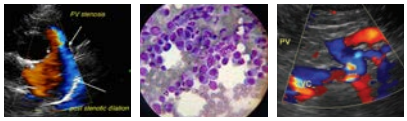
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

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DATE

4/5/23

PATIENT

Winter Woynovitz

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6/10/15

WEIGHT

9.5 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Paradise AH

REFERRING VET

Dr. Twardzik

INVOICE

46436

PRESENTING CLINICAL SIGNS

Initially presented in 12/22 for chronic weight loss; had lost 6.5 lbs in 2.5 years. Bloodwork at the time demonstrated a mild hypoalbuminemia, and abdominal ultrasound was recommended. Patient presented again on 4/1 for weight loss and scooting. On exam on 4/1, patient had lost an additional 2 lbs since December, and had a BCS of 2/5. Moderate tartar was noted with missing canine teeth. Anal glands were full and easily expressed.

Current Medications: Gabapentin 100 mg PO last night and this morning for ultrasound
Lab Results: Decreased albumin 2.5 g/dL.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, 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 (3.74 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 (3.96 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 0.41 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 0.43 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 (0.89 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.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The proximal bile duct is somewhat prominent and dilated, measuring 0.33 cm.

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 measures 0.30 cm. Visualized peristalsis appears appropriate. There is the general impression of slightly edematous/fuzzy thickened bowel with a prominent muscularis layer.

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 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. Prominent pancreatic duct noted.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are clusters of prominent mesenteric lymph nodes. One such cluster near the ileocecal junction has lymph nodes measuring 0.31, 0.50, 0.25, and 0.42 cm. The omentum is hyperechoic in this region.

ULTRASONOGRAPHIC FINDINGS

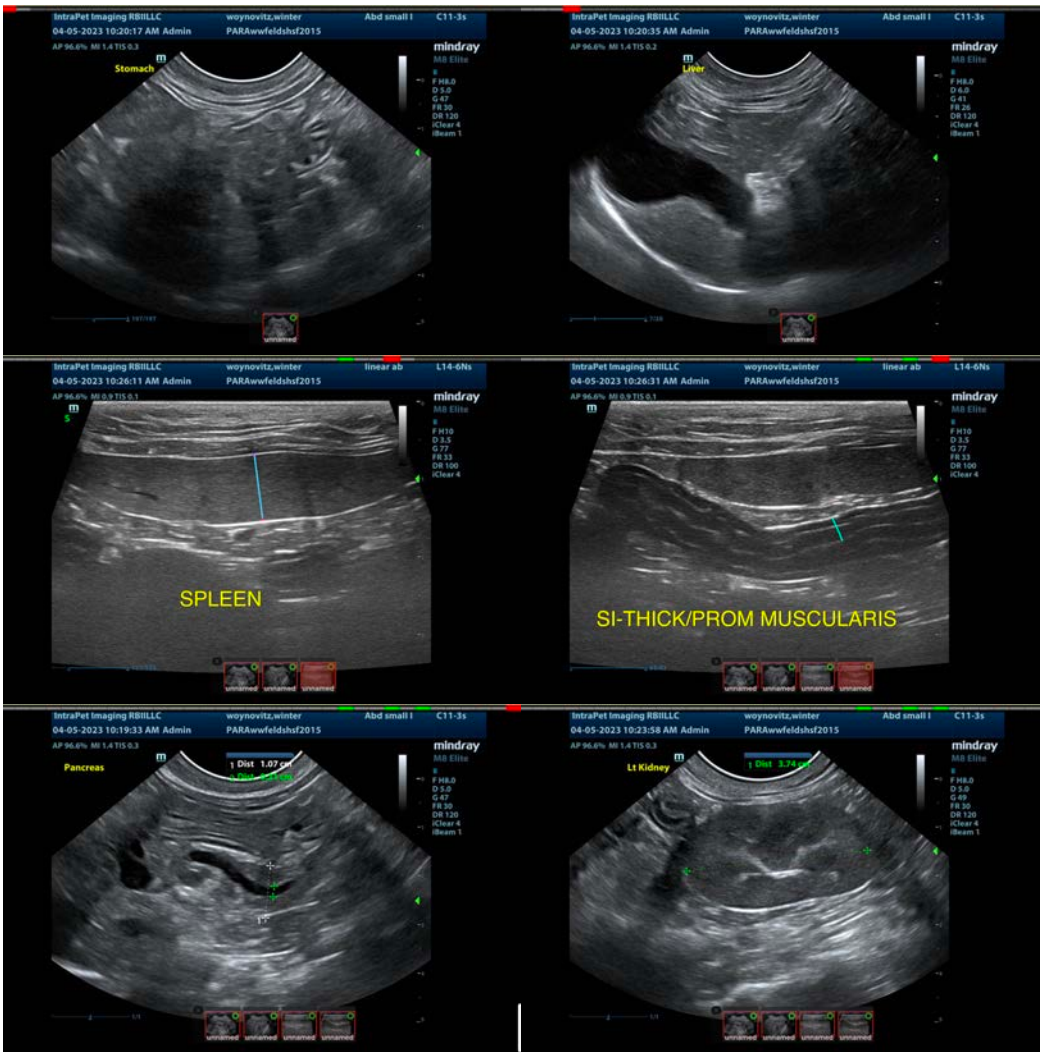
- Prominent, hypoechoic pancreas with prominent pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Prominent/tortuous bile duct – Correlate this with recent lab work. This is likely an incidental finding.
- Thick/edematous small intestine with a 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.

