

**DATE PRESENTING CLINICAL SIGNS**

2/25/22

NSF on exam, BW- WNL.

Current Medications: N/A.

Date of Previous IntraPet Ultrasound: No previous.

PATIENT

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Holly Criss

Imaging Performed By: Rachel Brillhart, RDMS.

SPECIES

Feline

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**BREED**

Domestic Shorthair

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.

SEX

Spayed Female

The left kidney has a normal shape and size (3.73 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.

AGE

3/1/09

The right kidney has a normal shape and size (4.1 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. Non-obstructive nephroliths were noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

WEIGHT

10.5 lbs

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.

INTERPRETED BY

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

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.

HOSPITAL NAME

Homeward Bound VS

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.

REFERRING VET

Dr. Vance

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.

INVOICE

96344

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. There is soft shadowing material in the gastric lumen. This is most consistent with ingesta or possible foreign material such as a hairball.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. The duodenum measured 0.43 cm and the jejunum measured 0.32 cm. 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. 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 mottled 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 are occasional prominent mesenteric lymph nodes with the gastric lymph node visualized at 0.62 cm and a caudal mesenteric lymph node measuring at 1.0 cm. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Prominent, hypoechoic pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Shadowing material in the gastric lumen. Findings could be consistent with ingesta or foreign material such as a hairball, etc. Correlate with feeding history.
- Prominent 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, mesenteric lymph nodes. 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 mild small intestinal thickening with prominent muscularis layer in addition to prominent, mesenteric lymph nodes, which is an indicator of possible inflammation in the GI tract. Additionally the pancreas is somewhat prominent.

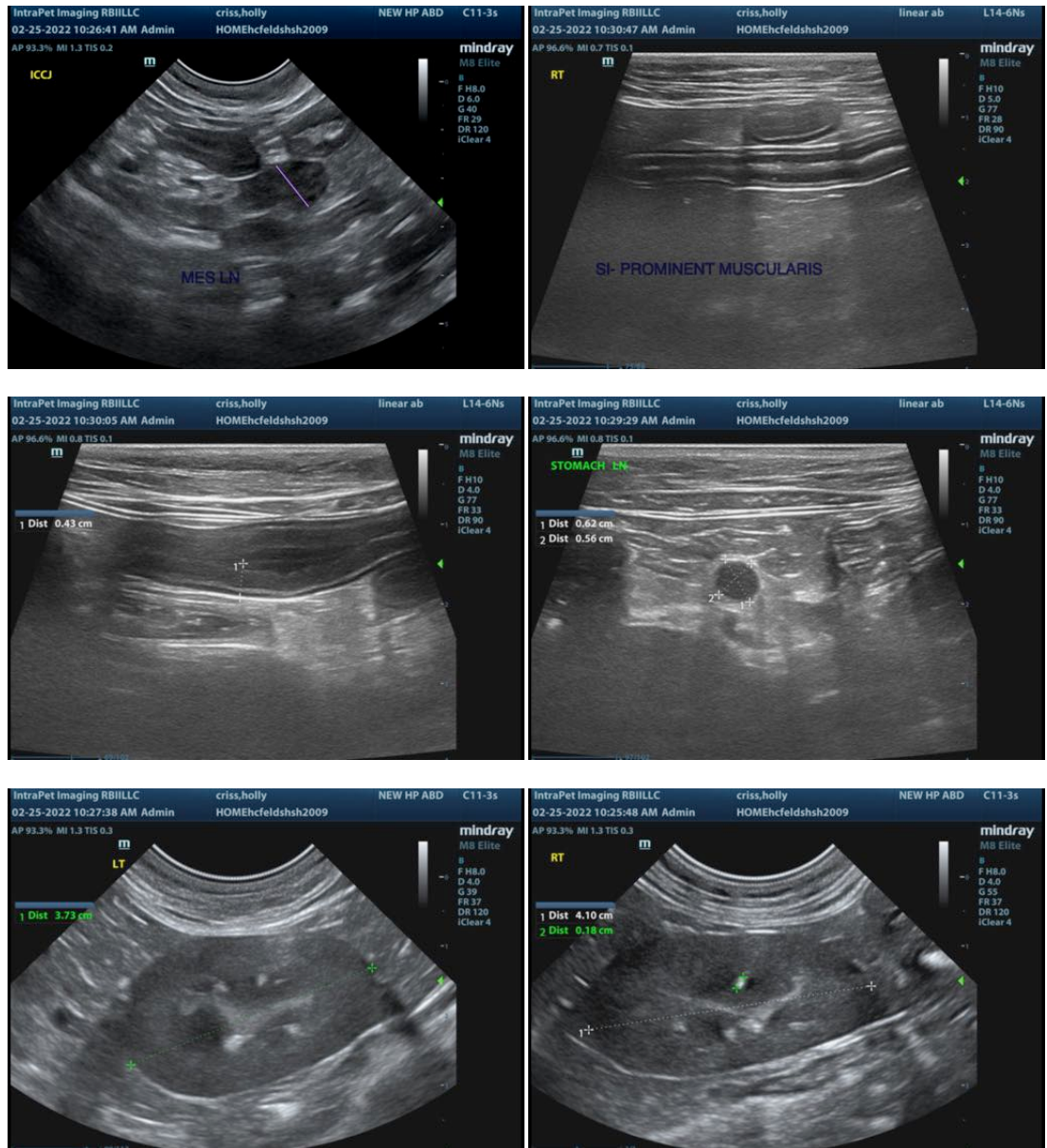
- Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreatic and small intestinal changes observed.
- Recommend a novel protein/hydrolyzed protein prescription diet.
- Recommend probiotic therapy.

