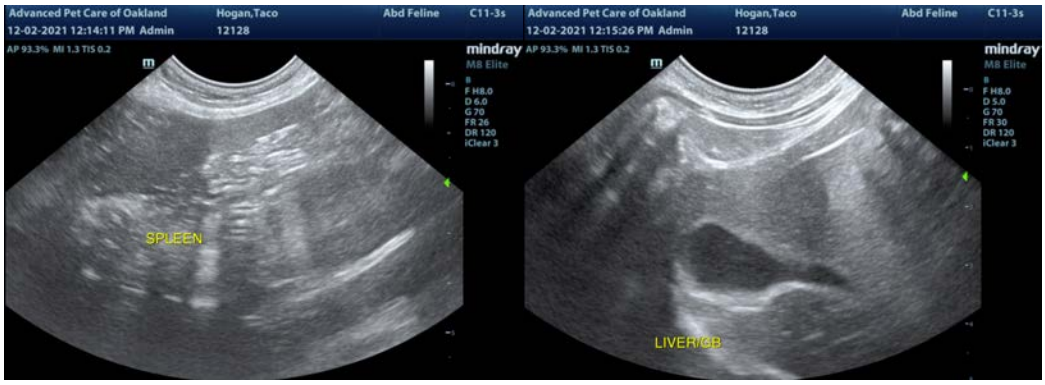
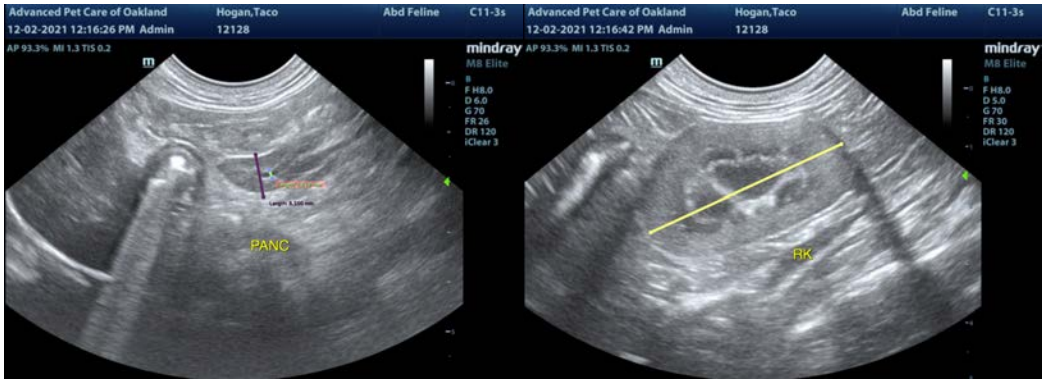
- You could consider a fine needle aspirate of the hypoechoic tissue or the local enlarged lymph node, but it is likely that a biopsy of this tissue would be necessary for a definitive diagnosis.
- Consider a GI panel to Texas A&M with quantitative fPLI, TLI, cobalamin and folate to both further evaluate the pancreatic changes observed and to evaluate for a B12 deficiency due to the lesion near the ileum.
- Recommend probiotic therapy.
- If surgical biopsies of the suspected bowel lesion are pursued, then you could consider a biopsy of the bladder wall at the same time (looking for bacterial or sterile cystitis).
- A contrast study may be necessary to definitively determine if there is pelvic dilation in the left kidney.





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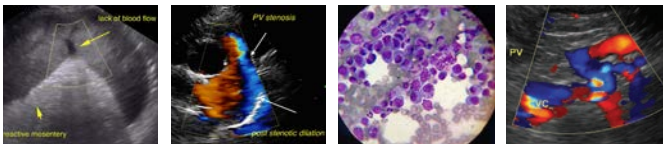

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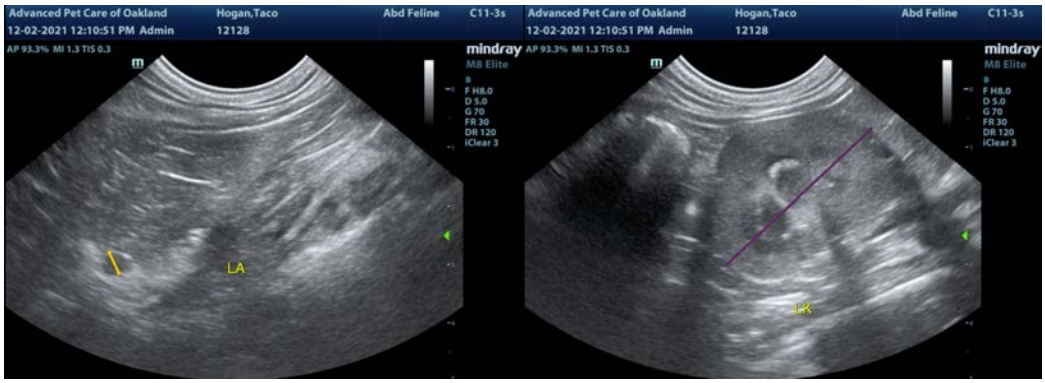

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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