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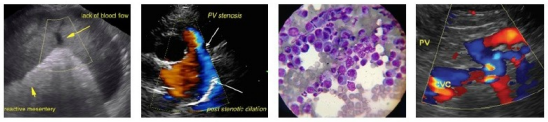

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Tessie Rakaczky

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

11 Years

WEIGHT

5.6 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Advanced Pet Care of NV

REFERRING VET

Dr. Alexiz Hazelwood

INVOICE

35582

DATE

2/10/22

PRESENTING CLINICAL SIGNS

presented 1/31 for episode of anorexia the previous week, sneezing, congestion, and epiphora. She is indoor/outdoor – not current on vaccinations and lives with large number of other indoor/outdoor cats. Upon exam, she showed moderate to severe muscle wasting, sneezing, nasal congestion (audible), crusted nasal discharge, and severe periodontal disease. O is unsure about urination/defecation/amount eating given the number of other cats in home. She did note, though, that her stools are very malodorous compared to the other cats. She was also quite thin with body condition of 2-3/9. Suspect URI + more serious condition – open dfdx, so labwork was sent out. Physical Exam Findings/Reason for Ultrasound: Muscle wasting, thin body condition, labwork changes – significant neutrophilia, mild lymphocytosis/monocytosis, thrombocytosis, hypoalbuminemia (2.0). 2+ protein in urine (not confirmed with UPC). Labs otherwise unremarkable. Ears: free of excessive debris and erythema, pinna and visible ear canal normal Eyes: mild epiphora OU, free of conjunctivitis and erythema; eyeballs, palpebrae, and surrounding structures normal Mouth/Teeth/Gums: severe gingivitis - concern for potential stomatitis, but exam limited by patient; calculus and gingivial recession, significant halitosis Nose/Throat: mild dark colored crusted nasal discharge - bilateral, audible nasal congestion, tracheal sounds normal Integument: haircoat healthy, no lesions or masses observed, no evidence of ectoparasites Lymph nodes/Thyroid gland: LN palpate soft, smooth, symmetric, normal in size Cardiovascular: No murmurs/arrhthymias auscultated Respiratory: Normal bronchovesicular lung sounds, no wheezes/crackles GI/Abdominal Palpation: soft, nonpainful, no overt organomegaly, thin Musculoskeletal: diffuse moderate to severe muscle atrophy Nervous System: not assessed - normal mentation and gait Urinary/Reproductive: naf - reported to be spayed female

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 (3.51 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 (3.54 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 0.32 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 0.41 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.

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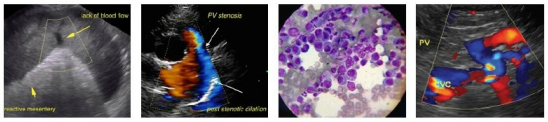

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Spleen

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 large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. 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 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 measured 0.39, 0.28 cm. Duodenum wall measured 0.43 cm. Visualized peristalsis appears appropriate. The bowel appears diffusely thickened with a very prominent muscularis layer. Additionally, there are some areas of bowel with focal loss of layering and wall thickness of a small intestine measuring up to 0.43 cm. In some areas, this gives the appearance of a bowel mass.

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

Scant anechoic free fluid is occasionally visualized. A mesenteric lymphadenopathy is visualized with prominent mesenteric lymph nodes measuring 0.93, 0.44 cm. Additional smaller nodes are observed at 0.38 cm and 0.37 cm. The omentum is generally of increased echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Diffusely severely thickened small intestine with areas of reduced distinction of wall layering - The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. A reduction in the detail of wall layering favors either severe

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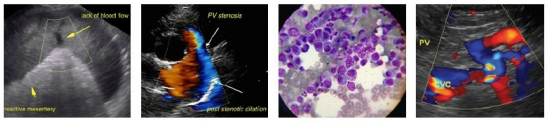

