

**DATE PRESENTING CLINICAL SIGNS**

12/14/21 History: Patient has a history of urinary blockages and very painful per owner. Had Perineal Urethrostomy Surgery on 7/16/2021.

**PATIENT**

Tabi Gibeck Current Medications: Fortiflora SID, Dasaquin SID and Gabapentin Mini 50mg 1 tablet BID.  
Lab Results: T4 upper end of normal; Few RBC in urine--can be from cysto. Attached separately.  
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

**SPECIES**

Feline

Sedation: Not required to complete full diagnostic ultrasound.  
Stat Report: Not requested.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****BREED**

DSH

**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.

**SEX**

Neutered Male

The left kidney has a normal shape and size (4.4 cm). Overall echogenicity is slightly hyperechoic with poor 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.

**AGE**

2/18/13

**WEIGHT**

11.69 Pounds

The right kidney has a normal shape and size (4.49 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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.

**INTERPRETED BY**

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

**Adrenal Glands**

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. 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.

**IMAGING PERFORMED BY**

Rachel Brillhart RDMS

**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.

**HOSPITAL NAME**

All Creatures AH

**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.

**REFERRING VET**

Dr. Meadows

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.

**INVOICE**

33416

**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 0.18 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. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid. The pancreatic duct measures 0.13 cm.

### ***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 age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- 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.
- Mildly decreased corticomedullary distinction in the kidneys – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The ultrasonographic lesions described are very mild and could be within normal limits for this individual. There are no obvious bladder lesions visualized. The bladder wall appears somewhat prominent but is not thickened. The proximal urethra appears relatively normal, but unfortunately with the dysuria and stranguria reported, the more distal urethra could be an issue. Consider a contrast cystourethrogram to look for any strictures, calculi, etc. With the history of a perineal urethrostomy, the risk for urinary tract infection is very high. Recommend urinalysis and culture and examination of the urethrostomy site for scarring, sores, etc.

The pancreas is somewhat prominent. Unfortunately, the ultrasonographic lesions do not always correlate with the clinical signs. If pancreatitis could be a source of abdominal pain, consider a GI panel to Texas A&M with a qualitative fPLI, TLI, cobalamin and folate.



**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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