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Clinical Sonography & Telecytology
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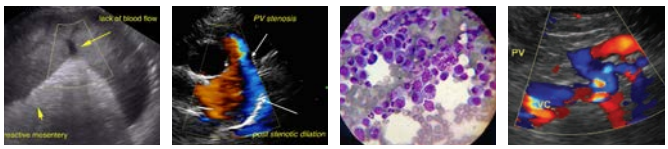

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1-800-838-4268 info@sonopath.com

PATIENT
Jujubee Smith

SPECIES
Feline

BREED
Balinese

SEX
Spayed Female

AGE
13

WEIGHT
10.2

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

IMAGING PERFORMED BY
Dr. Susan Lincoski

HOSPITAL NAME
University Drive VH

REFERRING VET
Dr. Susan Lincoski

INVOICE
46379

DATE
4/5/23

PRESENTING CLINICAL SIGNS

Jujubee presented for lethargy and inappetence on 4/3. She has a history of occasional v/d and asthma-like cough. A historic murmur was noted last year and radiographs/bnp normal at that time except possibly lower airway disease. She also is an allergy patient which presents as more overgrooming/hair loss but also suspect partly gi component. Patient had been on zd but owner recently switched to ID. On presentation 4/3 she seemed QAR but did appear to have mild increased RR/RE and flatter posture. I did not auscult the murmur but she was purring. We obtained radiographs did not elucidate cause (see report) and bloodwork showed normal and proBNP was WNL (last year it was as well). Treated 4/3 with sq fluids and cerenia. Patient has since eaten only small amounts and has not had a BM in 4 days (noted ileus on rad report). Patient ate small amount only this am per owner so did not draw for GI panel at this time.

Abnormal PE/Chem/CBC/UA Results: Bloodwork normal. PE unremarkable except mild wheezes, no murmur ausculted but historic.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (4.16 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.89 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.43 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.

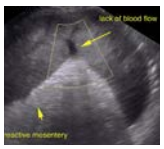
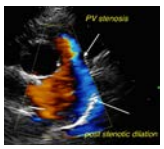
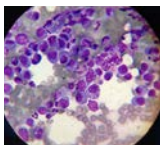
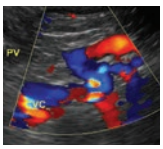
The right adrenal gland is normal in size measuring 0.36 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.58 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.

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains a moderate amount of ingesta and fluid. 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 mild to 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 measures 0.33 cm. Visualized peristalsis appears appropriate. There is the general impression of thickened bowel with some mild to moderate fluid distention. Occasionally, a more thickened bowel loop is visualized with less discrete layering. One such loop measures at 0.43 cm, but this could also be ileum approaching the ileocecal junction.

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. Colon wall measures 0.19 cm.

Pancreas

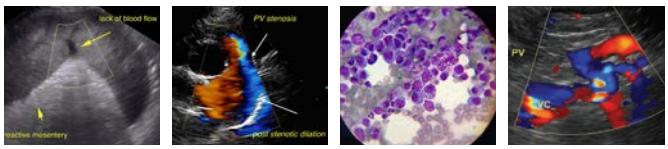
The pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes visualized measuring 0.37 and 0.39 cm, and the omentum is generally of normal echogenicity.

PRIMARY FINDINGS

- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting. Incidental gall bladder debris is less common in cats.
- Moderate fluid and ingesta visualized within the gastric lumen – Correlate these findings with feeding history. If the patient was adequately fasted, this likely represents delayed gastric emptying or partial outflow tract obstruction (none clearly observed).
- Diffusely thickened small bowel with prominent muscularis layer – The small intestinal wall changes could be consistent with an underlying inflammatory process. These types of changes can sometimes be seen in normal older cats. Correlate with clinical signs.
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.



