

**DATE PRESENTING CLINICAL SIGNS**

3/9/22

Patient presented on 2/7/22 for vomiting. Owner reported that pet had been known to have hairball vomiting a couple of times per week but at the time of this appointment it had increased to multiple times per day. On PE pet was BAR, slightly overweight, adequately hydrated, soft, non painful abd. Owner opted for supportive care at the time and pet was given SQ fluids, Cerenia and a bland diet. Patient responded well with treatment but was seen again on 2/11/22 for recurrence of the vomiting. Again exam was grossly normal. Bloodwork was obtained at this visit- results below. Pet was placed on oral Cerenia and bland i/d diet. Pet presented again on 2/18 because as soon as Cerenia was stopped pet began to vomit again. Radiographs were obtained--results listed below. Discussed with owner the need for abdominal US and GI panel

PATIENT

Meli Mohogianis

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7/25/11

WEIGHT

11.06 Pounds

INTERPRETED BYStephanie Pearce
RDACS, RVT**IMAGING PERFORMED BY**Stephanie Pearce
RDACS, RVT**HOSPITAL NAME**

Westminster VH

REFERRING VET

Dr. Hall

INVOICE

36032

Current Medications: None at this time. Gabapentin 100mg upon arrival to hospital prior to scan.

Lab Results: 2/11/22: snap fPL: NORMAL. 2/11/22: CBC: Neutrophils: 1.663K/uL (2.62-15.17), neutrophils appear slightly toxic; Chem27: Nothing abnormal to report; TT4: 2.0ug/dL (0.8-4.7); UA: USG: 1.030; pH: 6.0; WBC: 0-2/HPF; RBC: 0-2/HPF; rare epithelial cells.

GI panel to TAMU to be submitted prior to US,

Radiographs: 2/18/22: Radiology Report: 1. Unremarkable thorax.
2. Unremarkable abdomen.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

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 (3.93 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 (4.01 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 0.37 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 0.37 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. 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 0.27 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.

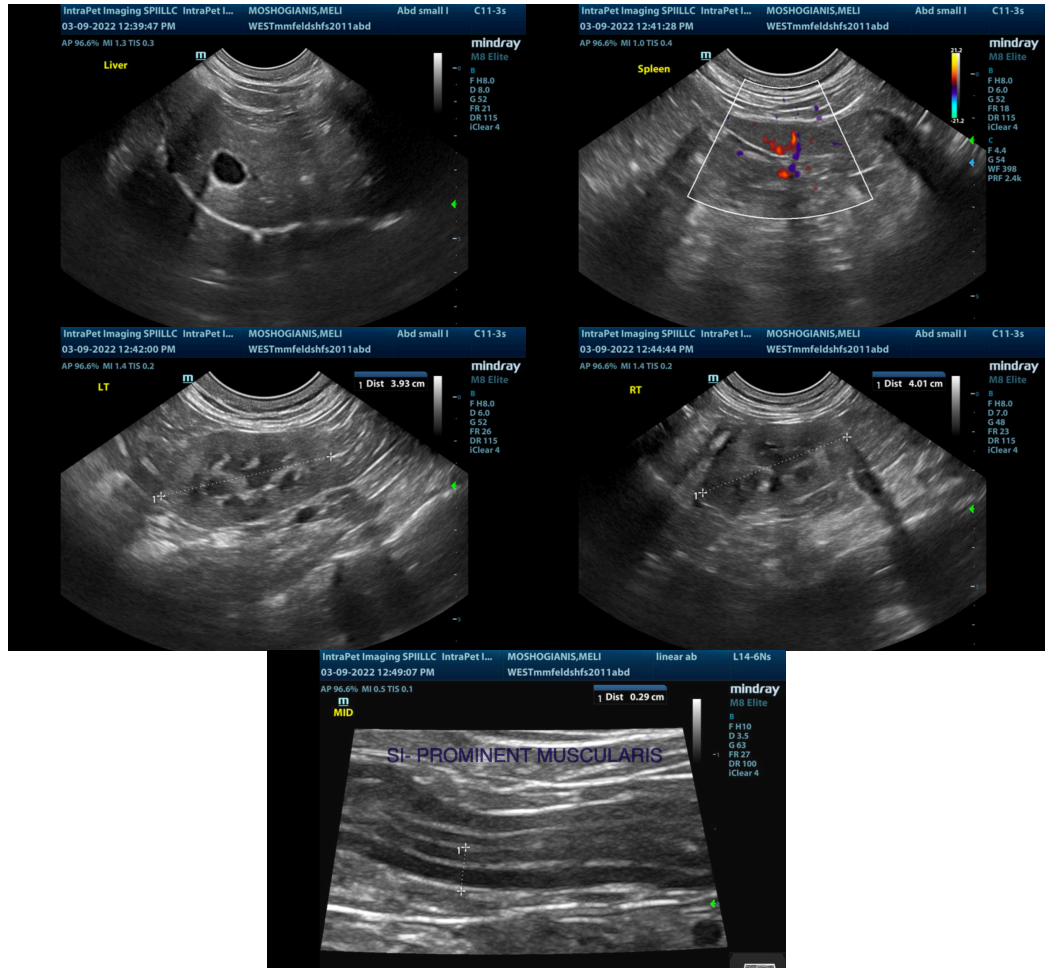
ULTRASONOGRAPHIC FINDINGS

- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are no significant focal lesions observed in the GI tract. In general, the small intestine appears mildly prominent with a significantly increased muscularis to mucosal ratio. This can be associated with inflammation, less likely underlying neoplasia, and can sometimes be seen in normal older cats. Consider such differentials as food allergy/dietary intolerance, GI parasites, IBD, less likely intestinal neoplasia, etc.

- Recommend a novel protein/hydrolyzed protein prescription diet.
- Recommend a GI panel to Texas A&M for fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine (I believe this is already planned).
- Consider chronic probiotic therapy.
- If symptoms persist, consider 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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