

IMAGING PERFORMED BY

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**DATE PRESENTING CLINICAL SIGNS**

3/8/22

P has had on and off diarrhea for a while and has been on Metronidazole and strictly RC gastro food. O stated that there are no plants in the home. P is indoor only. O stated vomit usually has food in it. O thinks P may overeat or eat too fast. O has never seen any blood. P hasn't been boarding recently or otherwise. O stated the frequency of the vomiting changes; sometimes P vomits multiple times a day, sometimes not at all but usually vomits a minimum of once a week. O stated there are candles in the home but they do not light them. P is not known to eat from the trash or steal human food. O doesn't give human food either.

**PATIENT**

Sinatra Medicus

**SPECIES**

Feline

Current Medications: None.  
Lab Results: NSF.  
Date of Previous IntraPet Ultrasound: No previous.  
Sedation: Not required to complete full diagnostic ultrasound.  
Stat Report: Not requested.

**BREED**

Persian

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**SEX**

Neutered Male

**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**

8/30/19

The left kidney has a normal shape and size (3.68 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.

**WEIGHT**

10 Pounds

The right kidney has a normal shape and size (3.92 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.

**INTERPRETED BY**

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

**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.

**IMAGING PERFORMED BY**

Rachel Brillhart RDMS

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.

**HOSPITAL NAME**

Banfield AH Abingdon

**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.

**REFERRING VET**

Dr. Hatchett

**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.

**INVOICE**

35968

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 dilated with a large amount of 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 moderate 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 0.21, 0.29 cm. Visualized peristalsis appears appropriate. While no focal lesions are observed, a partial obstruction cannot be definitively ruled out.

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***

There is a scant amount of free abdominal fluid visualized. There is a significant mesenteric lymphadenopathy present at the mesenteric root, with mesenteric lymph nodes measuring 0.68 cm and 0.50 cm. The omentum is generally of normal echogenicity.

## **PRIMARY FINDINGS**

- Large ingesta-filled stomach – This patient was adequately fasted. Therefore, possible differentials would include delayed gastric emptying or a partial outflow tract obstruction.
- Subjectively thickened small intestine with diffuse fluid dilation and a prominent muscularis layer – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Moderate mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

