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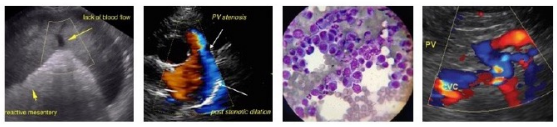


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Feta Mendoza

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2 Years

WEIGHT

3.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Sixteen Mile VC

REFERRING VET

Dr. Gibbs

INVOICE

36481

DATE

3/25/22

PRESENTING CLINICAL SIGNS

appetite change, frequent vomiting, recent weight loss, no change in stools, coughing

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 (3.32 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 (3.52 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 0.26 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 0.29 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

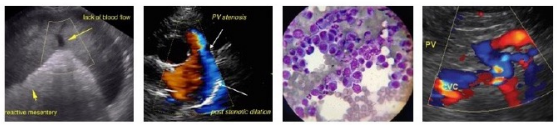
The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. There is a small hyperechoic nodule visualized measuring 0.55 cm within the parenchyma.

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 moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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



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with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measured 0.28 cm. 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, 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

- Moderate distention of the gastric lumen with ingesta – Correlate these findings with abdominal radiographs and feeding history. If the patient was adequately fasted, then consider possible ingestion of foreign material or delayed gastric emptying time.
- 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.
- Small, hyperechoic foci visualized within the hepatic parenchyma – The appearance of this lesion trends towards a benign process, but an underlying neoplastic lesion cannot be excluded. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No large focal lesions are visualized associated with the gastrointestinal tract to explain the vomiting and decrease in appetite described. The small intestine generally is mildly fluid distended, and the muscularis layer is slightly prominent. This can be an indicator of underlying inflammation. Additionally, there is ingesta within the gastric lumen. Correlate this with feeding history and abdominal radiographs. If the patient was adequately fasted, the consider such differentials as delayed gastric emptying, partial outflow tract obstruction, etc. If metabolic causes such as hyperthyroidism, etc. have been ruled out, then consider primary GI causes such as food allergy/dietary intolerance, GI parasitism, dysbiosis, pancreatitis, dietary indiscretion, less likely IBD and intestinal neoplasia.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Recommend the aforementioned GI panel for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Recommend chronic probiotic therapy.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- If symptoms persist, consider obtaining GI biopsies.

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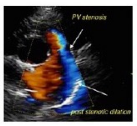
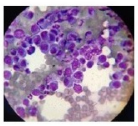
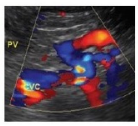

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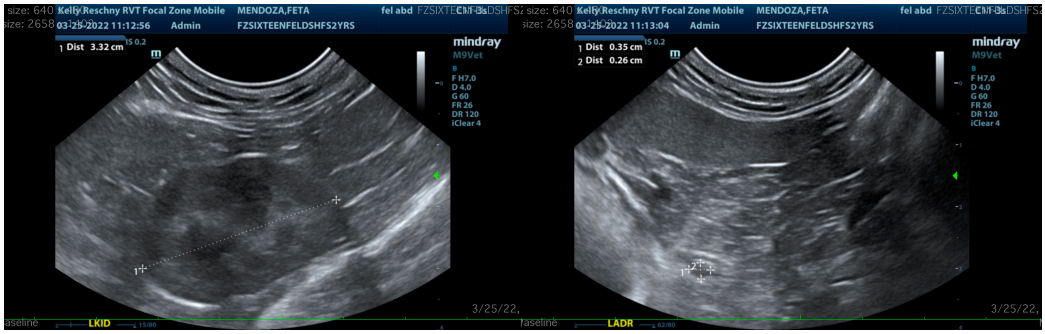

