

**DATE**

2/22/22

PRESENTING CLINICAL SIGNS

Periodic vomiting since October 2021. Lost 2.5 pounds in 2 months after switching from Blue Buffalo HF dry to wet. Radiographs and BIPS study November 2021 indicative of slow GI motility. Three episodes of hematemesis since January 2022. Pre-existing asthma (resistant to steroids) diagnosed March 2019 by prior vet. Feline coronavirus titer, toxoplasma diagnosed December 2020
Current Medications: Terbutaline 0.25mL BID since October 2020, Omeprazole 0.5mL SID since February 2022.

PATIENT

Simon Marte

SPECIES

Feline

BREED

Domestic Shorthair

Lab Results: 11/3/21- CPK 638 (56-529), other chem normal, hematology normal, thyroid normal. 2/26/21 allergy panel- multiple environmental- candida, staph bacteria. Food- barley, corn, flax, pumpkin, rice, tomato, white potato. 12/24/20- serology FCV 1:400 positive, 1:1600 negative toxoplasmosis, IGG 1:128 positive, IGM negative.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Stephanie Pearce RDCS, RVT.

SEX

Neutered male

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 2cm) 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.

AGE

2/12/13

WEIGHT

8.3 lbs

The left 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.

INTERPRETED BY

Kathleen Sennello
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ACVIM (Small Animal
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The right kidney has a normal shape and size (3.71 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.

HOSPITAL NAME

Friendly Paws VC

Adrenal Glands

The left adrenal gland is normal in size measuring 0.37 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.

REFERRING VET

Dr. Price

The right adrenal gland is normal in size measuring 0.44 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.

INVOICE

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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 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.

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.

Many of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Some have moderate fluid distension and some intraluminal gas. Wall thickness is normal. The jejunum measured 0.15 cm. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. 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

PRIMARY FINDINGS:

- 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.
- Hypoechoic, prominent, pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

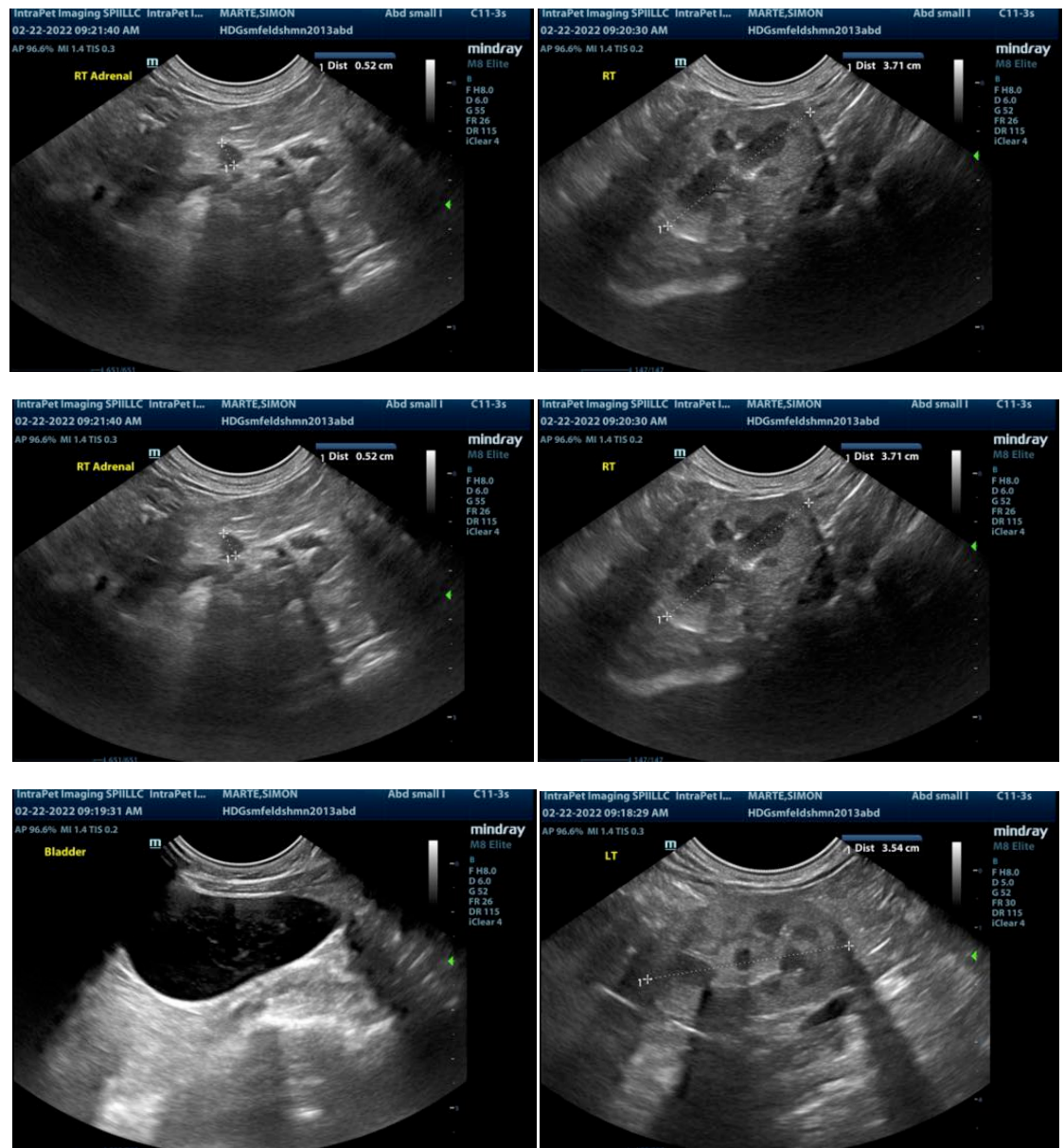
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

