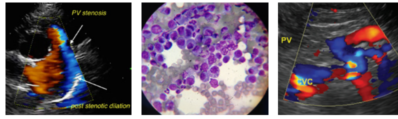
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

2/16/22

PATIENT

Scamp Schwab

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9/1/08

WEIGHT

9.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Paradise AH

REFERRING VET

Dr. Pound

INVOICE

35692

PRESENTING CLINICAL SIGNS

History: ~6-month history of weight loss. Hyporexia and intermittent anorexia for ~3 months. PE: Fluid filled intestines, subjectively thickened on palpation. Diffuse mild cachexia.

Current Medications: Mirataz 1.5 inch strip on ear pinnae Q24h PRN (since 2/9/22). Convenia injection given at emergency clinic 10/29/22
Lab Results: Mild anemia - 6.97 (7.12).
Radiographs: 3-view radiographs performed at emergency clinic - reportedly NSF.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 (4.35 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 (4.11 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 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 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 severely dilated with fluid. It measures at a normal thickness of <0.36 cm with some variability due to the presence of rugal folds. The distinction of gastric wall layers is adequate and there is no impression of reduced peristaltic activity. Findings could be consistent with severe ileus or a gastric outflow tract obstruction, but no evidence of an obstruction is visualized.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter, which is severely dilated with fluid. Wall thickness largely appears normal, and bowel loops are following a normal curvilinear path. The duodenum measures as normal. The jejunum measures as normal at 0.24 cm. Visualized peristalsis appears slightly diminished. 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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are many prominent mesenteric lymph nodes measuring 0.81, 0.67, 0.73 cm. The omentum is of increased echogenicity, particularly around the enlarged lymph nodes.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic pancreas surrounded by hyperechoic mesentery – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

- Severely dilated stomach and small intestine – Both the stomach and small bowel are diffusely dilated and fluid filled with a reduction in progressive motility and no observable obstruction. Findings are most consistent with generalized gastrointestinal ileus or a distal obstruction (none observed).

- Mild to moderate mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

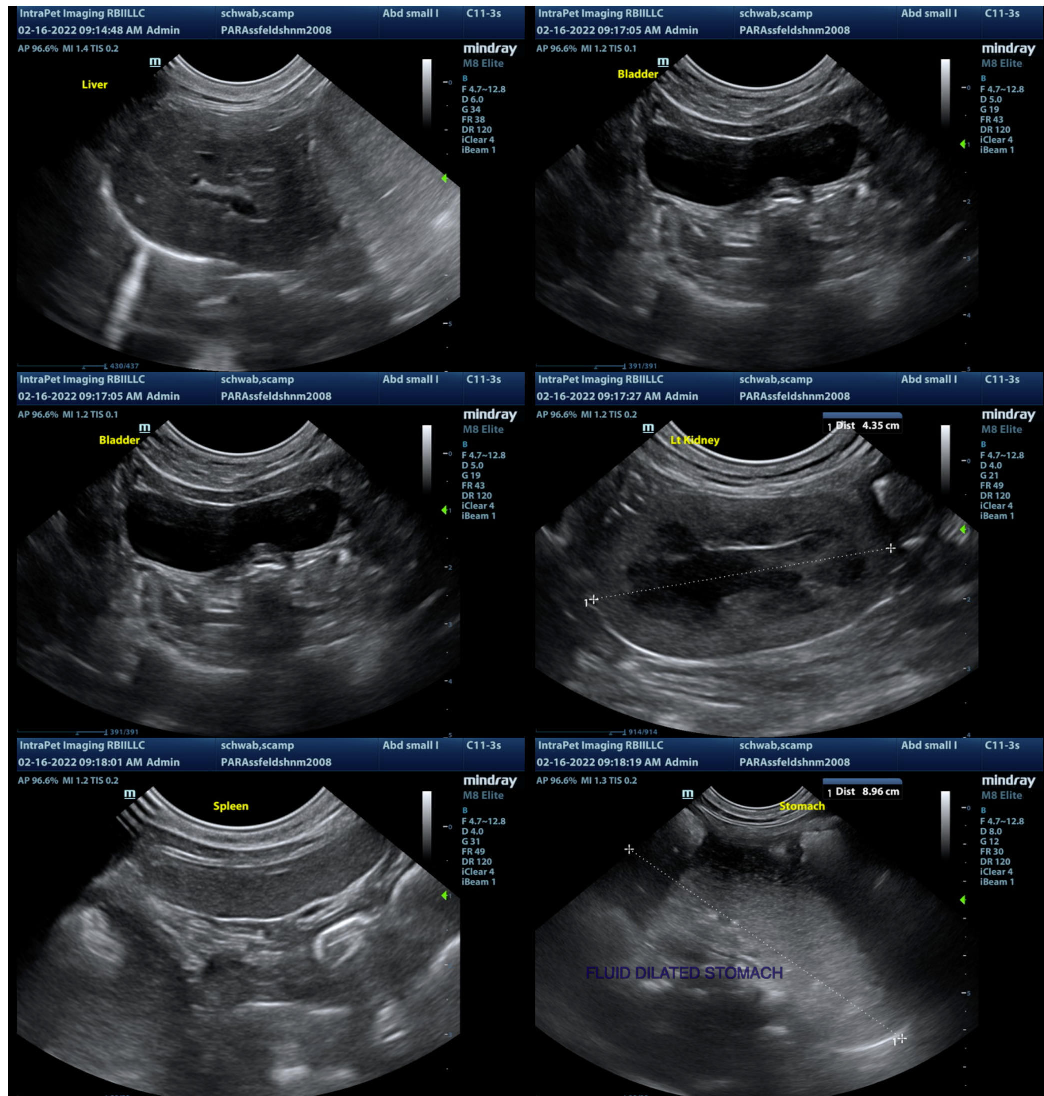
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

