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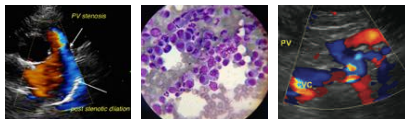

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Clinical Sonography & Telecytology
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PATIENT

Grayson West

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

2/18

WEIGHT

11 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Greenbrier VC

REFERRING VET

Dr. Boccanfuso

INVOICE

94718

DATE

12/17/21

PRESENTING CLINICAL SIGNS

History: Got into trash on 12/8 and as of 12/12 has been vomiting and not eating.

Current Medications: Famotidine and Cerenia given SQ 12/14 - No oral medications at this time.

Lab Results: Lab work WNL.

Radiographs: Unknown substance in stomach upon initial X-ray. Repeat fasted X-ray showed some improvement but still a concern for foreign body.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

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 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 (3.93 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 (4.04 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 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.

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.

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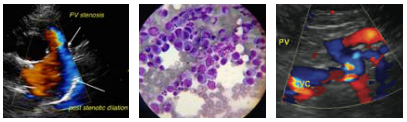

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Liver

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 gallbladder 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 <0.7cm 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 measured 0.19 cm and 0.25 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 mottled 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.

Free Abdomen

Occasional prominent mesenteric lymph nodes are visualized. The largest lymph node measured 0.58 cm and the omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Hypoechoic, prominent pancreas with prominent pancreatic duct. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- 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

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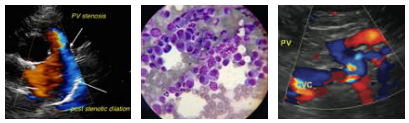

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SECONDARY FINDINGS:

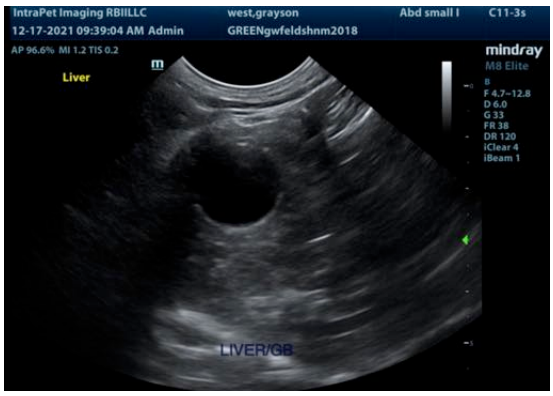
- Occasional, prominent mesenteric lymph node. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No significant focal lesions were observed on today's scan to explain the acute vomiting described. The stomach largely appeared empty. Unfortunately ultrasound can be insensitive at picking up some types of foreign material so a foreign body cannot be 100% excluded, but there was no evidence of an obstructive pattern or gastric dilation on today's scan.

- Consider a GI panel to Texas A&M with a qualitative fPLI, TLI, cobalamin, and folate to further evaluate the pancreatic and bowel changes observed.
- If patient starts eating again consider a hydrolyzed protein or novel protein diet.
- Consider medical therapy if not already done (such as anti-nausea medications, fluids as needed, appetite stimulants, probiotics, etc.).
- Correlate with abdominal radiographs, but if symptoms persist you can consider exploratory to definitively rule out foreign material and obtain biopsies of the GI tract +/- place a feeding tube.

The history reports that we are at day 6 of anorexia, which is concerning particularly for a bigger cat. You can consider placement of a feeding tube (nasogastric or esophagostomy). I find that sometimes if you can get some food moving through they start to feel better and are more inclined to eat. With acute vomiting with no clear cause I will also consider syringe feeding if they do not seem clinically nauseous. The findings are most consistent with enteritis/pancreatitis.



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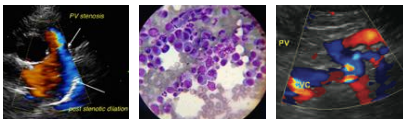