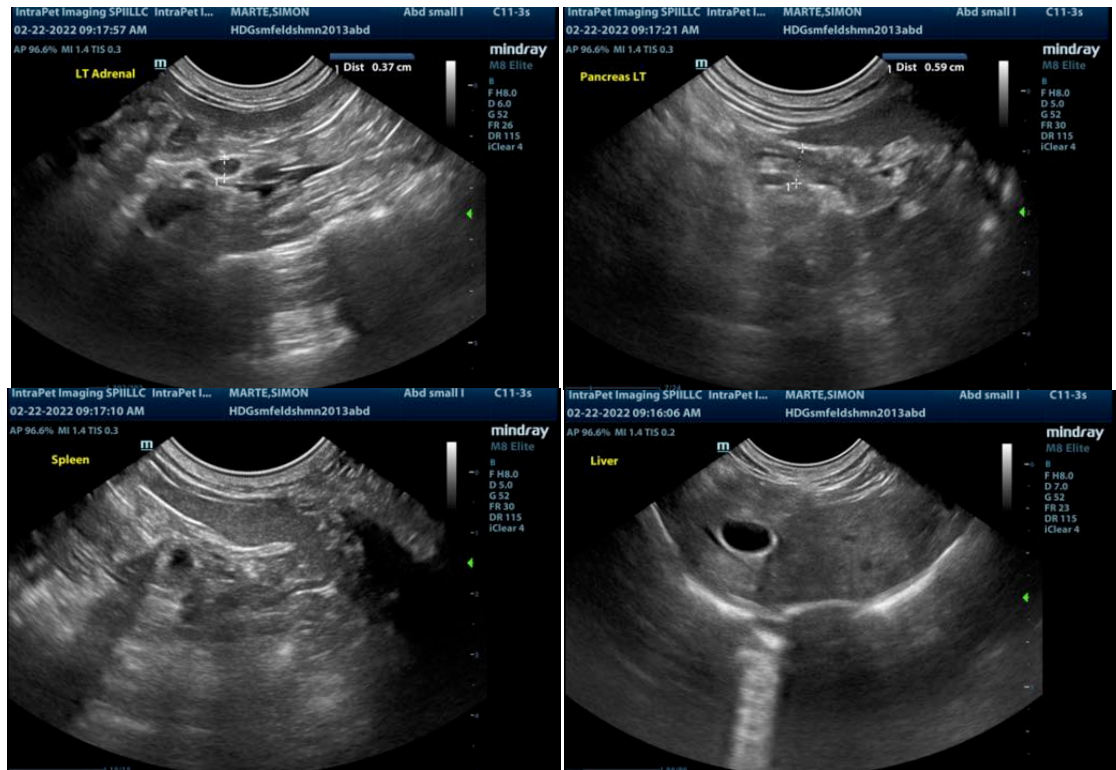
No focal lesions are visualized associated with the gastrointestinal tract. The pancreas is somewhat prominent. This could be consistent with current chronic pancreatitis or a previous episode. Based on the vomiting reported I would suspect gastrointestinal disease as the primary issue. Unfortunately there are many causes for vomiting which cannot be definitively diagnosed by ultrasound alone.

- Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the small intestine and pancreas.

- Recommend a hydrolyzed protein or novel protein prescription diet.
- Consider chronic probiotic therapy.

It is unclear what component the pulmonary disease has in this situation. In a cat this young I would consider tapering off the steroids if there has been no clinical response and perform an airway wash and obtain GI biopsies (likely endoscopic) to confirm the diagnosis as the pulmonary pattern is concerning for a cat of this age. If a diet cannot be obtained, which follows the requirements of the allergy panel then consider consultation with a veterinary nutritionist regarding a homemade, hypoallergenic diet. Many of the Universities provide this service on an outpatient basis. Consider inhaled steroids if inflammatory pulmonary disease is diagnosed/persists.





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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