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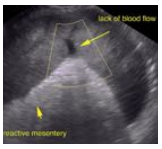
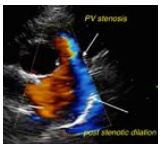
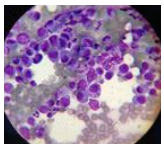
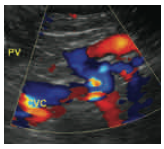

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1-800-838-4268 info@sonopath.com

PATIENT
Sadie Bank

SPECIES
Feline

BREED
Domestic Longhair

SEX
Spayed Female

AGE
11 years

WEIGHT
6.1 lbs

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

IMAGING PERFORMED BY
Dr. Bartus

HOSPITAL NAME
Valley VS

REFERRING VET
Dr. Bartus

INVOICE
95993

DATE
2/9/22

PRESENTING CLINICAL SIGNS

Weight loss of 3# in 15 months. Chronic, intermittent vomiting of food and diarrhea. Always hungry. Indoors only.
Abnormal PE/Chem/CBC/UA Results: SDMA 21 (0-14), BUN 39 (16-36), TP 9.2 (5.7-8.9), ALB 4.0 (2.3-3.9), normal T4, neg FeLV/FIV

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 right kidney has a normal shape and size (3.78 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal size (3.6 cm), but is irregular in shape likely from a previous infarct involving the caudal pole. . 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. There is no evidence of pyelectasia, nephroliths 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.

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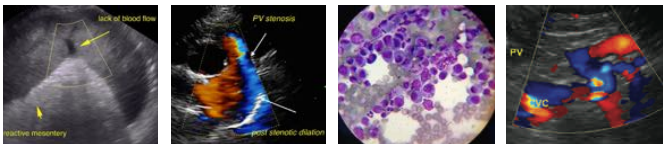

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Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.7cm 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. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with significant diffuse fluid distension. Wall thickness appears normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (between 0.13-0.38 cm in wall thickness) and the jejunum measured as normal (between 0.17 cm, 0.18 cm and 0.24 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 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 evidence of effusion. There is a significant mesenteric lymphadenopathy present with lymph nodes at the root of the mesentery measuring 0.75 cm, 0.74 cm. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Diffusely fluid distended bowel. The findings are most consistent with generalized ileus or malabsorption.
- Moderate mesenteric lymphadenopathy. The moderate mesenteric lymphadenopathy could be concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick born disease-such as bartonealla, fungal infections, FIP (cats)) etc.. A fine needle aspirate with cytology is recommended for further evaluation.
- Mildly reduced corticomedullary distinction in both kidneys and a suspected infarct in the right kidney. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Hypoechoic, prominent pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

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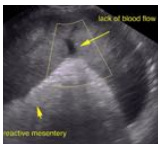
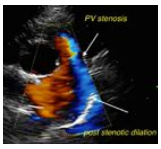
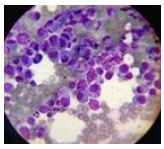
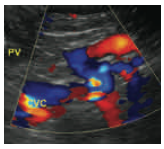

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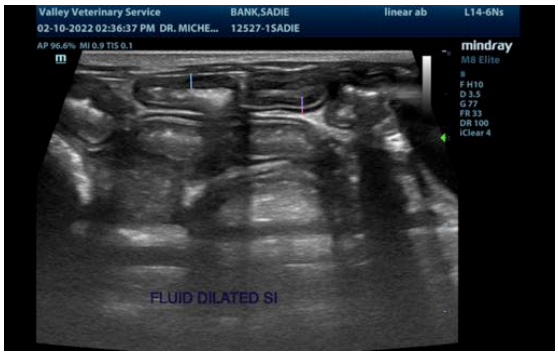
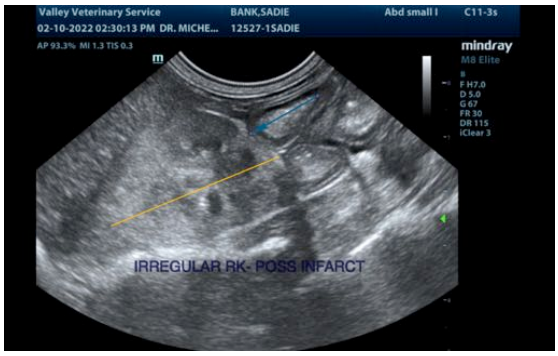
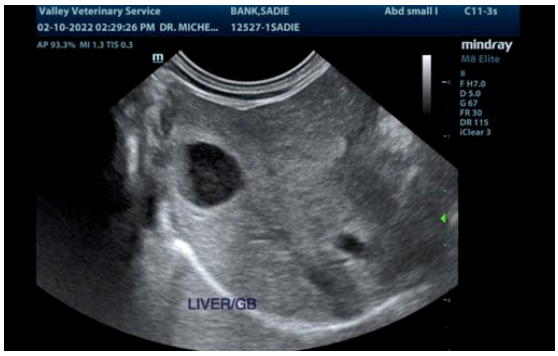
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