PAWS
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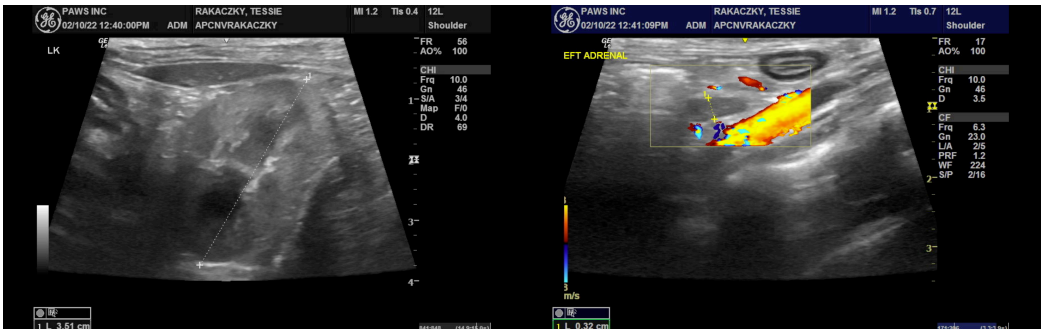
intestinal disease or neoplastic infiltration. Biopsy is recommended.

- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Mild/moderate mesenteric lymphadenopathy – 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 bowel is diffusely abnormal and thickened with a very prominent muscularis layer in some areas, and other areas have more hypoechoic wall and a loss of the distinction of wall layering, most concerning for a severe infiltrative process such as severe IBD or intestinal neoplasia. Additionally, there are prominent mesenteric lymph nodes, which could be reactive or represent neoplastic change.

- Consider fine needle aspirate of the mesenteric lymph nodes and liver.
- Consider GI panel with qualitative fPLI, TLI, cobalamin and folate to Texas A&M to further evaluate the small intestine and pancreas.
- Consider a novel protein/hydrolyzed protein prescription diet.
- Recommend GI biopsies, as I suspect there is a protein losing enteropathy going on.
- Recommend 3-view thoracic radiographs to rule out concurrent intrathoracic disease.



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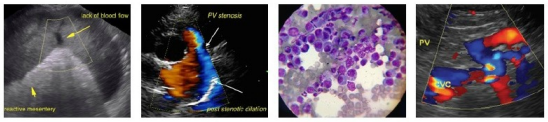

