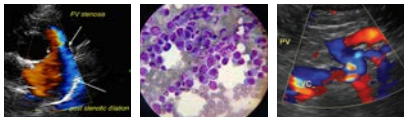
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

3/29/23

PATIENT

Mary Kate Mixter

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6/18/06

WEIGHT

9.75 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Charm City VH

REFERRING VET

Dr. Hansen

INVOICE

46270

PRESENTING CLINICAL SIGNS

Will have intermittent vomiting/anorexia episodes. Historical Gastrotomy in ~2017 - SI biopsies at that time were ok. IBD was suspected post extensive work up 3-4 years post biopsy date. Hx Hyper T4 treated with radioactive iodine. Lost 0.75 lbs. since last visit 4 months ago.

Current Medications: Ondansetron 1-2 mg PO q12h PRN.
Lab Results: CBC/CHEM/T4 were WNL.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

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 (3.59 cm) with small non-obstructive nephroliths. Overall echogenicity is normal with adequate 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.19 cm) with occasional small non-obstructive nephroliths. Overall echogenicity is normal with adequate 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, infarcts or hydroureter. Renal vasculature is normal.

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 is visualized.

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 is visualized.

Spleen

The spleen is subjectively normal in size (0.73 cm in thickness), 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 primarily anechoic, but there is a focal 0.40 cm hyperechoic structure visualized, consistent with a small stone or accumulation of hyperechoic debris. 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.

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. Duodenum wall measures 0.30 cm. Jejunum wall measures 0.25 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 left limb of the pancreas is prominent and hypoechoic with surrounding hyperechoic mesentery. The pancreatic duct appears severely distended in this limb, measuring approximately 0.44 cm with thickened wall. No obvious obstruction is visualized. The right limb of the pancreas appears somewhat mottled, but is markedly more normal.

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.

PRIMARY FINDINGS

- Severely dilated left pancreatic duct with wall thickening and surrounding hyperechoic mesentery – Findings are concerning for a possible obstructive process, infiltrative disease, or severe inflammatory process.

- Small hyperechoic structure visualized in the gallbladder lumen – Findings could be consistent with a small cholelith or accumulation of hyperechoic debris.

SECONDARY FINDINGS

- Small non-obstructive nephroliths visualized in both kidneys – The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

