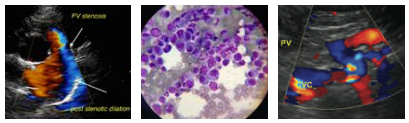
IMAGING PERFORMED BY

IntraPet.com



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DATE
12/2/21

PATIENT
Josephine Hack

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Spayed Female

AGE
7/06

WEIGHT
7.75 lbs

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

IMAGING PERFORMED BY
Rachel Brilhart RDMS

HOSPITAL NAME
Everhart VC

REFERRING VET

INVOICE
94280

PRESENTING CLINICAL SIGNS

History: weight loss.
Current Medications:
Lab Results: Chem: BUN – 37, Ca - 11.7, Chol - 273 CBC/T4: WNL, UA: Sp. Grav. 1.030, trace proteinuria, 3+ hematuria (11-20rbcs/hpf). Attached separately.
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 (3.1 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. A non-obstructive nephrolith was noted and measured 0.23 cm. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.02 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. A non-obstructive nephrolith was noted and measured 0.46 cm. Mild pyelectasia was noted and measured 0.28 cm. There is no evidence of 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.

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 <0.36cm 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. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. The jejunum measured 0.25 cm, 0.28 cm.

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. The pancreatic duct was prominent measuring 0.21 cm. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mild mesenteric lymphadenopathy present with mesenteric lymph nodes that measured 0.36 cm, 0.4 cm. The omentum is of increased echogenicity around the enlarged lymph nodes.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

Subjectively thickened small intestine with a prominent muscularis layer. The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

Prominent, hypoechoic pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

Decreased corticomedullary distinction in both kidneys with non-obstructive nephroliths and mild right-sided pyelectasia. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.

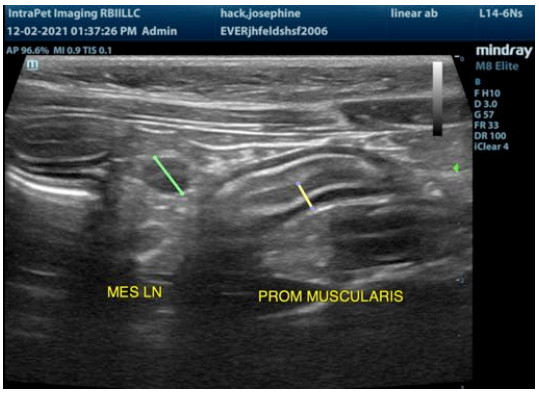
Prominent, mesenteric lymph nodes. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

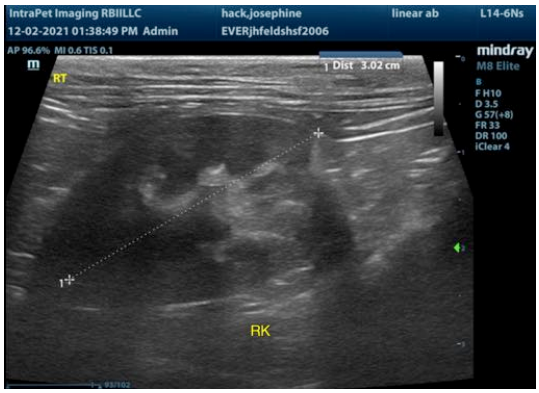
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

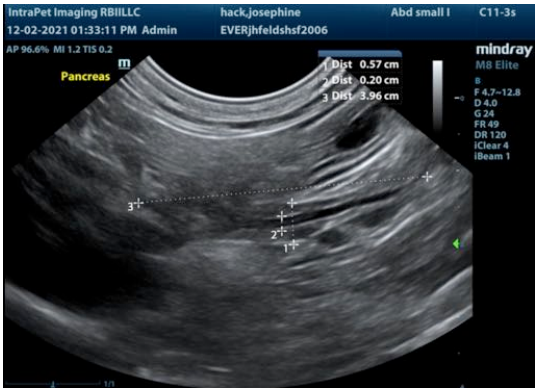
The small bowel appears somewhat prominent with a prominent muscularis layer. This can be normal in older cats, but that combined with the prominent mesenteric lymph nodes and prominent pancreas increase concerns for underlying gastrointestinal disease. Consider a GI panel to Texas A&M with a quantitative fPLI, TLI, cobalamin and folate to evaluate for pancreatitis, exocrine pancreatic insufficiency and a cobalamin deficiency, which could be an indicator of chronic small intestinal disease.

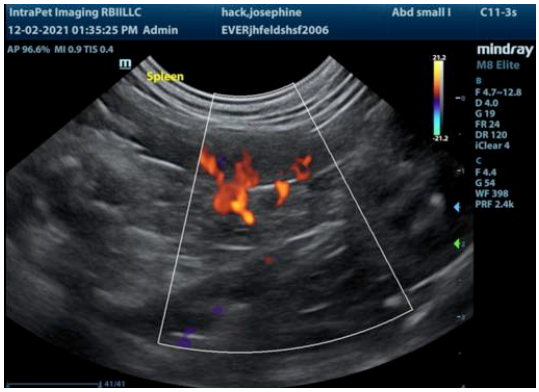
No lesions were visualized in the lower urinary tract to explain the hematuria reported. I recommend urinalysis, culture and blood pressure evaluation. There was mild pyelectasia of the right kidney so an occult infection is possible.

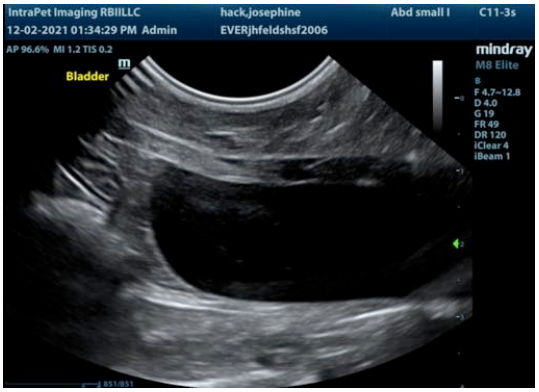
- Consider hydrolyzed protein/novel protein diet.
- Consider a GI panel to further evaluate the pancreas and small intestine (as mentioned above).
- Consider starting probiotic therapy.
- If weight loss continued consider obtaining GI biopsies.
- Consider running an ionized calcium as the serum calcium was elevated earlier in the month.
- Recommend three view thoracic radiographs to evaluate for concurrent intrathoracic disease.

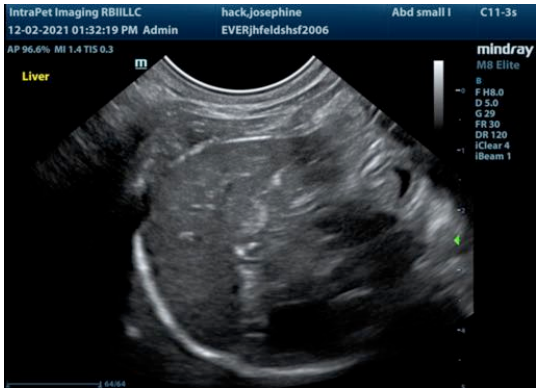












The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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