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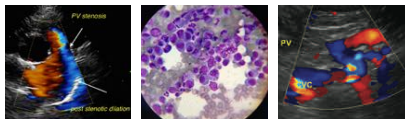

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DATE
3/22/22

PATIENT
Linus McCluskey

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
8/29/08

WEIGHT
9.8 lbs

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

HOSPITAL NAME
Hickory VH

REFERRING VET
Dr. McNesby

INVOICE
97059

PRESENTING CLINICAL SIGNS

Patient presented Jan 2021 for intermittent vomiting. Labwork revealed hyperthyroidism, all else WNL. Patient treated with Methimazole - controlled TT4 but vomiting persisted. Changed to sensitive stomach OTC diet (Blue buffalo sensitive skin and stomach), added Cerenia 4 mg Q24 -48 hours. Vomiting controlled, but patient began to lose weight. Patient has now lost approx. 25% of body weight in last year, T4 is low. Decreased dose of Methimazole. Physical exam 3/11/22 - large thyroid nodule palpable, thickening of distal small intestine (ileocecal
junction), firm feces, loss of body condition.
Current Medications: Methimazole 1.25mg BID, Maropitant 4mg q24-48 hours.
Lab Results: See attached.
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.

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 (3.67 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 (4.42 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 0.47 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 0.37 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.

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 is minimally distended with luminal contents. The gastric wall appears thickened particularly in the region of the pylorus with reduced detail of layering. Thickness in this area measures at a maximum measurement of 0.94 cm and extends at least 3.26 cm in length. The findings are most consistent with focal gastric wall thickening.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. The jejunum measured 0.19 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 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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a prominent, gastric lymph node visualized at 0.59 cm and the omentum is generally of normal echogenicity. 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:

- Focally thickened gastric wall. The focal thickening observed could be consistent with inflammation, gastric ulceration, edema, infiltrative neoplasia or imaging artifact due to rugal folds, other.

- 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 gastric lymph node. 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 a focal area of the stomach wall that appears thickened and has decreased layering detail. This area is concerning for a neoplastic process, but given the chronicity of the symptoms, gastric ulceration, edema, hyperplasia, etc. could be differentials. Consider biopsy of the gastric wall in this area. If a less invasive procedure is desired you can also consider trying a FNA of the thickened area (see images provided).

Additionally the muscularis layer is somewhat prominent in the small intestine. This can be a normal finding

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

- Consider hydrolyzed protein/novel protein diet in case there is dietary sensitivity present.
- Consider ulcer therapy.
- Recommend three view thoracic radiographs.

If surgical biopsies of the stomach are considered I recommend obtaining biopsies of the small intestine and gastric lymph node as well.

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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