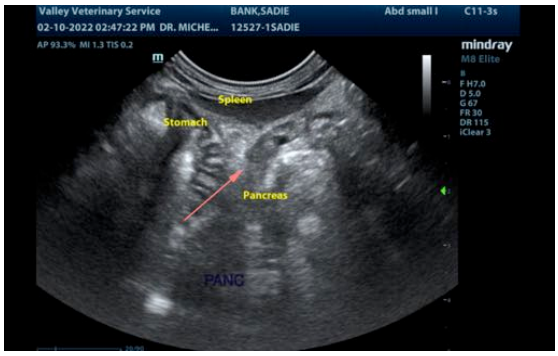
The small bowel is diffusely fluid dilated with a relatively normal appearing wall. These types of changes are typical for a diffuse ileus or possibly malabsorption particularly with the polyphagia that is reported. These are non-specific findings typically seen with primary GI disease.

- Consider GI panel to Texas A&M for qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreatic changes and small intestinal changes observed.
- Consider promotility treatment such as Metoclopramide to see if this helps with bowel distension, etc.
- Recommend chronic probiotic therapy.
- Consider a novel protein/hydrolyzed protein prescription diet.
- Recommend a FNA of the enlarged mesenteric lymph nodes.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- If symptoms are persisting consider obtaining GI biopsies.









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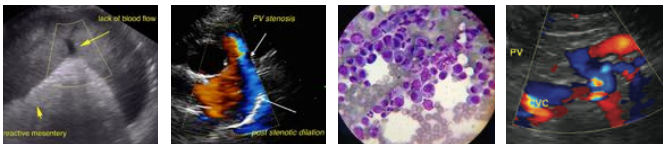

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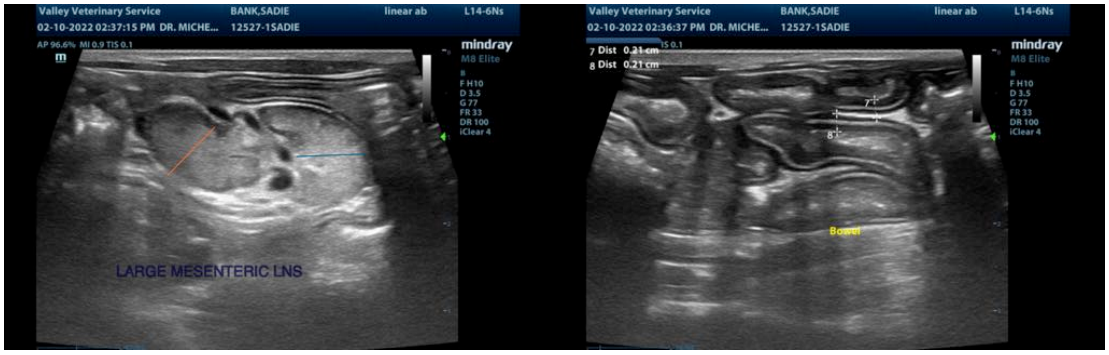

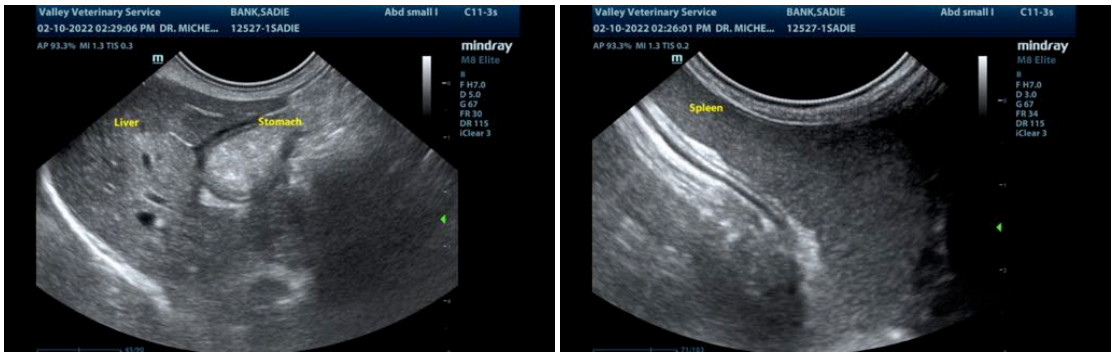

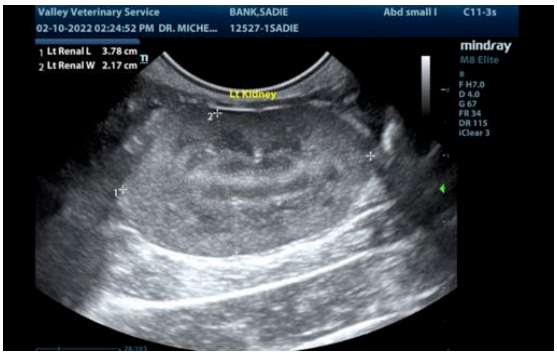

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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