IMAGING PERFORMED BY

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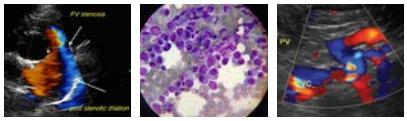

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DATE

12/15/21

PATIENT

Scout Perlman

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

3/20/09

WEIGHT

12.63 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Stephanie Pearce RDCS, RVT

HOSPITAL NAME

Charm City VH

REFERRING VET

Dr. Karbonik

INVOICE

33470

PRESENTING CLINICAL SIGNS

History: P has lost 5# over the past 9 months (2# in the past 2 months)
good appetite, no vomiting or diarrhea; has some mobility issues in the hind end - is scheduling w/ a neurologist. P is otherwise doing well.
Current Medications: Atopica twice weekly for skin.
Lab Results: Pending.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: DKT.
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 (4.66 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 (4.57 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 0.44 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 0.38 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 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. Duodenum wall measured 0.32 cm. Jejunum wall measured 0.31, 0.29 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. Pancreatic duct measures 0.21 cm.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a diffuse mesenteric lymphadenopathy present with a cluster of prominent lymph nodes around the ileocecal junction measuring 0.53, 0.57, 0.83 cm. Additionally, there is a prominent, hypoechoic, rounded structure measuring 0.91 cm in circumference that likely represents an atypical mesenteric lymph node. The omentum is hyperechoic, particularly around the ileocecal junction.

PRIMARY FINDINGS

- Diffusely thickened small intestine with prominent muscularis layer – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.
- Mesenteric lymphadenopathy with surrounding hyperechoic mesentery – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