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SECONDARY FINDINGS

- Mildly echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

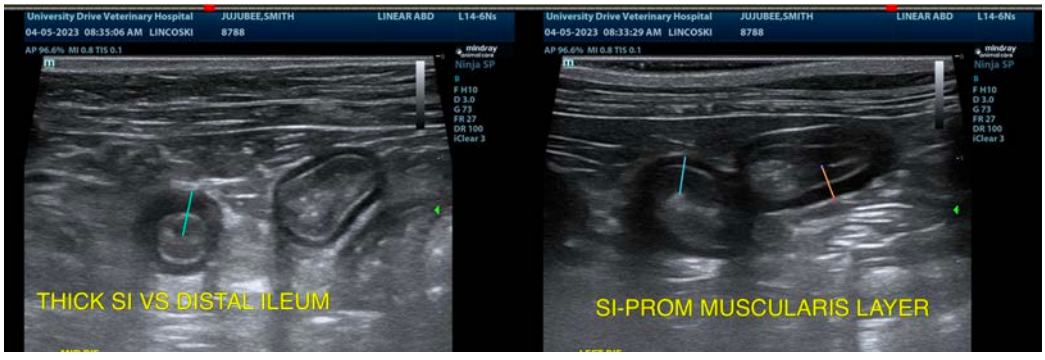
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small bowel appears diffusely thickened with a prominent muscularis layer. There are occasional loops of bowel that appear to have more focal thickening, but no discrete mass effect is observed. Additionally, the stomach is significantly distened with ingeta and fluid, and some bowel loops are distended with fluid. You get the general impression of lack of progressive motility/ileus. No obstructive process is observed, but this cannot be definitively ruled out. Additionally, there are some prominent mesenteric lymph nodes that are more consistent with reactive lymph nodes, but an underlying neoplastic process cannot be ruled out.

The pancreas appears prominent with a dilated pancreatic duct. It does not appear overtly inflamed, but these changes could be consistent with mild inflammation or previous episodes of inflammation. Consider a quantitative PLI level and empirical treatment for pancreatitis.

- 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 and are largely believed to be due to small intestinal disease, consider obtaining GI biopsies.
- Additionally, you could consider serial radiographs to ensure that material is out of the stomach into the small bowel.

The gallbladder has a moderate amount of debris in it. This is somewhat unusual for a cat. The significance of this is unknown if there is no liver enzyme elevation, but continued monitoring for cholecystitis is warranted.



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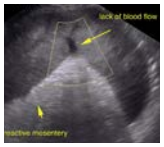
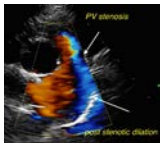
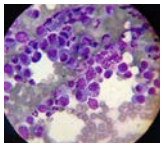
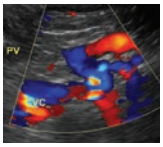

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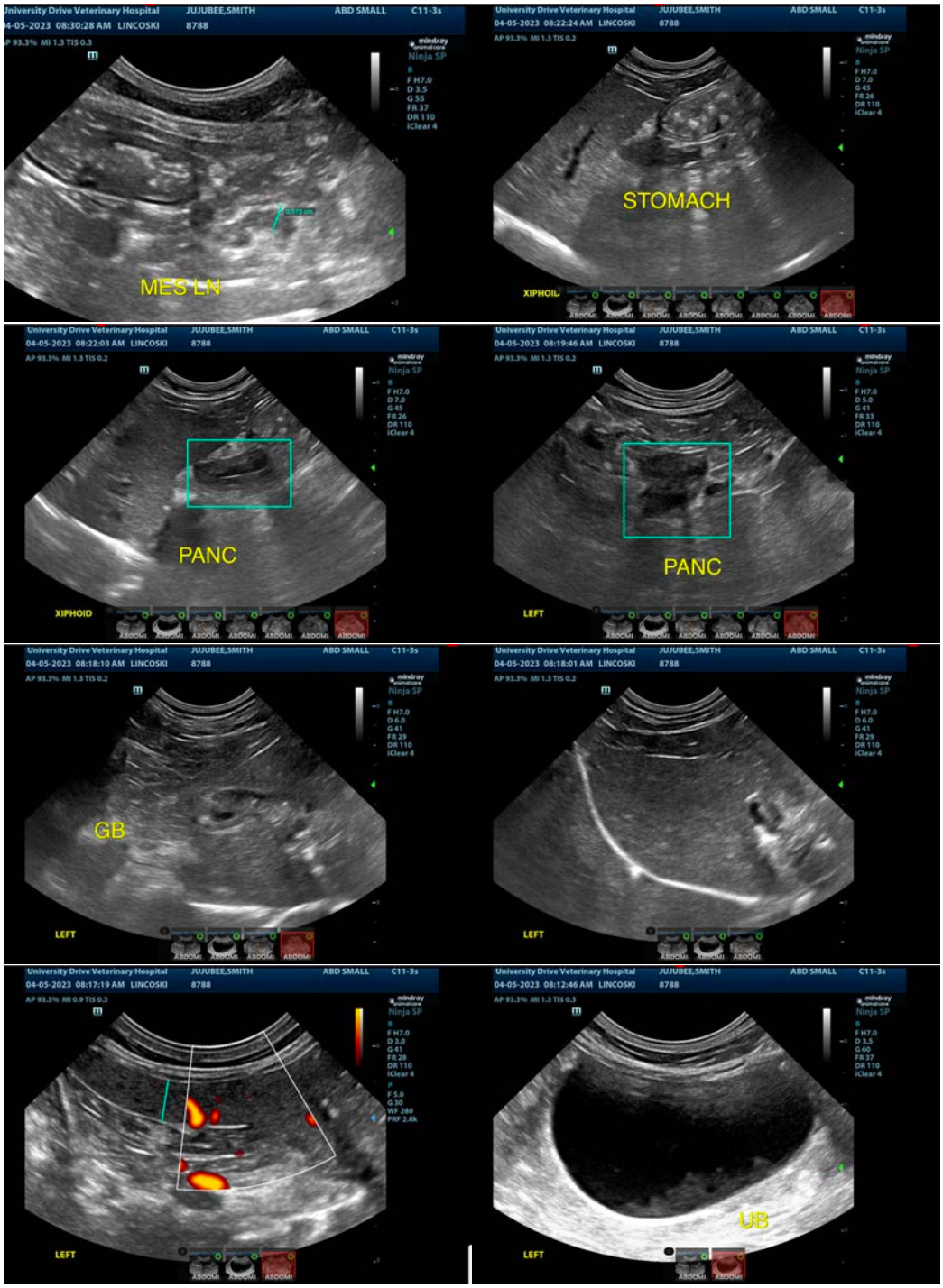

