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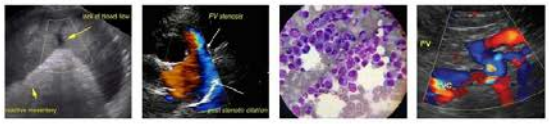


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Rufus Duncan

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

8 Years 8 Months

WEIGHT

10.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Grass Valley VH

REFERRING VET

Dr. Kristi Cortright

INVOICE

43657

DATE

12/21/22

PRESENTING CLINICAL SIGNS

No sedation, extremely tense abdomen- Reason for Ultrasound: Chronic Diarrhea and vomiting, 5 months- Hx of FB exploratory/sx (in jejunum) not recent but uncertain of exact date- History:09/21/22 Diarrhea and vomiting x 2 months. His stools have improved and are just intermittently loose, and twice he just produced mucus (w/ no obvious blood) from rectum. He vomits at least twice a day (after eating) and sometimes in between meals (fluid). He had a large hairball last week. Was seen at BGVH for this and put on probiotics and antibiotics (Metronidazole) which helped for a while. Not currently on any medications. On revolution. Feeds GF Blue Buffalo wilderness chicken and turkey and some dental chew treats. No recent diet change and appetite is good. 11/23/22 Owner finally finished old food and transitioning to strictly z/d diet 10 days ago. Rufus is still vomiting some fluid (a bit less frequently) and has mucoid diarrhea. He has gained a bit of weight, has a good appetite and energy level.
Abnormal PE/Chem/CBC/UA Results: No recent LABs done-

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 (4.3 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

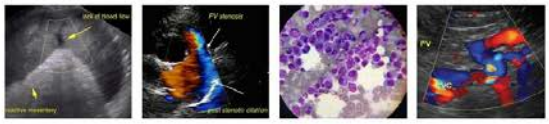
The left adrenal gland is normal in size measuring 0.39 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.44 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 (0.79 cm in width at the level of the hilus), 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



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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 appears bilobed with two moderately distended gallbladder lumens. The walls of the gallbladders are not thickened and have smooth mucosal surfaces. There is minimal echogenic debris. 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. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. No focal mass lesions are visualized, but there are regions of small intestine and duodenum that appear somewhat corrugated and have focal areas of fluid dilation. One of these areas appears to have some hyperechoic shadowing material within the lumen. This could represent ingesta, a hairball, or other foreign material. The fluid dilation could represent segmental ileus or a partial obstruction. The corrugation is most consistent with enteritis.

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 normal and isoechoic to surrounding 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 evidence of effusion. There are prominent mesenteric lymph nodes throughout the abdomen. Examples measure 0.49, 0.46, 0.49, and 0.51 cm. The omentum is generally of normal echogenicity.

PRIMARY FINDINGS

- Diffusely prominent muscularis layer of 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.
- Focal areas of bowel corrugation, fluid dilation, and some intraluminal shadowing material – I suspect these changes are most consistent with passing hairballs and are secondary to primary gastrointestinal disease present, but monitoring is warranted for an obstructive process.
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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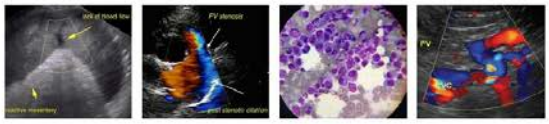

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SECONDARY FINDINGS

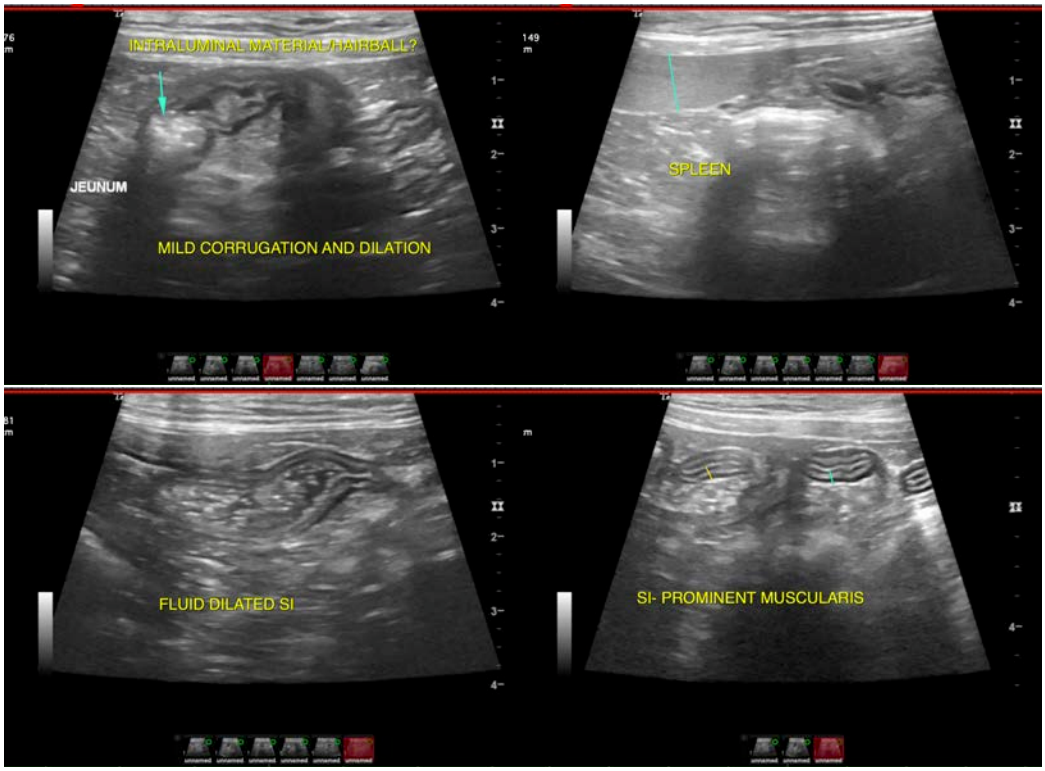
- Bilobed gallbladder – likely an incidental finding.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Based on the history provided, I suspect there is chronic gastrointestinal disease present. This correlates with the prominent muscularis layer of the small intestine. These changes can be associated with inflammatory, infectious, autoimmune, or even neoplastic disease processes. It is likely that GI biopsies would be necessary to better differentiate. Additionally, there are some areas of bowel that appear irritated, and fluid dilated with some shadowing intraluminal material. I suspect this is passing of hairballs but continued monitoring with serial radiographs and possibly a recheck ultrasound with heavier sedation to look for evidence of progression of an obstructive process. Additionaly, you could consider a fine needle aspirate of a mesenteric lymph node.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