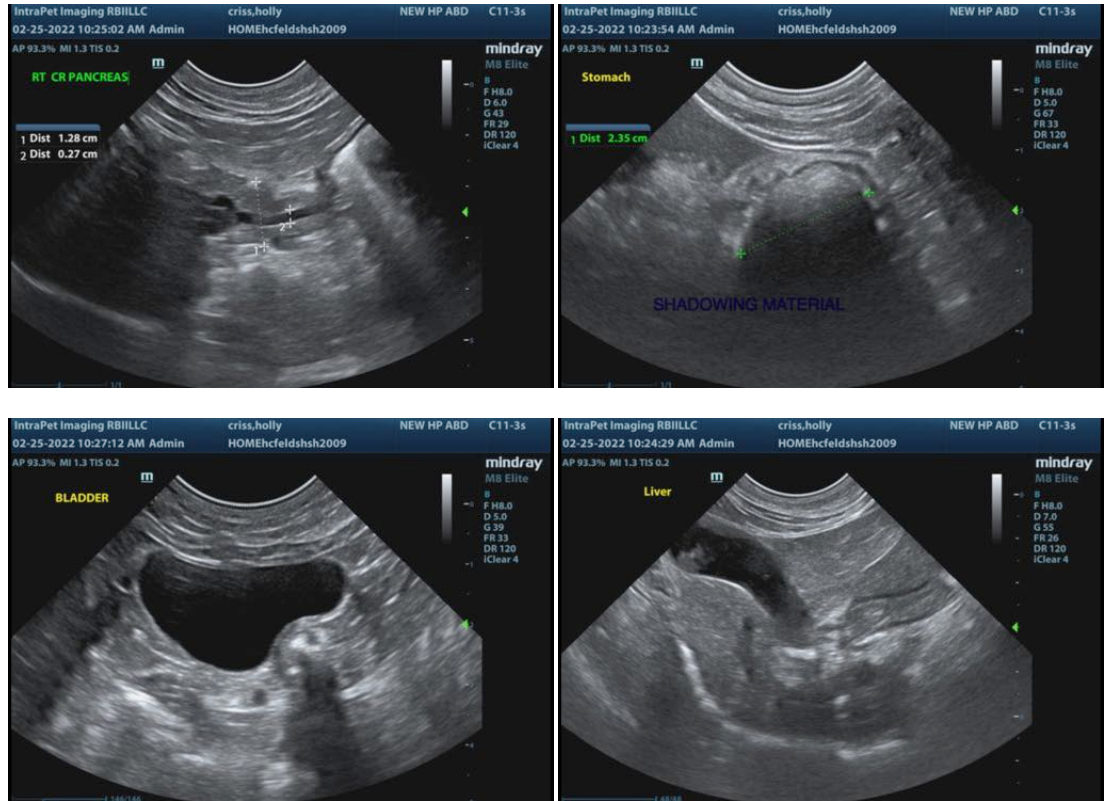
Additionally there is shadowing material in the gastric lumen, which could be consistent with ingesta, large hairball, etc. Correlate with abdominal radiographs and feeding history.

If symptoms persist consider obtaining GI biopsies and evaluating the stomach contents.

Some of the mesenteric lymph nodes border on large enough for a FNA and this could be a consideration as well.

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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