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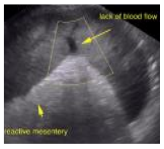
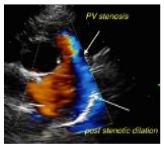
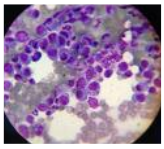
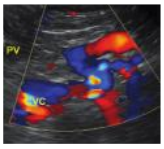

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Gus Kuklok

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7 Months

WEIGHT

11.3 Lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

All Creatures Great & Small VC, Corvallis, OR

REFERRING VET

Beth Marszewski

INVOICE

12815

DATE

12/2/21

PRESENTING CLINICAL SIGNS

History: O concerned P ate the tail end of a cat toy since he V light pink clear liquid at 5:30pm last night. P didn't eat dinner last night. Had another spell of V around 8 pm same pink liquid and again at 10 pm, 1 am, 2 am. V spells got progressively more bloody and P didn't eat breakfast this morning. Seemed lethargic and not nearly as active. Unusual for P not to eat food since he is highly food motivated. No V this afternoon, ate some bits of food and seems more like self. O relayed he seems tender in abdomen.

Abnormal PE/Chem/CBC/UA Results: NSF on PE other than 5% dehydrated; abdomen soft, non - painful CHEM/CBC: WNL Lack of appetite despite cerenia, SQF

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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.6 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 (3.89 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 0.33 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 0.28 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 gall bladder 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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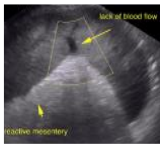

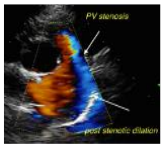

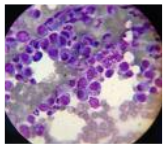
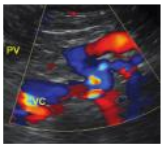

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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36 cm 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.

Some of the visualized areas of jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Other areas appear mildly to moderately fluid distended and some areas, particularly the proximal duodenum, appear somewhat corrugated and inflamed. Wall thickness is normal. Bowel loops exhibit a normal wall layering. The duodenum measured 0.33 cm, and the jejunum measured 0.26 cm. There were no definitive focal lesions consistent with an obstructive foreign body are appreciated but this remains a possibility.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with liquid fecal material and a large amount of 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.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any free fluid. Occasional prominent mesenteric lymph nodes are visualized, measuring 0.36 cm and 0.46 cm. The omentum is generally slightly increased in echogenicity.

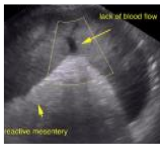
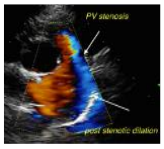
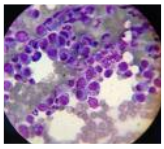
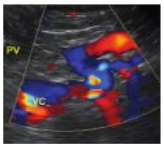
ULTRASONOGRAPHIC FINDINGS

- Moderate corrugation and fluid dilation in some sections of small intestine. This finding could be consistent with localized enteritis but could also be seen with foreign material. A discreet obstruction is not observed but cannot be ruled out.
- Hypoechoic prominent pancreas adjacent to corrugated duodenum. The pancreatic changes most consistent with mild/moderate acute pancreatitis. Serial sonographic monitoring for pancreatic abscessation should be considered.
- Mild mesenteric lymphadenopathy. 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

There is definitely an enteritis present, as some of the bowel loops appear corrugated and fluid filled. The stomach appears relatively normal and empty, but I cannot rule out the possibility of a foreign body in the small bowel. Given the age and possible history of this patient, it needs to be strongly considered. If clinically appropriate, consider medical supportive care and frequent monitoring with radiographs +/- ultrasound to see if symptoms improve. If not, I would recommend surgical exploration with biopsies of the small intestine.

Additionally, the pancreas is prominent and inflamed. This could be a result of bowel inflammation or