It sounds as if you've made some progress with the diet change and some initial therapy. I would also consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, and if these symptoms all started at the time of surgery, consider the possibility of dysbiosis secondary to systemic antibiotics to adhesions, etc.



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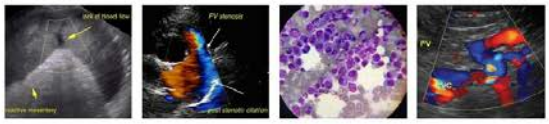

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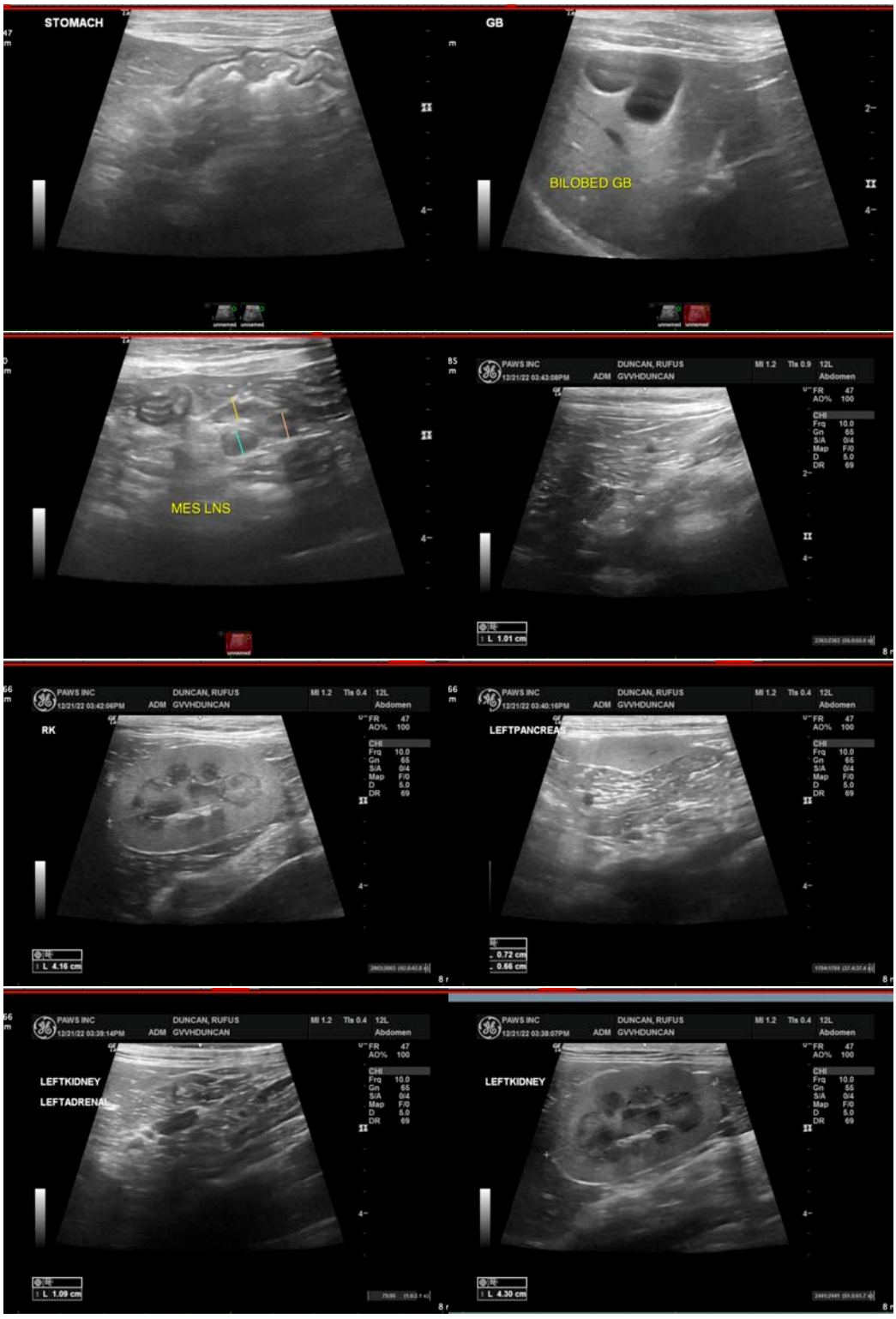

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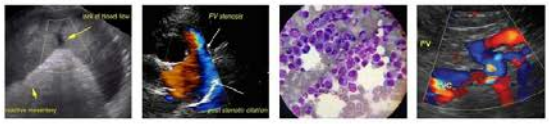

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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