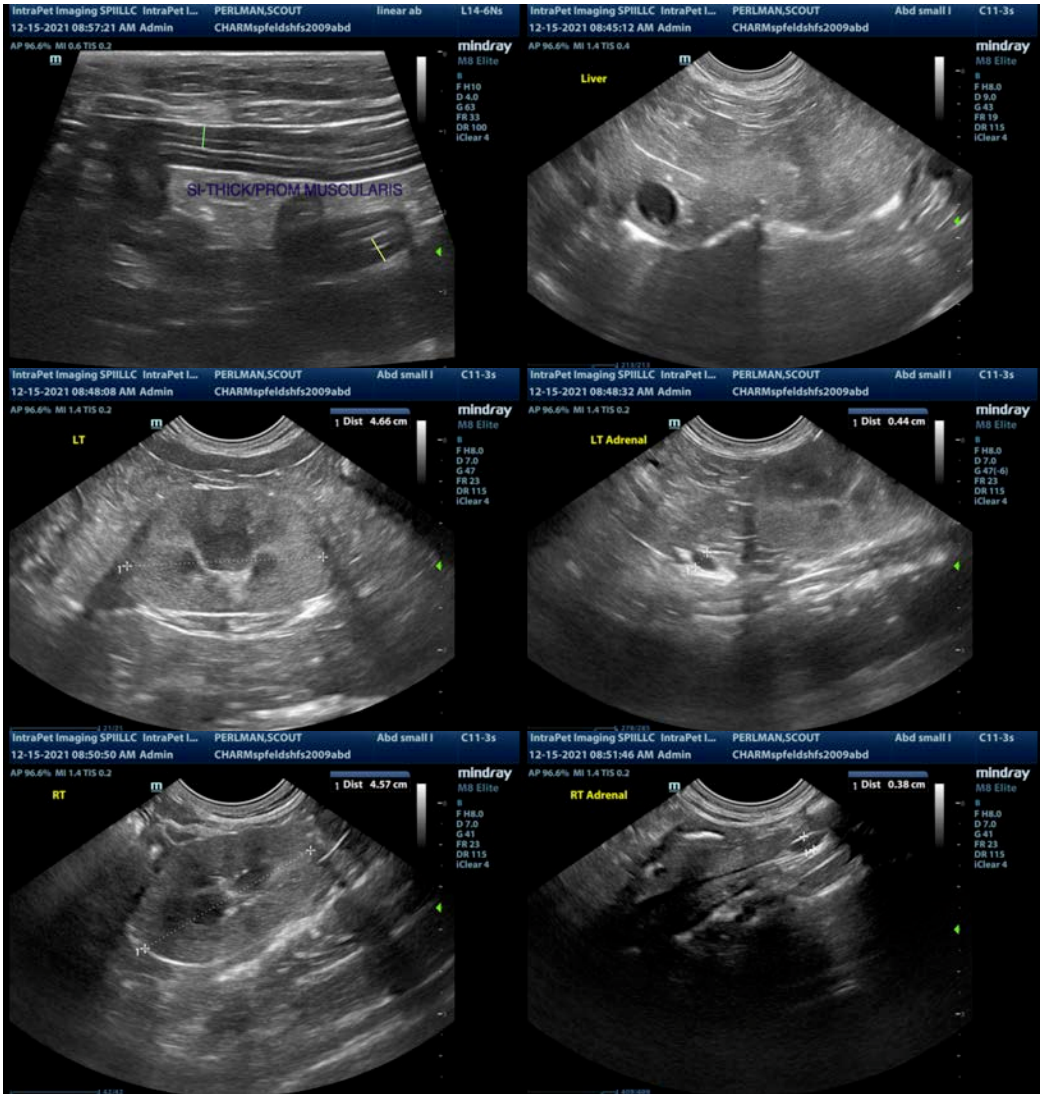
SECONDARY FINDINGS

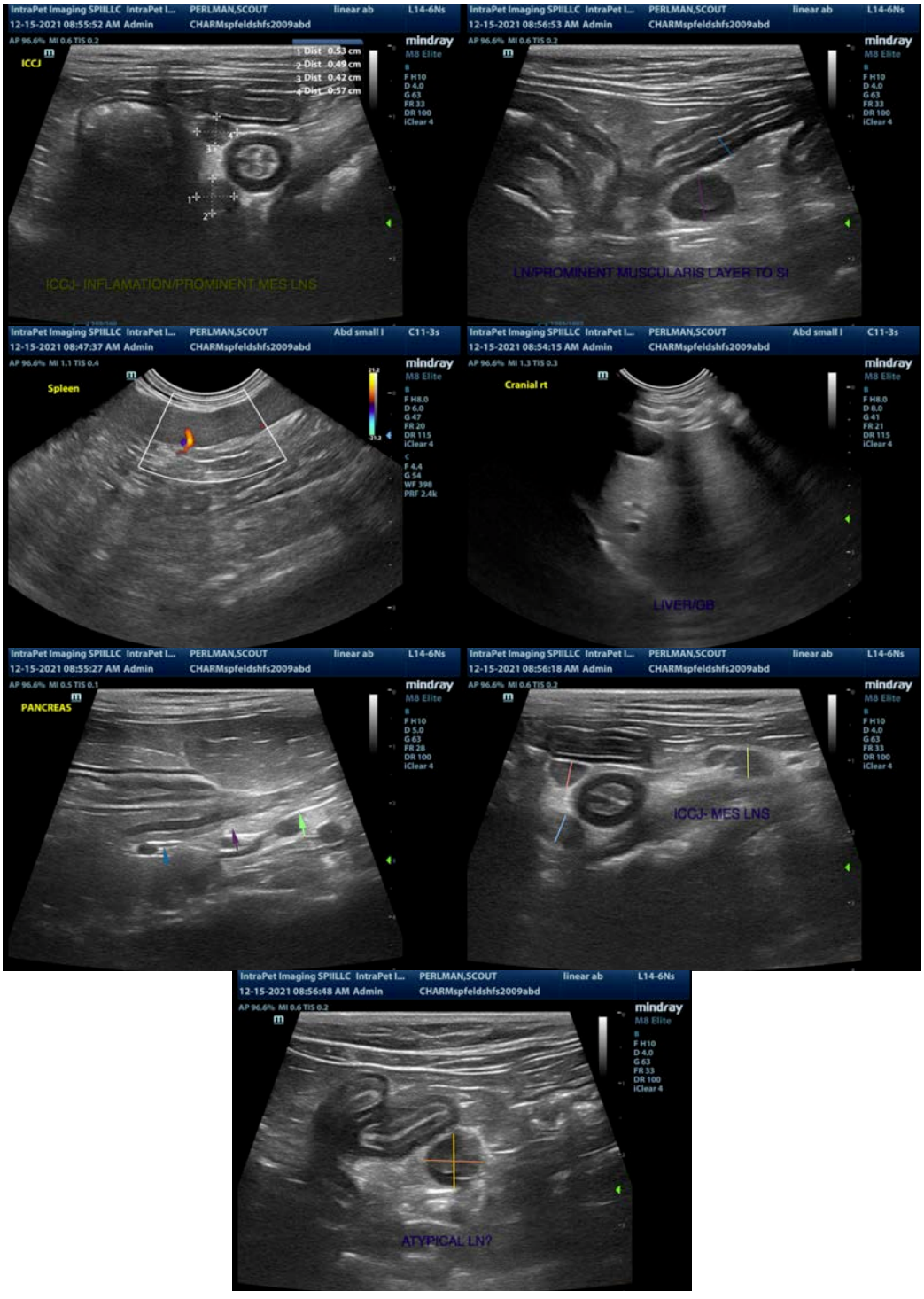
- Focal hypoechoic lesion in the mid abdomen – I suspect this represents an atypical mesenteric lymph node/emergent mass effect.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is diffuse small intestinal thickening with prominent layering visible throughout the abdomen. Additionally, there is a mesenteric lymphadenopathy and an isolated, larger hypoechoic structure, which could be an early lymph node transitioning to a mass effect (?). These findings are likely most consistent with primary GI disease such as IBD or less likely infiltrative neoplasia.

- Consider a fine needle aspirate of the prominent mesenteric lymph node.
- Recommend a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreatic changes observed and the small intestine. This will also screen for exocrine pancreatic insufficiency, which could be an issue in this situation.
- Consider probiotic therapy.
- Consider novel protein/hydrolyzed protein prescription diet.
- Quantitate food intake to ensure adequate calories.
- If not already done, recommend thyroid testing.
- If symptoms persist, recommend obtaining biopsies of the small intestine +/- mesenteric lymph nodes.
- Recommend 3-view thoracic radiographs.

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mindray
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ICCJ
1 Dist 0.53 cm
2 Dist 0.49 cm
3 Dist 0.42 cm
4 Dist 0.57 cm
ICCJ- INFLAMATION/PROMINENT MES LNS
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LN/PROMINENT MUSCULARIS LAYER TO SI
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Cranial rt
LIVER/GB
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PANCREAS
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ICCJ- MES LNS
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mindray
M8 Elite
ATYPICAL LN?

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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