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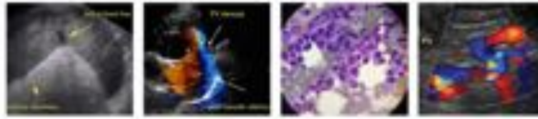


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8348

PATIENT

Calcifer Hood

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

03/12/2016

WEIGHT

7.9kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Aspen Animal Wellness Center

REFERRING VET

Dr. Betsy Phillips

INVOICE

10148

DATE

3/28/2023

PRESENTING CLINICAL SIGNS

History * Chronic intermittent vomiting, weight loss Working diagnosis Renal disease, GI disease (IBD vs emerging intestinal infiltrative dz) Summary of Abnormal LABs mild azotemia (pre-renal vs renal), hypokalemia, hyponatremia, hypochloremia, hypogcholesterolemia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with echogenic 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 (4.19 cm). Overall echogenicity is slightly hyperechoic with mildly poor corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal 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 (4.25 cm). Overall echogenicity is slightly hyperechoic with mildly poor corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal 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 0.42 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 but somewhat atypical in appearance it measures at 0.43 cm in width. There is an ill-defined subtle hyperechoic region visualized in the right adrenal measuring approximately 0.80 cm x 0.49 cm. No evidence of vascular invasion is visualized.

Spleen

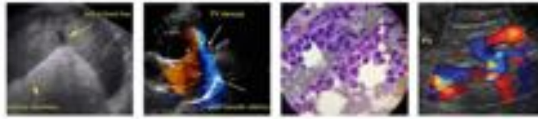
The spleen is subjectively normal in size (0.96 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal



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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.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. The jejunum measured as normal (0.19 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 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.

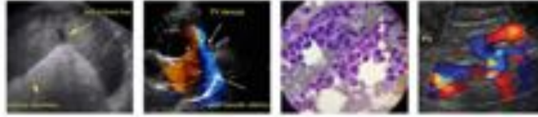
Free Abdomen

Evaluation of the peritoneal cavity did reveal scant amount of free fluid. There are prominent lymph nodes visualized throughout the abdomen. The mesenteric lymph nodes near the ileocecal junction measure 0.89 cm x 2.4 cm. A mesenteric lymph node is visualized at 0.42 cm and the sub lumbar lymph nodes are normal measuring 0.41 cm and 0.35 cm. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is generally of normal echogenicity.

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.
- Mildly reduced corticomedullary distinction in both kidneys. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Prominent mottled pancreas. The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis, or chronic pancreatitis.
- Subtle hyperechoic region in the right adrenal. This is likely an incidental finding, but I cannot rule out an early neoplastic lesion. Recommend continued monitoring.
- 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



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No focal lesions are visualized associated with the gastrointestinal tract to explain the vomiting and weight loss reported. Unfortunately, there are many causes for chronic vomiting which cannot be diagnosed by ultrasound alone.

Consider such differentials as food allergy/dietary intolerance, GI parasitism, chronic pancreatitis, IBD and less likely neoplasia, etc.

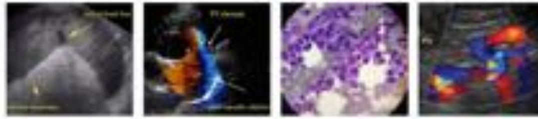
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- If symptoms persist despite taking these measures, consider obtaining GI biopsies.

There is a mild reduction of in the corticomedullary distinction in both kidneys. This could be a sign of early renal disease. Correlate these findings with bloodwork, a blood pressure evaluation, urinalysis, and culture. Additionally, there is some echogenic debris in the urinary bladder. These tests will help screen for urinary tract infection.

The prominent lymph nodes in the abdomen are most likely reactive lymph nodes. If symptoms are persisting, you could consider a fine needle aspirate.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

There is an ill-defined hyperechoic region in the right adrenal this could be an incidental finding consistent with hyperplasia or other irregularity but there is also the possibility that this could be an early neoplastic lesion. The previously recommended blood pressure will help to screen for a pheochromocytoma. If hypertension is present consider obtaining catecholamine levels and consider reevaluation of this lesion in 8-12 weeks, looking for evidence of change which could indicate a more aggressive lesion.