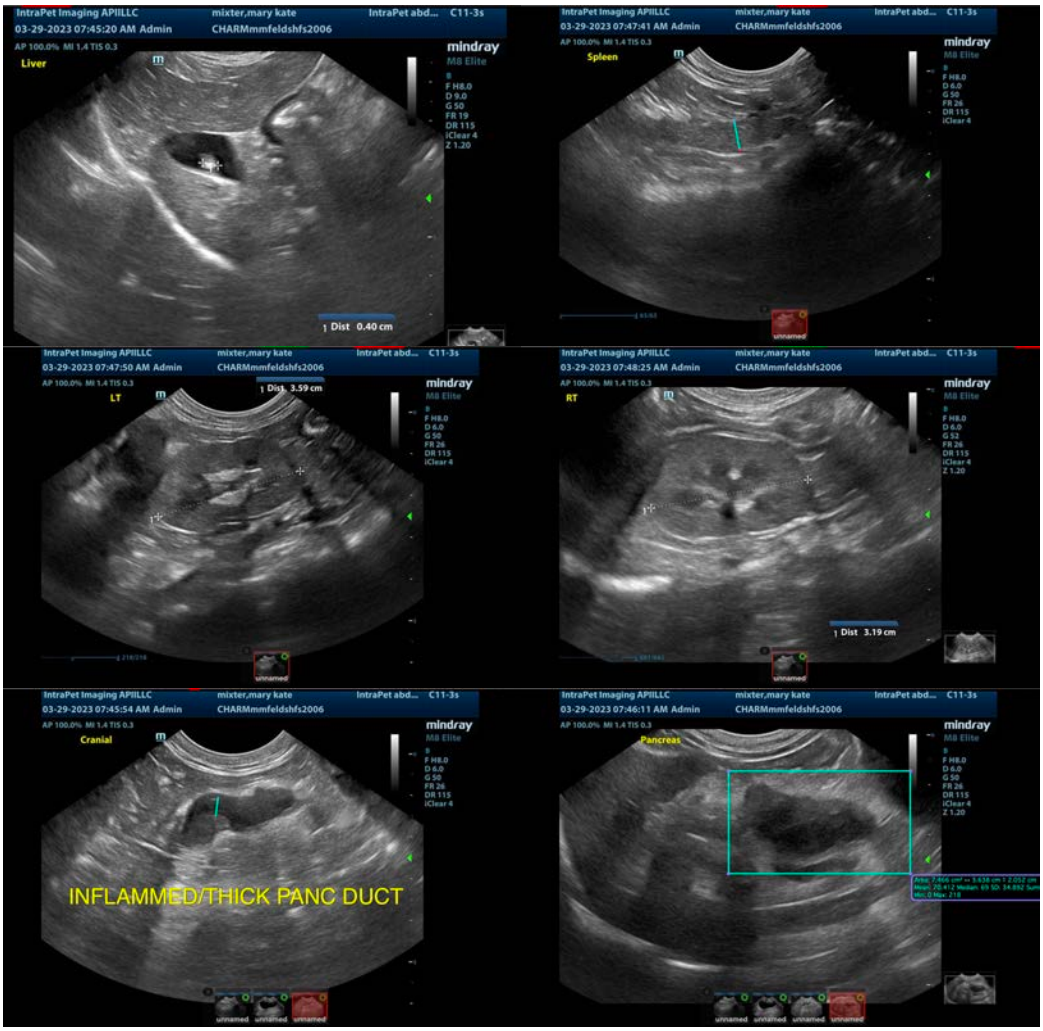
The most prominent finding on today's exam is a large hypoechoic distended pancreatic duct with wall thickening and severe inflammation surrounding. There is some hypoechoic pancreatic tissue, but this is not as prominent as the bile duct dilation. Findings are concerning for infiltration of the pancreatic duct and/or obstruction with likely secondary pancreatitis present.

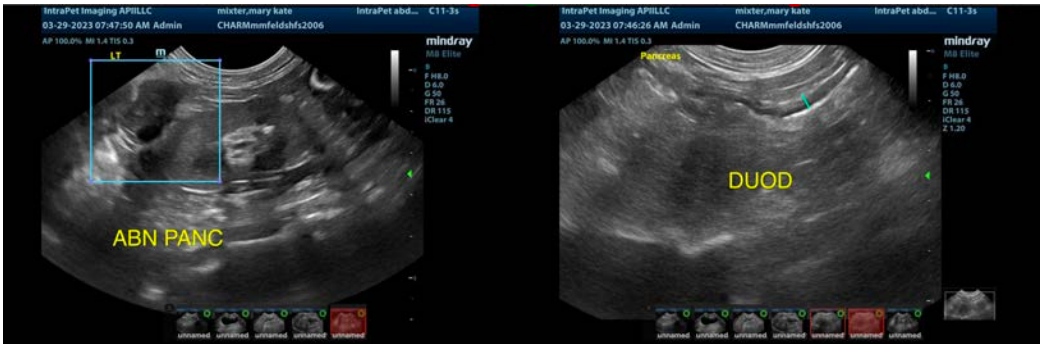
The right limb of the pancreas appears relatively normal. You could consider aggressive therapy for pancreatitis and reevaluation of the pancreatic duct in 5-7 days (earlier if not doing well). Ideally, a fine needle aspirate of the pancreas would be performed if enough solid tissue can be visualized. If symptoms persist, surgical evaluation of the pancreas and pancreatic duct with flushing and biopsies may be necessary. While an obstructed duodenal papilla is not visualized, a lesion in this area of the duodenum would also be

possible.

Unfortunately, there still can be significant gastrointestinal disease present despite the lack of focal lesions. You could consider a novel protein/hydrolyzed protein prescription diet. Additionally, a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate may help to further evaluate the pancreas and small intestine.

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





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.

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