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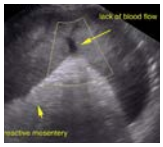
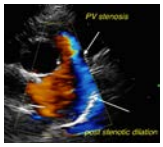
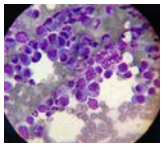
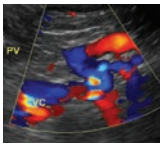

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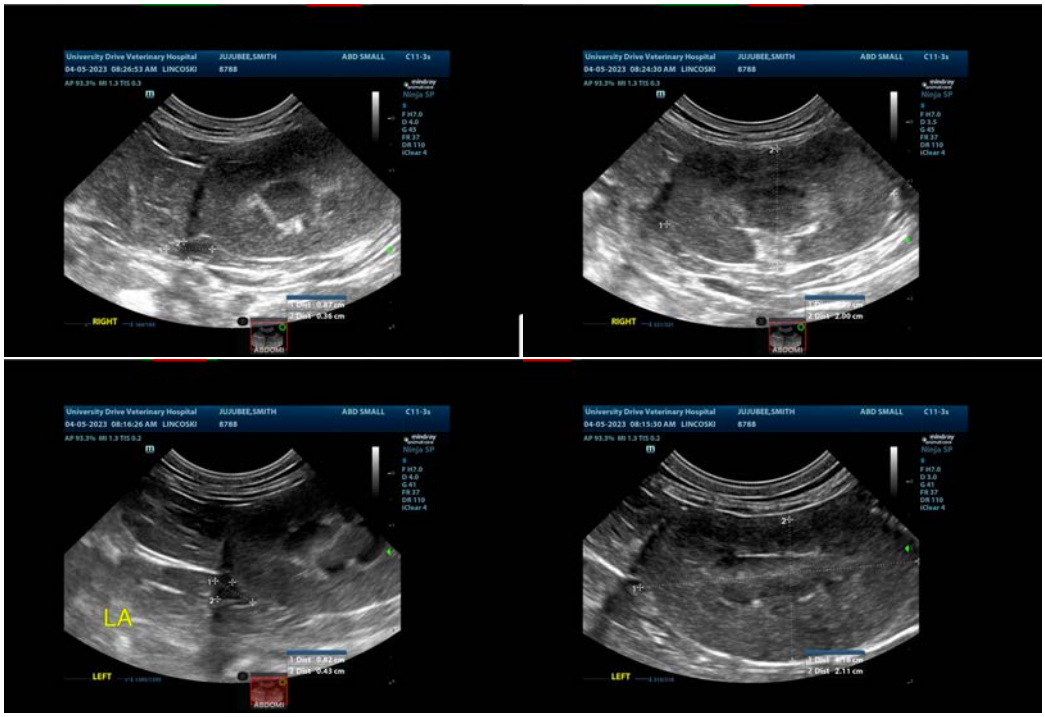

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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