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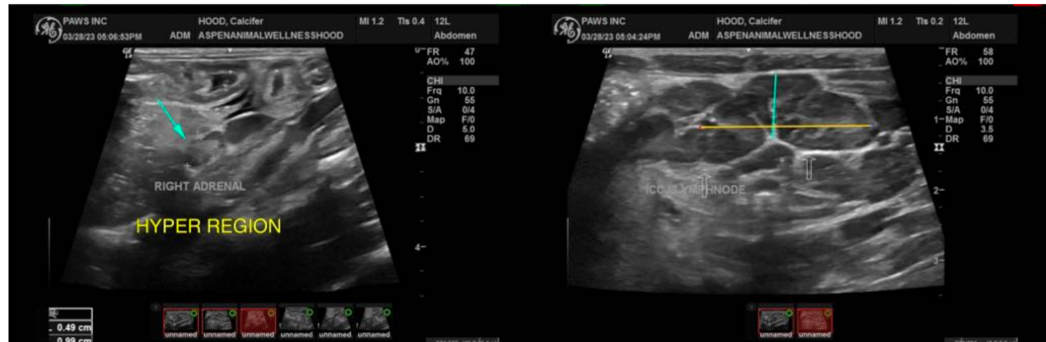

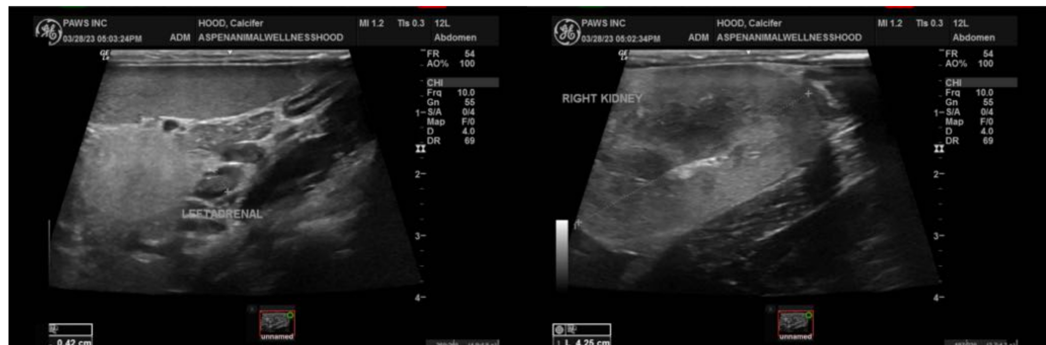

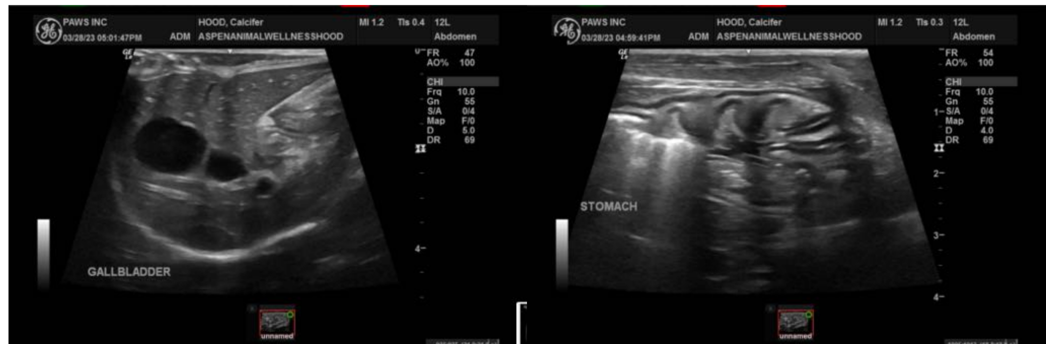

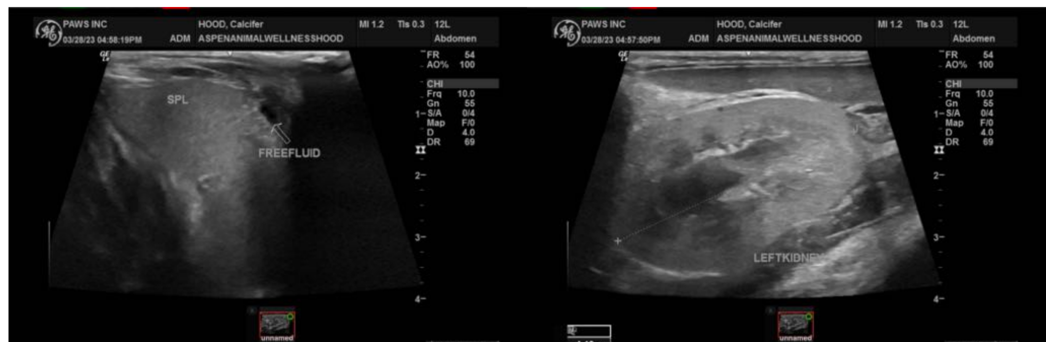