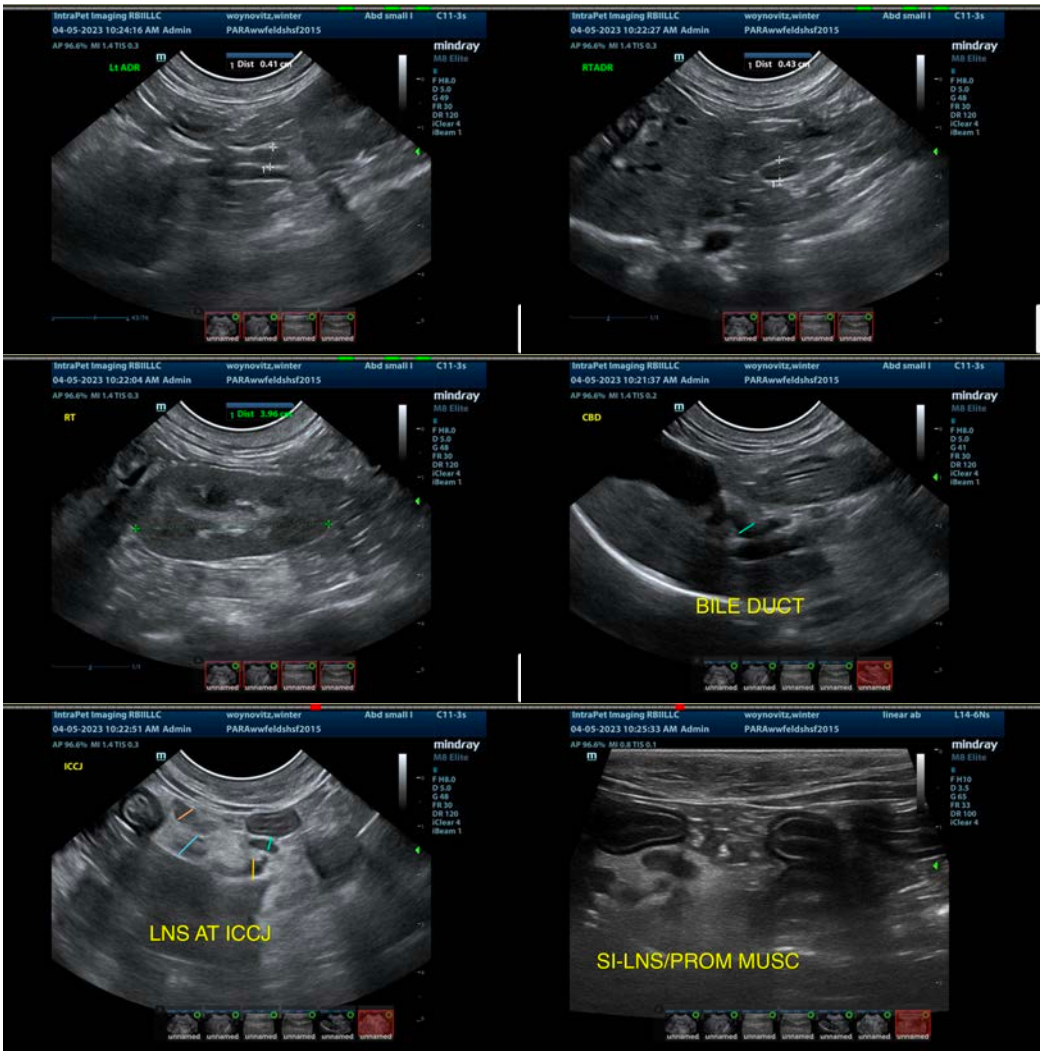
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are diffuse changes visualized with the small intestine, including generalized thickening, “fuzzy” wall layering and a prominent muscularis layer. These findings are most consistent with primary gastrointestinal disease. Differentials would include dietary intolerance/food allergy, chronic pancreatitis, GI parasitism, exocrine pancreatic insufficiency, IBD, intestinal neoplasia, etc.

- Recommend current bloodwork including thyroid evaluation (if not already done).

- Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.
- If hypoalbuminemia persists, recommend a liver function test and a urine protein to creatinine ratio to look for additional sources of protein loss.
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- If primary gastrointestinal disease is determined to be the primary source of the symptoms described, 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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