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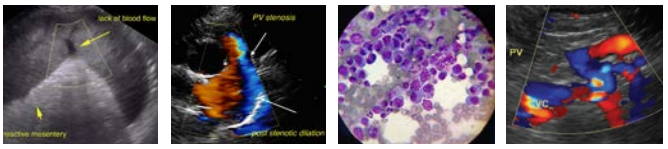


PATIENT

Willow Mroczek

SPECIES

Feline

BREED

Siamese

SEX

Spayed Female

AGE

11 Years 3 Months

WEIGHT

5.15 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Preston

HOSPITAL NAME

All Creatures AH

REFERRING VET

Dr. Krisha Salmon

INVOICE

33673

DATE

12/22/21

PRESENTING CLINICAL SIGNS

History of gradual weight loss over the past 6 months. 2 weeks ago, pet vomited 5 times over a few days and developed complete anorexia. Pet is predominantly an indoor cat and especially the past months due to the winter weather. No recent diet change, pet is fed a mixture of canned and dry foods. Labwork from 12/15: CBC- normal, minor platelet clumping. Chem 17: all normal UA: USG > 1050, quiet sediment T4: 1.6 (N) A fecal test has not been performed, the pet was given a general dewormer for tape worms and round worms on 12/15. Pet has received SQ fluids and cerenia injections twice over the past 2 weeks, once cerenia wears off, pet starts vomiting again (bile or syringe fed canned food). No recent stool production, no diarrhea reported in litterbox. Screening thoracic and abdominal radiographs are unremarkable today. Ultrasound images to evaluate gastro intestinal tract further. Would you recommend gastric biopsies at this point? Is their any intestinal layering or lymph node enlargement that is a concern for potential lymphoma?

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 (3.2 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 (3.2 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 0.35 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.

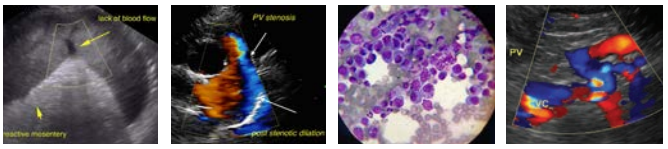
The right adrenal gland is normal in size measuring 0.30 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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.



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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. The pyloric area appears subjectively thickened and prominent, measuring 0.21 cm with intact layering. There is no evidence of an outflow tract obstruction.

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 measured 0.2 cm. Duodenum wall measured 0.21 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 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 occasional prominent mesenteric lymph nodes visualized, measuring 0.35, 0.37 cm. The omentum is of increased echogenicity in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- 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.
- Occasional prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Prominent pyloric wall – This area is subjectively prominent, but does not measure as thickened. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The general impression of today's scan is that of mildly thickened small intestine with prominent muscularis and mild mesenteric inflammation with prominent mesenteric lymph nodes. These are non-specific findings, most consistent with primary GI disease. If metabolic workup including thyroid evaluation makes systemic disease unlikely, then consider primary GI causes such as GI parasitism, mild pancreatitis, bacterial dysbiosis, food allergy, IBD, and less likely intestinal neoplasia.

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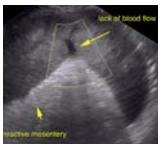
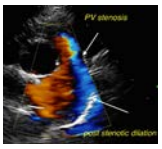
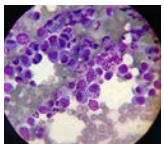
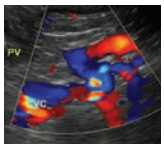

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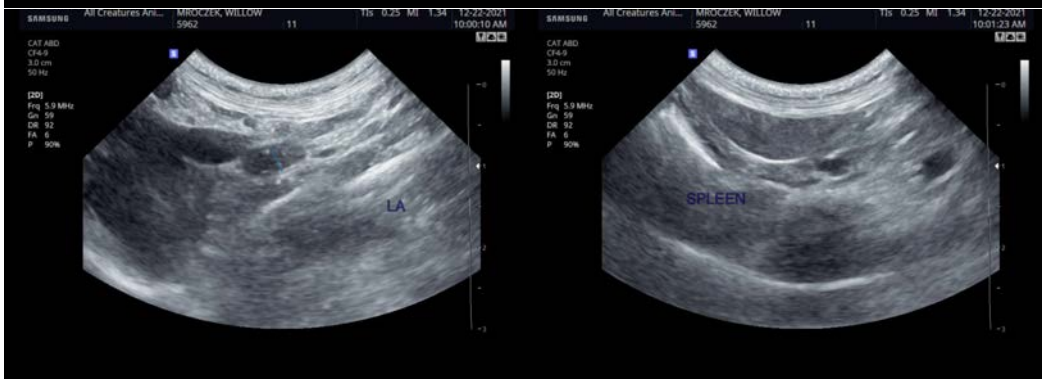
In an older pet with more chronic symptoms, I would most strongly consider food allergy, IBD, and intestinal neoplasia.

- Recommend a diet trial with a novel protein/hydrolyzed protein prescription diet.
- Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Consider probiotic therapy.
- If symptoms are progressing, consider obtaining GI biopsies +/- biopsies of prominent mesenteric lymph nodes.
- Recommend 3-view thoracic radiographs to rule out concurrent intrathoracic disease.



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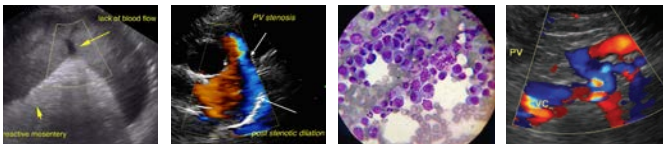

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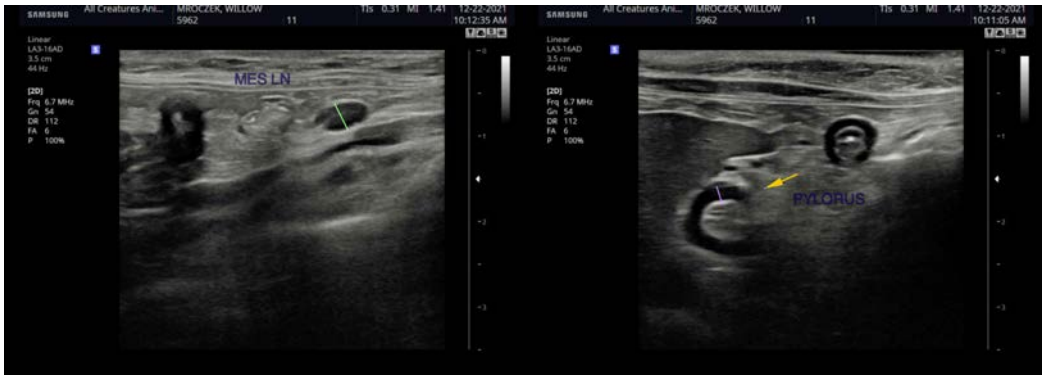

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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