

**DATE PRESENTING CLINICAL SIGNS**

3/8/22

Chronic intermittent vomiting over the past 4 weeks, responsive to supportive care but then recurs. When vomiting flares up, p is less active- but otherwise behaves normally. Indoor only. PE overall WNL, no lesions or foreign material noted under the tongue.

PATIENT

George Matzinger

Current Medications: Received SQ fluids, B12, Pepcid and Cerenia on 2/26- responded well. Started I/D RX diet at this time also.

SPECIES

Feline

Lab Results: T4/Chem/CBC WNL.

Radiographs: Two view abdominal rads showed possible mineralized material in area of ascending colon on VD, but cannot rule out mineralized mass vs mineralization associated with foreign material or R kidney given location.

BREED

DSH

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

SEX

Neutered Male

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.

AGE

11/16/13

The left kidney has a normal shape and size (3.05 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 perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

WEIGHT

6.4 Pounds

The right kidney has a normal shape and size (3.66 cm). Overall echogenicity is slightly hyperechoic with poor 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.

INTERPRETED BY

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

Adrenal Glands

The left adrenal gland is normal/borderline large in size measuring 0.49 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.

IMAGING PERFORMED BY

Rachel Brilhart RDMS

The right adrenal gland is normal/borderline large in size measuring 0.61 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.

HOSPITAL NAME

Churchville VC

REFERRING VET

Dr. Uhland

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.

INVOICE

35979

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. 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 uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. 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. Jejunum wall measured 0.18 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. There is a cluster of prominent mesenteric lymph nodes at the mesenteric root measuring 0.3, 0.44 cm. The omentum is of normal echogenicity.

Other

A brief view of the heart was submitted. No significant pericardial effusion was seen.

PRIMARY FINDINGS

- 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.

SECONDARY FINDINGS

- Mildly decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Borderline enlarged adrenal glands – The significance of this is unclear, and unlikely to be related to the symptoms described. Consider blood pressure evaluation and monitoring for signs of adrenal disease.

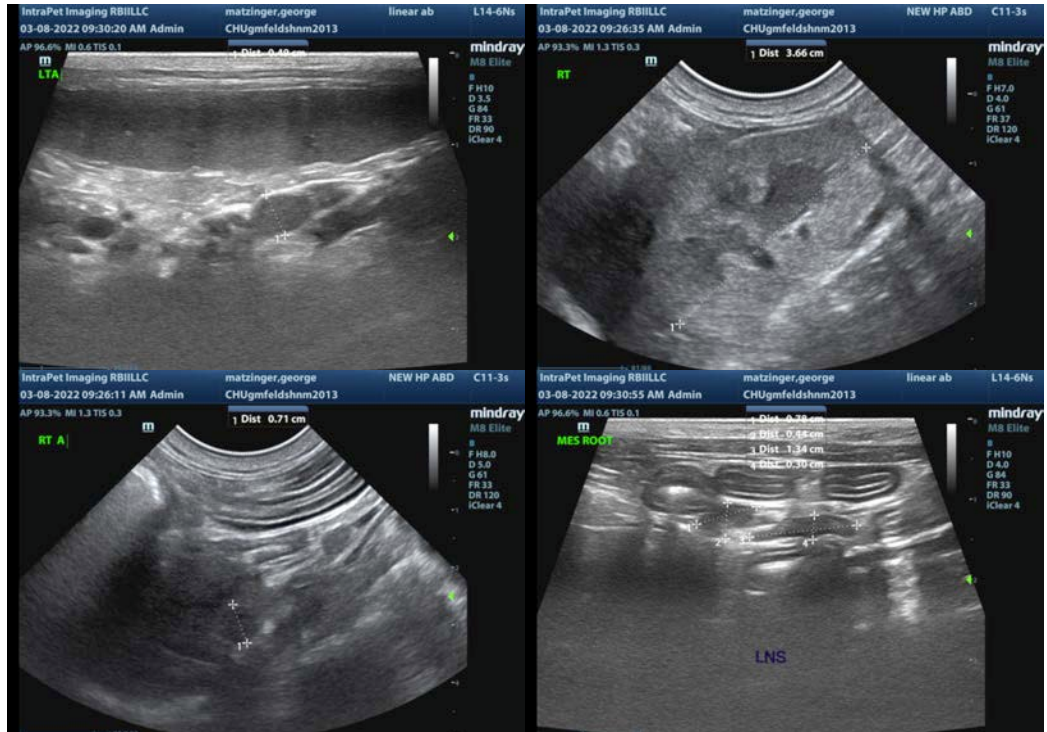
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bowel appears somewhat “ropey” with a prominent muscularis layer. This could be an indicator of inflammatory disease. This is supported by the observation of prominent mesenteric lymph nodes. Possible

differentials to consider would be food allergy/dietary intolerance, GI parasites, bacterial dysbiosis, pancreatitis, IBD, and less likely intestinal neoplasia.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Recommend chronic probiotic therapy.
- Recommend screening and treatment for GI parasites (if not already done).
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- Recommend a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the small intestine and pancreas.
- If these measures do not improve clinical signs, recommend obtaining GI biopsies.





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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