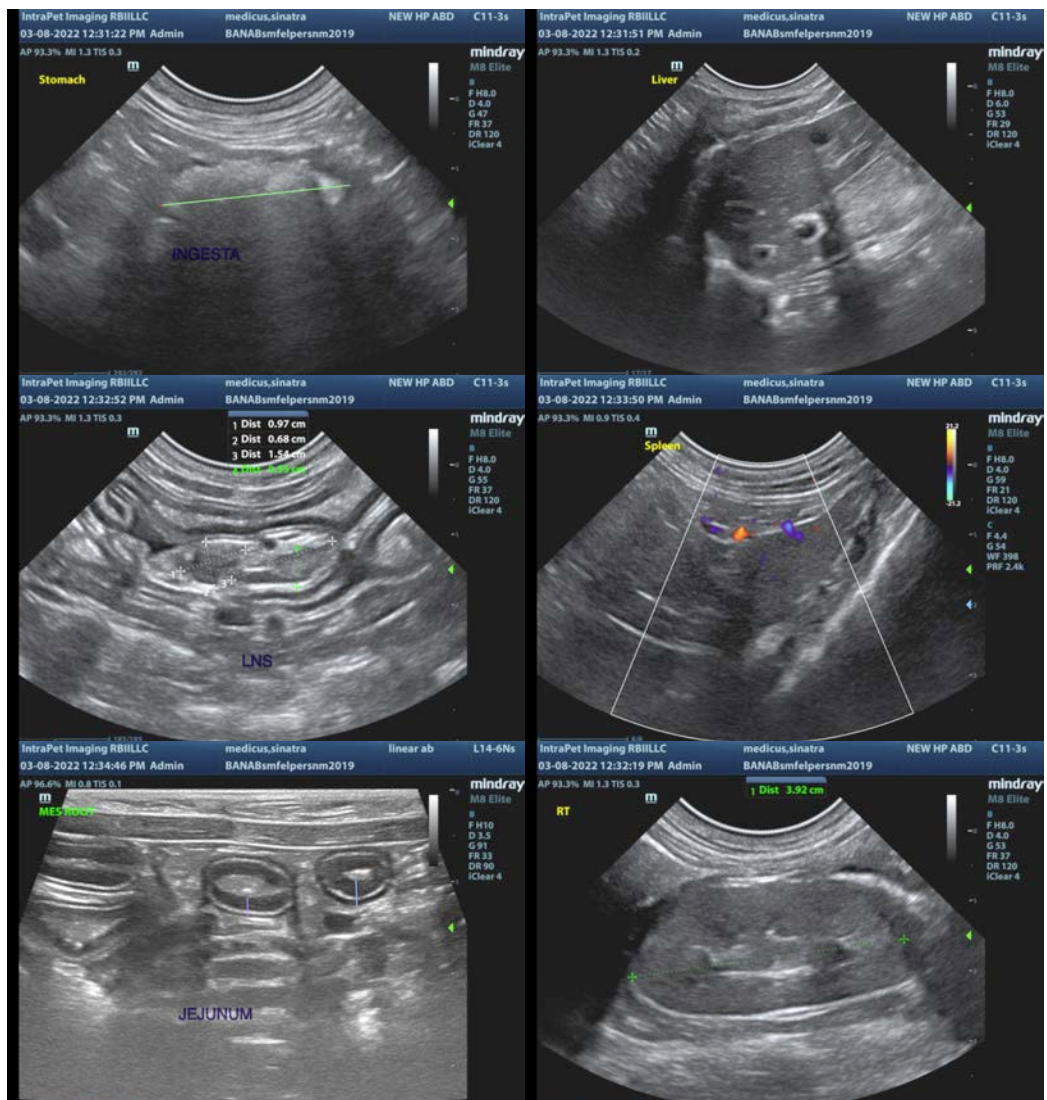
## **SECONDARY FINDINGS**

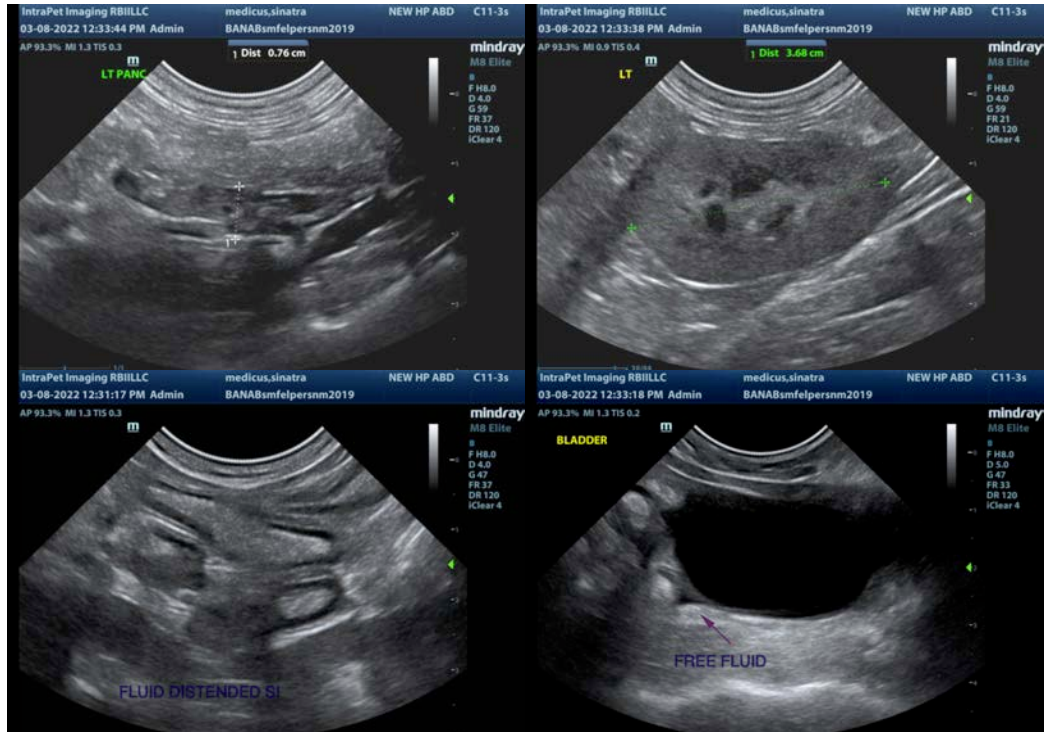
- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Small volume free abdominal fluid