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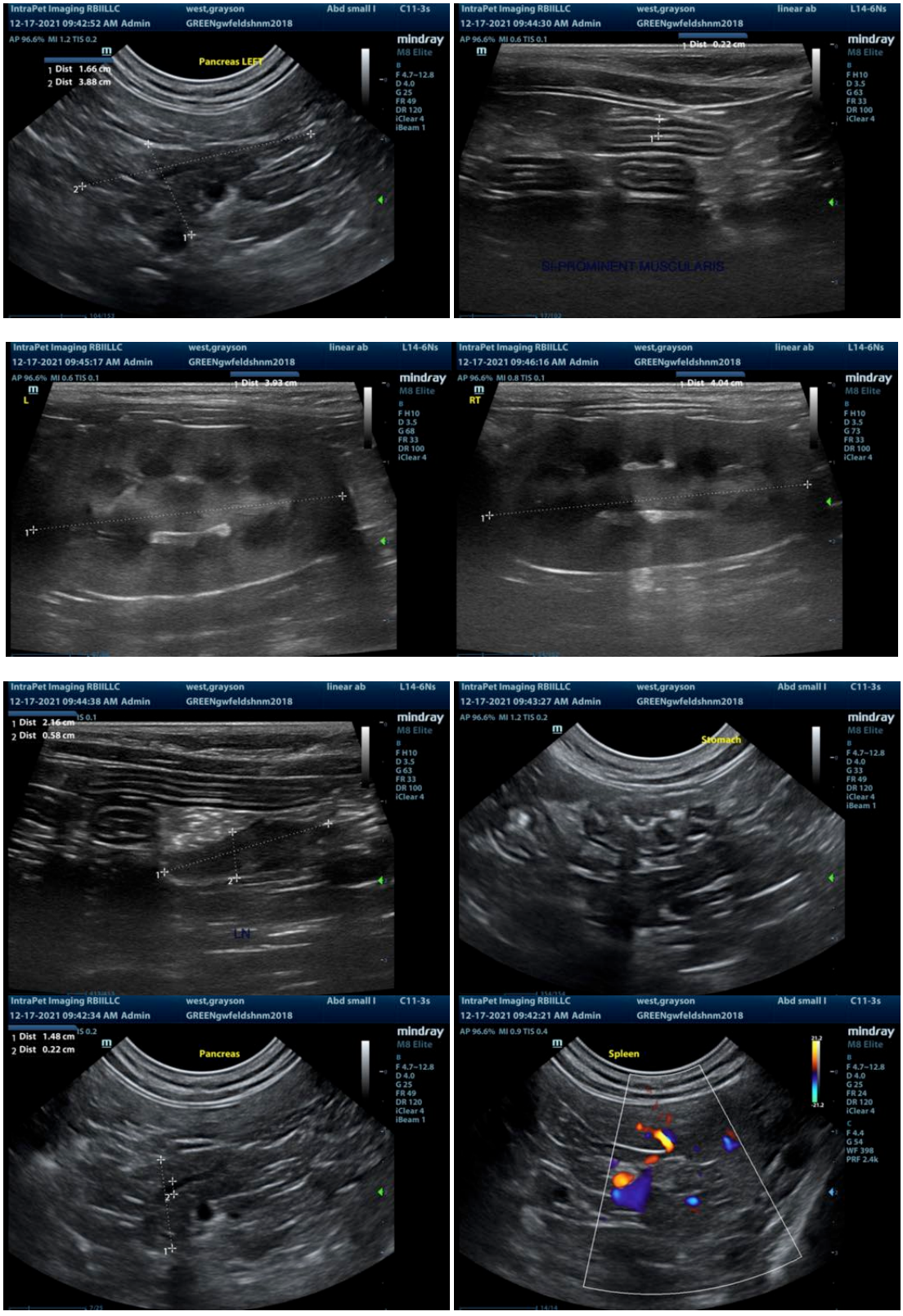

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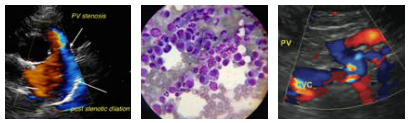

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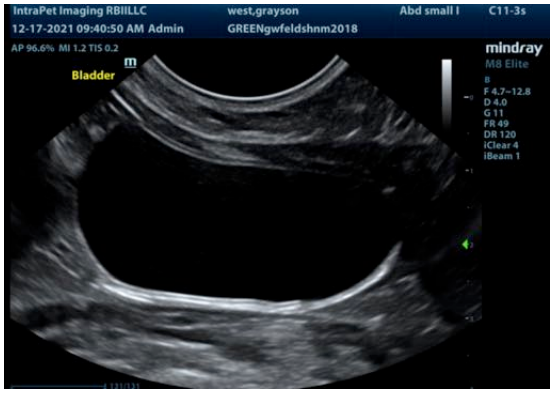

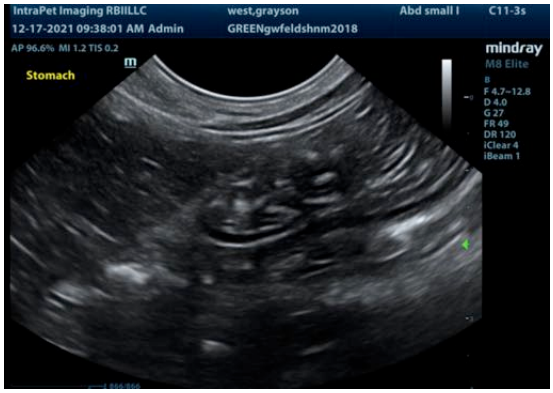

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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