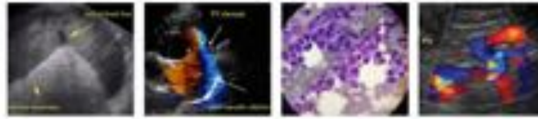

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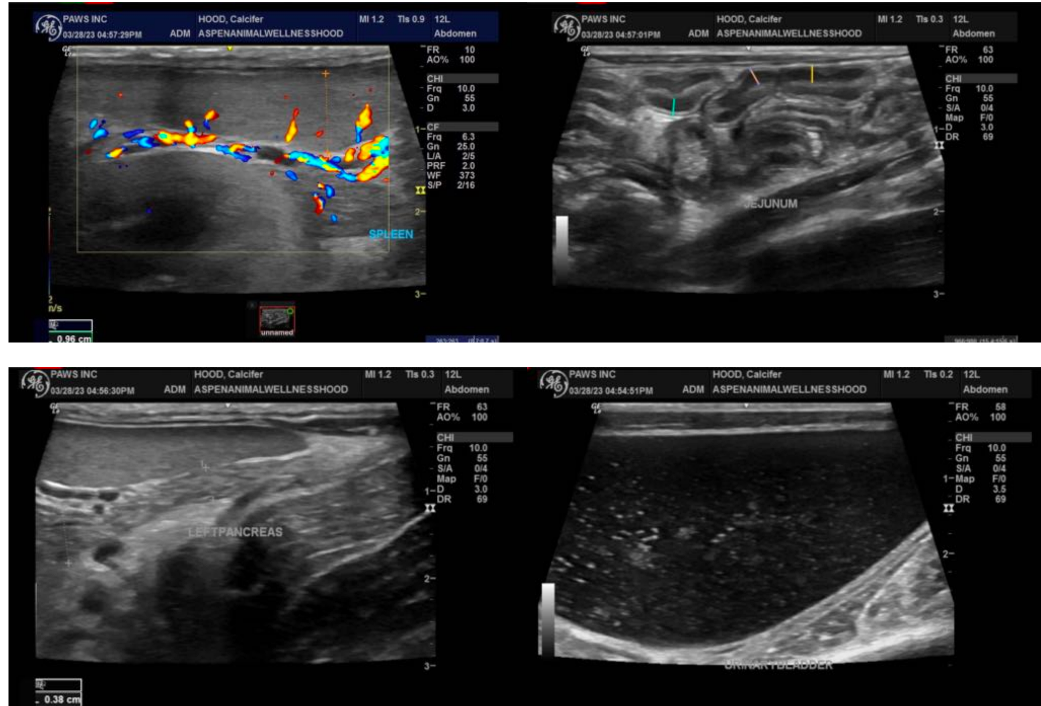

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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