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The overall impression of the GI tract is that of diffuse fluid distention and wall thickening with intact layering. This patient is reported to be fasted, so this would be an abnormal finding, potentially consistent with some degree of decreased motility/ileus or less likely a partial obstruction (by wall thickening, foreign material, etc.). These findings and the history are most consistent with diffuse small intestinal disease.

- Consider a GI panel to Texas A&M for qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Recommend chronic probiotic therapy.
- Recommend hydrolyzed protein/novel protein prescription diet (the history refers to a GI diet, but I'm not sure of what this entails).
- If possible, you could consider obtaining a fine needle aspirate from a mesenteric lymph node.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- Given the young age of this patient, I would recommend obtaining GI biopsies in order to provide the most appropriate treatment. Possible differentials could include dietary intolerance, food allergy, GI parasites, less likely intestinal neoplasia, FIP, etc.



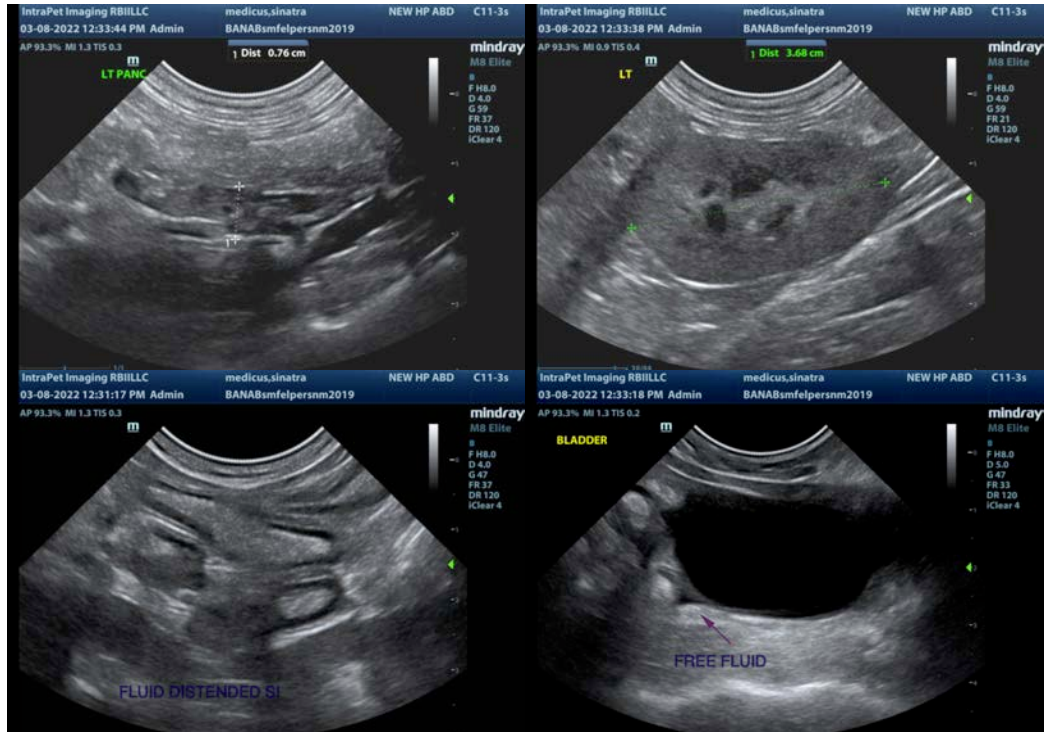


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)  
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