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**DATE PRESENTING CLINICAL SIGNS**

2/10/22

History: Acute onset emesis. Regurgitation of undigested food ranging from a few mins to a few hours post meal. Possible FB ingestion but 'unlikely' as per owner. 3d of diuresis after single dose SC Cerenia- P responded well. Emesis returned 4d after Cerenia. In mean time- eating well and normal stools. Contrast agent uptaken by suspected FB in transverse colon radiographically on day 2.

**PATIENT**

Hopps Cameron

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

11/22/10

**WEIGHT**

18.6 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Rachel Brilhart RDMS

**HOSPITAL NAME**

Belvedere Vet Center

**REFERRING VET**

Dr. Eden

**INVOICE**

35596

Current Medications: Single dose Cerenia SC on d1. Daily IV fluid diuresis d1-3, Cerenia 16mg and burpees oral. PO D6,7,8, Day of abd US d9.

Lab Results: High normal creatinine (1.9). Urinalysis pending  
Amylase and PSL pending.

Radiographs: Day 1 rads- suspension for FB pyloric region. Day 2 rads- suspected FB moved to transverse colon. Day 6 rads- elongated colonic material, different radiodensity to normal stool that was rectal removed digitally. Loss of serosal detail craniotomy-ventral abd.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

***\*\*A large amount of gastric ingesta limits evaluation, and a gastric foreign body cannot be definitively ruled out.***

***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 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 (4.9 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 0.45 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 0.42 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 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 is dilated with a moderate to large amount of fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering is adequate and there is no impression of reduced peristaltic activity. While no focal lesions are observed, the shadowing ingesta impairs evaluation of the pyloric region.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measured 0.33 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, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

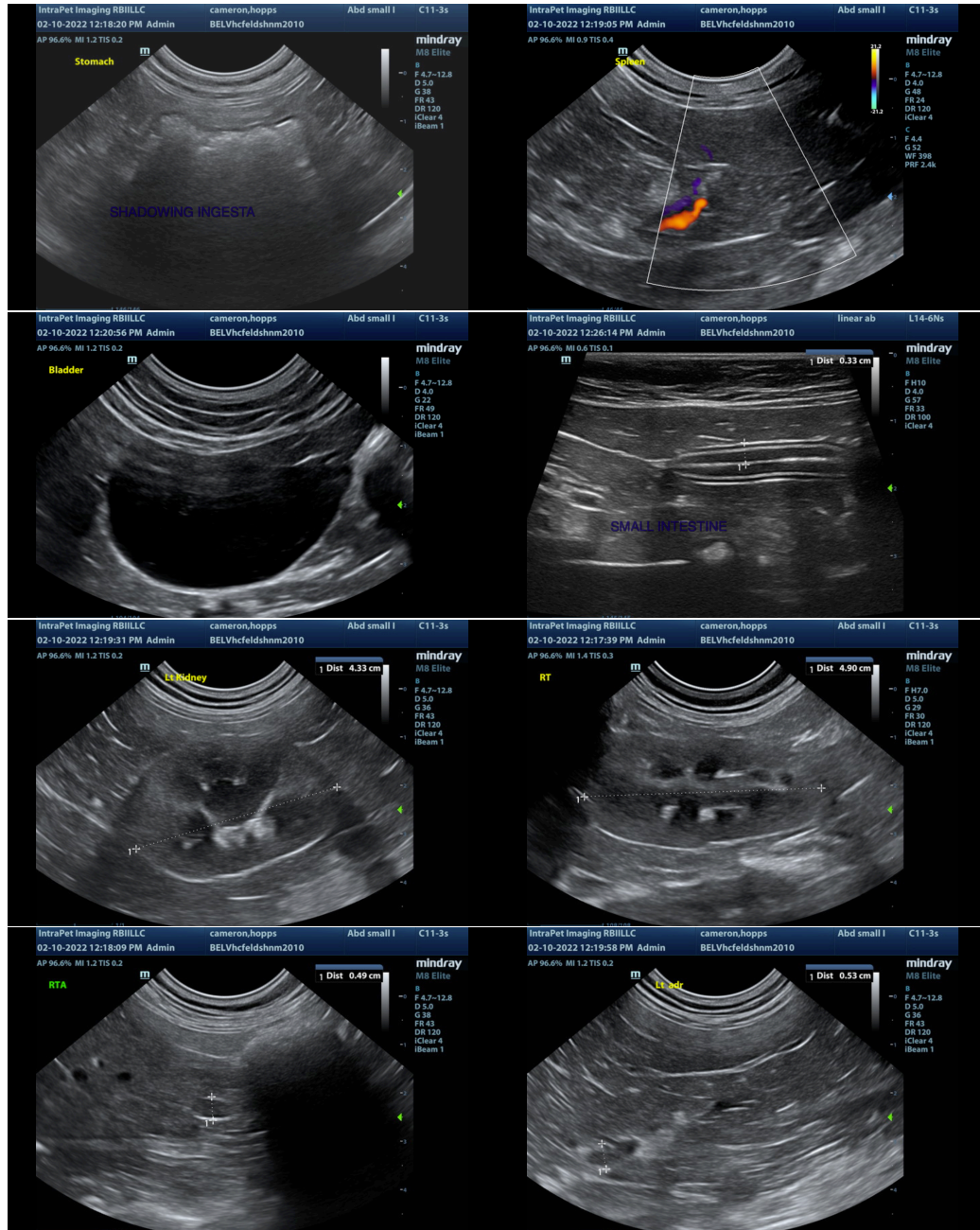
## **ULTRASONOGRAPHIC FINDINGS**

- Dilated gastric lumen with shadowing ingesta – Correlate with feedings history and abdominal radiographs. If adequately fasted then consider such differentials as delayed gastric emptying or a partial outflow tract obstruction (none visualized).

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

No focal small intestinal or pancreatic lesions were observed, but the stomach was significantly dilated with shadowing ingesta, making it difficult to evaluate for possible foreign material or gastric wall abnormalities. Provided metabolic workup is normal (lab work, thyroid levels, etc.), then a primary GI or esophageal cause would be the most common issue to cause vomiting/regurgitation. Possible differentials would include ingestion of foreign material, inflammatory disease such as gastroenteritis, GI parasites, pancreatic disease, dietary intolerance, IBD, or less likely intestinal neoplasia. You could consider repeating the contrast study to see if material moves out of the stomach in a normal fashion, and if the previously observed suspected foreign material has passed. If symptoms persist, you could consider surgery to obtain GI biopsies and rule out foreign material.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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.

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