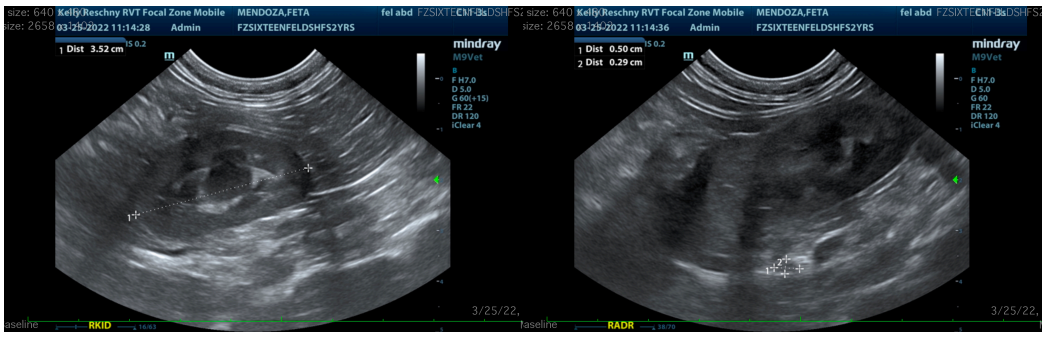

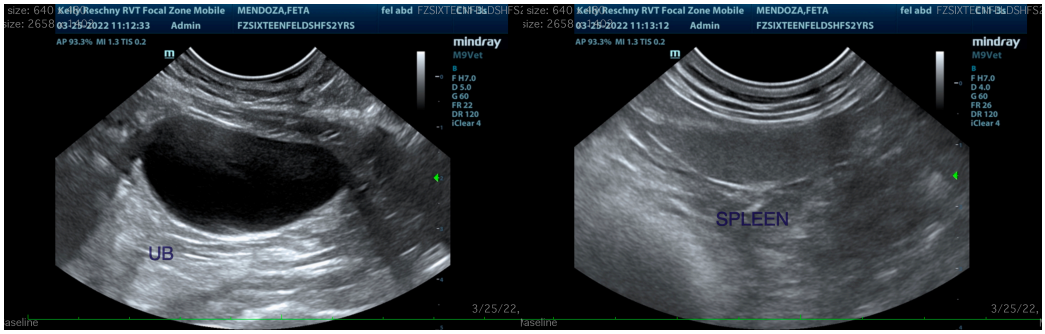

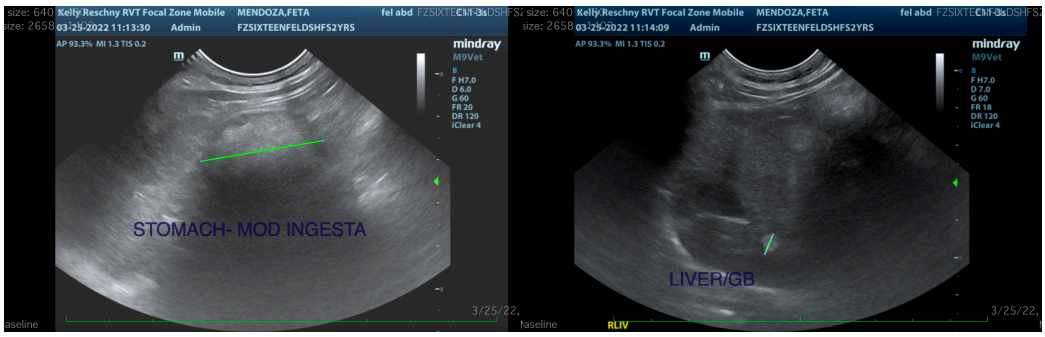

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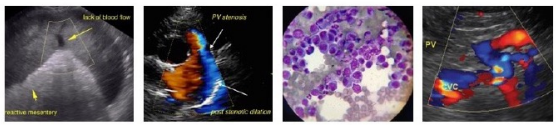

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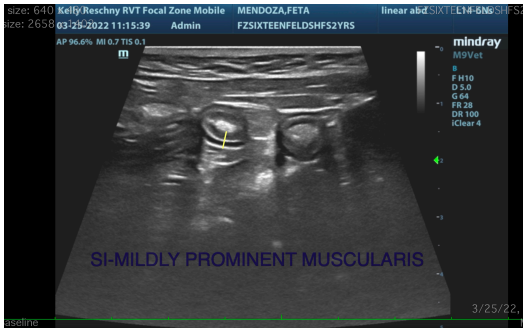

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com