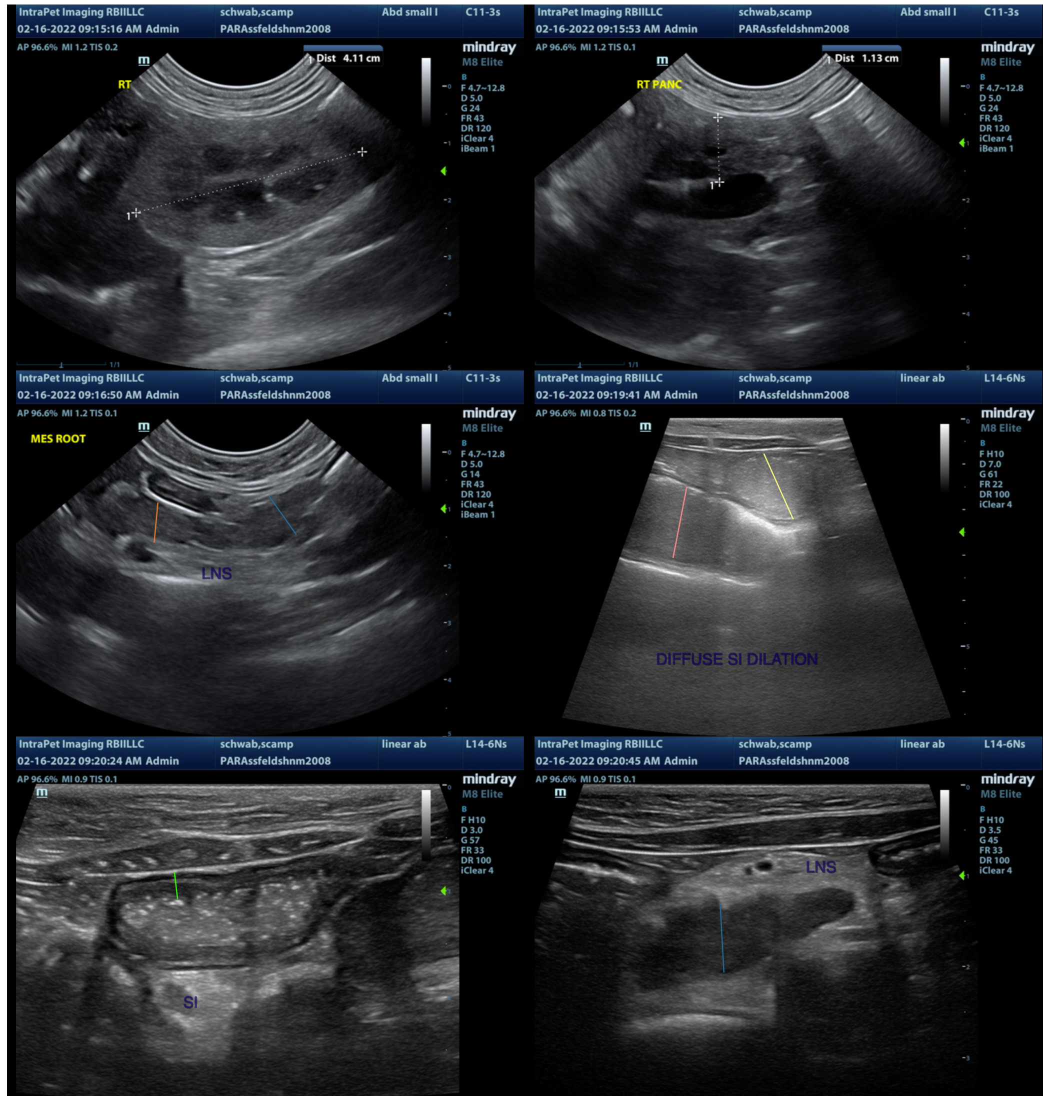
There is diffuse dilation of the entire GI tract with fluid. No obstructions are visualized (but cannot be ruled out), although with this level of fluid distention, complete evaluation is very difficult. Consider placement of NG tube to decompress the stomach. Recommend starting promotility drugs such as Metoclopramide. The most common cause of generalized ileus is underlying gastrointestinal disease, electrolyte disturbances, or less likely dysautonomia. Recommend 3-view thoracic radiographs to look for evidence of concurrent intrathoracic disease and/or megaesophagus.

Recommend stabilization while trying to decompress the GI tract and stimulate motility. Biopsies of the GI tract may be necessary, and further evaluation to rule out a possible distal obstruction such as concurrent radiographs, serial imaging, a GI panel to Texas A/M for fPLI, TLI, cobalamine/folate testing, a fine needle

aspirate of a GI lymph node, etc. Consultation with a veterinary ophthalmologist regarding the possibility of dysautonomia (if this has been seen in your area of the country), etc.

Depending on the status of this patient, a feeding tube may need to be placed to start a liquid diet with aggressive supportive therapy.





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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