**DATE PRESENTING CLINICAL SIGNS**

2/11/22

PATIENT

Jack Atansio

History: History of presumed IBD and pancreatitis in April of 2020. Pet has been on Budesonide 1 mg EOD since and doing well. Recently presented for possible weight loss. Pet did drop about a pound of weight, was slightly underweight on his physical exam but otherwise the exam was unremarkable. Bloodwork showed borderline pancytopenia.

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

Current Medications: Budesonide 1 mg - EOD (owner to increase to daily as of 2/8/22), Lactulose 3 times daily.

Lab Results: 2/4/22 - HCB 31.5%, RBC 5.87, Hemoglobin 9.9 (non-regenerative), WBC 2.2, neutrophils 1753, lymphocytes 326, eosinophils 51, Plt decreased (microclots present but estimated count between 10000-30000). Chem - unremarkable, T4 - 2.4, UA unremarkable. Attached separately.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Rachel Brillhart, RDMS.

AGE

9/3/10

WEIGHT

8.3 Lbs.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.58 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 (3.69 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 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 right adrenal gland is normal in size measuring 0.34 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.

INTERPRETED BY

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

HOSPITAL NAME

Greenbrier VC

REFERRING VET

Dr. Boccanfuso

INVOICE

13876

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 gall bladder 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. The jejunum measured 0.27 mm in diameter. 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, 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

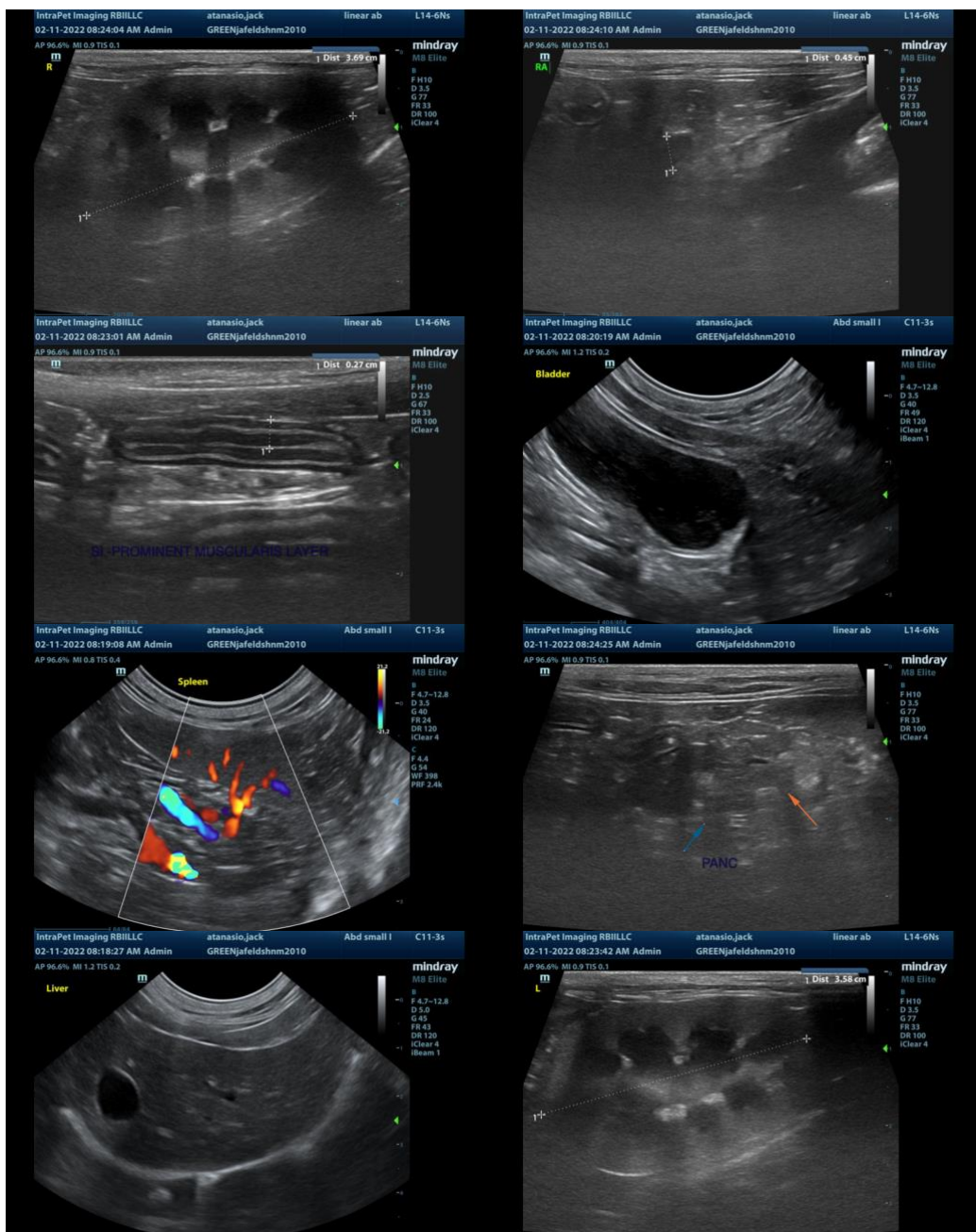
- Increased muscularis layer to the small intestine- The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma
- Prominent hypoechoic pancreas- The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Mildly echogenic debris in the urinary bladder- The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The lesions observed on today's scan were very mild and somewhat nonspecific. No focal bowel lesions were observed. These findings could be consistent with progression of the presumptive diagnosis of IBD, but this is very difficult to say.

- Consider a GI panel with qualitative fPLI, TLI, cobalamin and folate, to further evaluate the pancreatic and small intestinal changes observed.

- If a definitive diagnosis is desired, consider tapering the Budesonide for a week or two and then consider obtaining GI biopsies (this would be the ideal scenario). Otherwise, implement a novel protein/hydrolyzed protein diet (if not already done). Probiotic therapy and you can consider adjustment of the Budesonide dose knowing that if there is no response to therapy, it is difficult to obtain a diagnosis.
- 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. 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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