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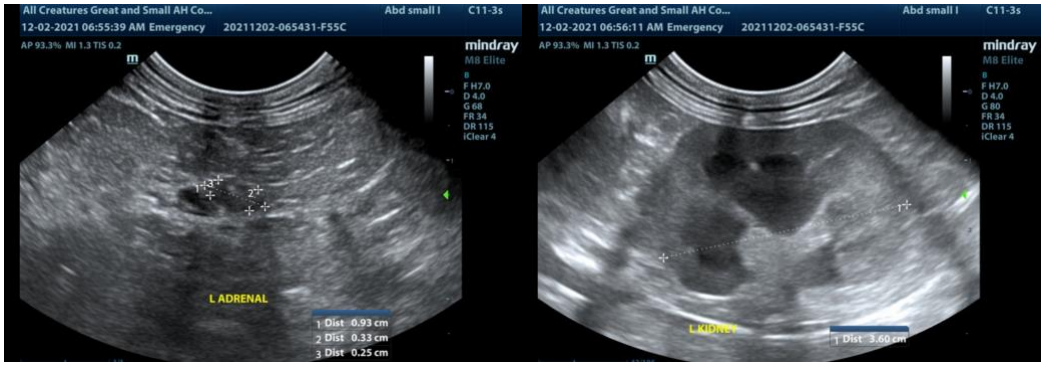
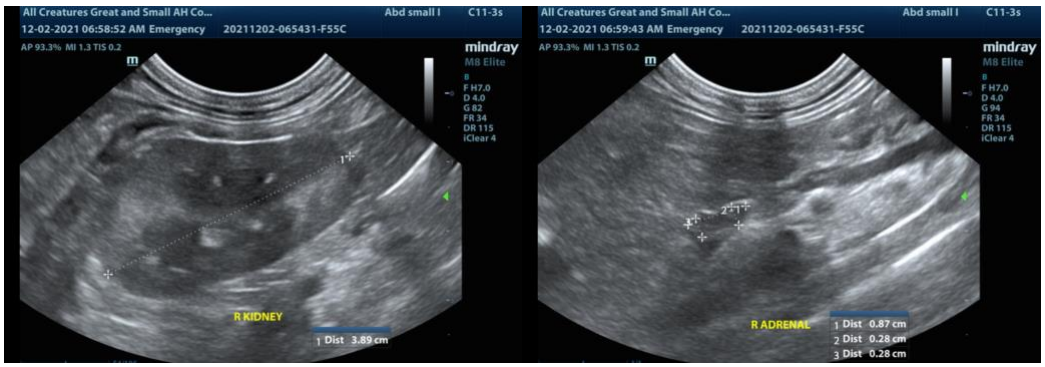
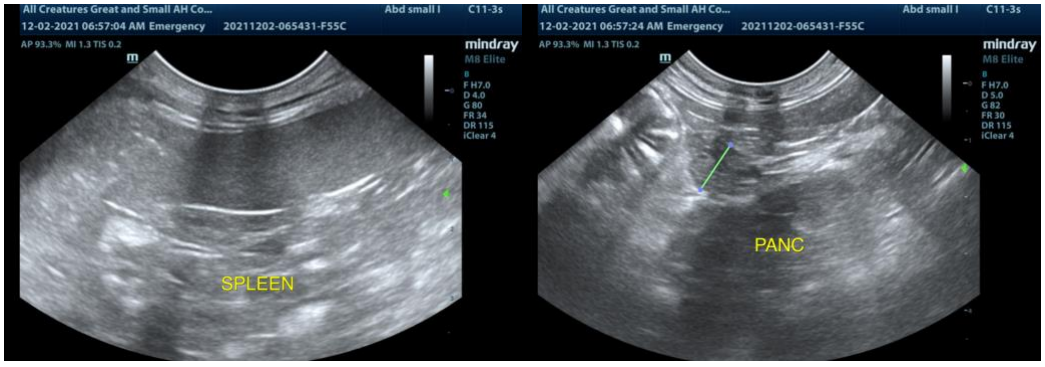
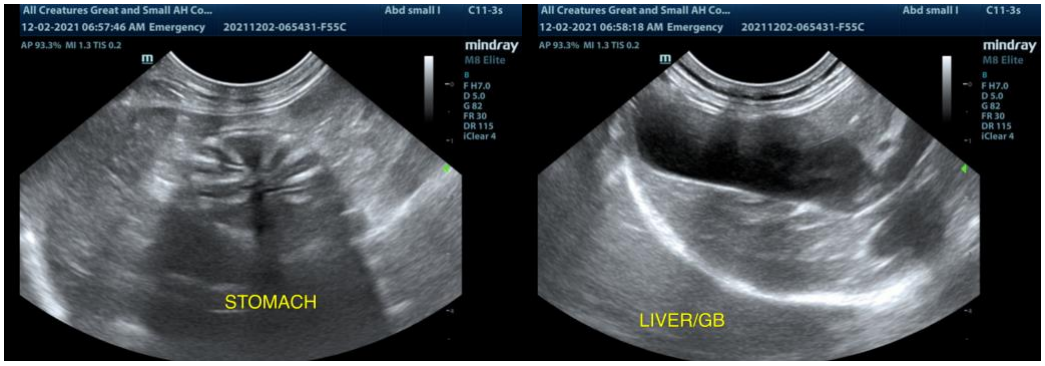
could be causing it. Consider a GI panel with a quantitative FPLI, TLI, cobalamin and folate (to Texas A & M University) to get more information regarding the pancreas and small intestine.









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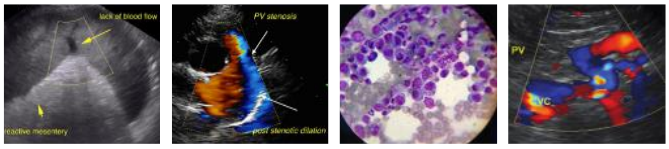

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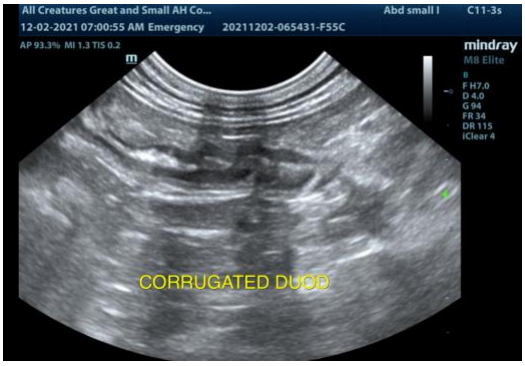

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com