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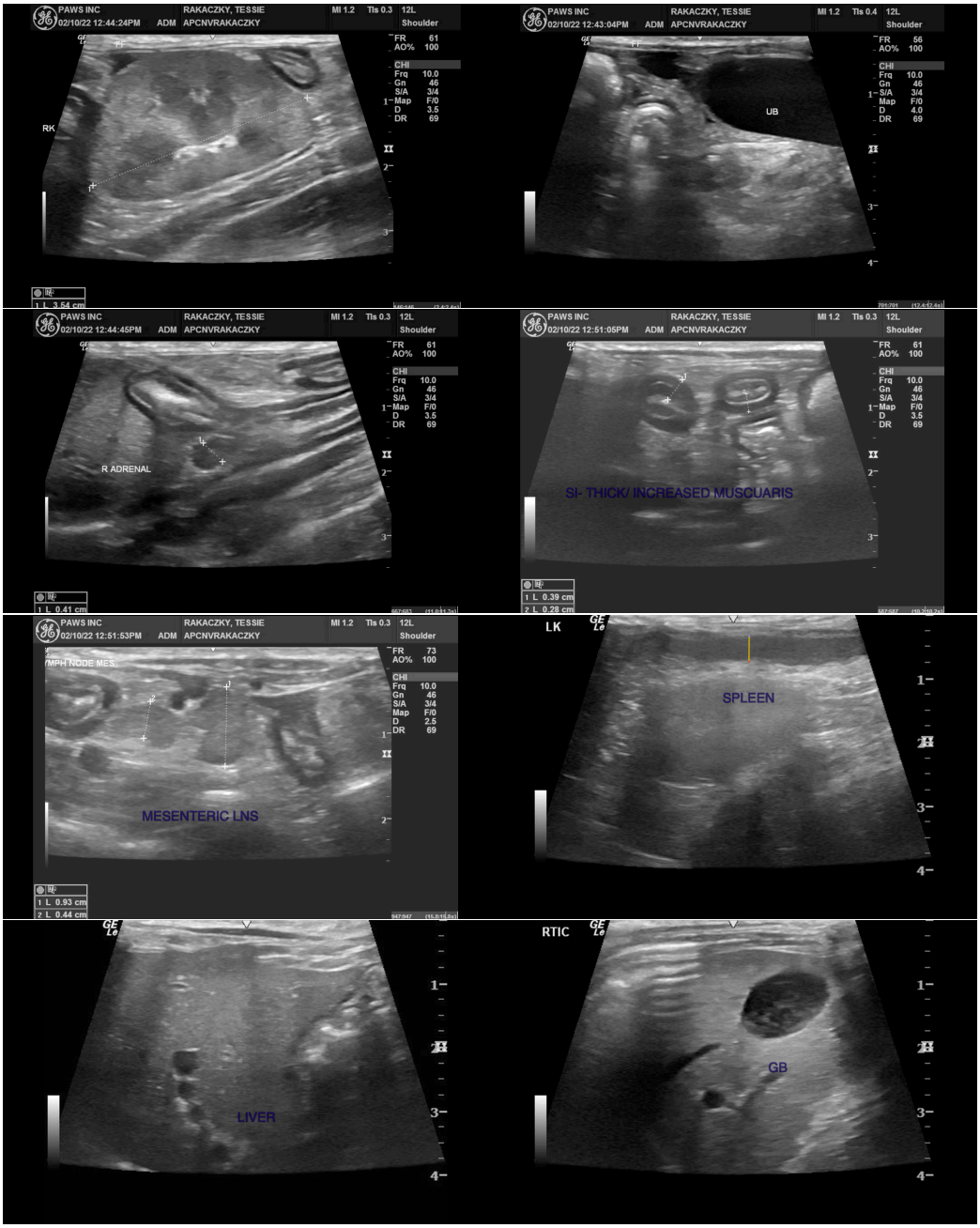

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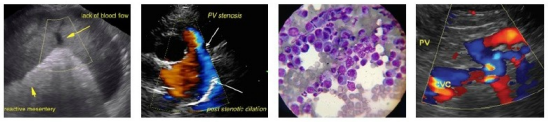

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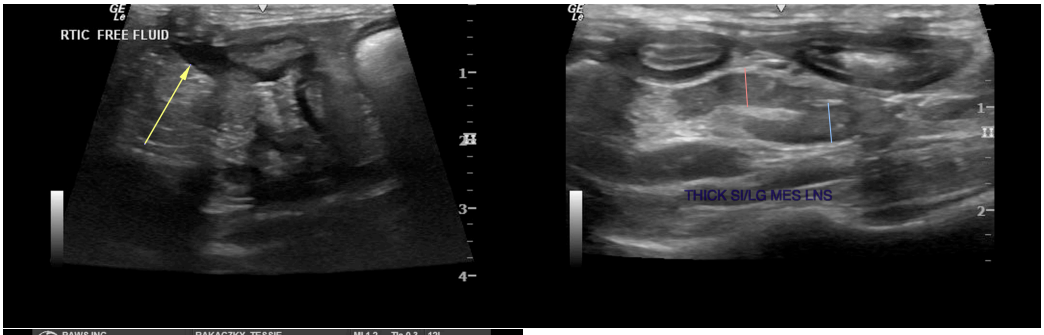

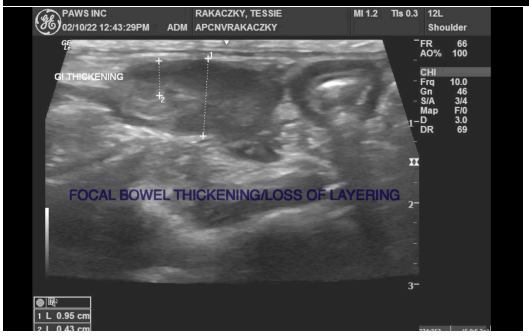

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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