

**DATE PRESENTING CLINICAL SIGNS**

4/7/23 Has vomited intermittently in the past, but increased in frequency past 3 months. Starts with kibble then goes to bile (6-7 x overnight primarily). Occurs randomly- sometimes a week w/o incidence and sometimes 2x/week. On PE BCS 9/9 (longstanding)- hard to fully palpate abdomen due to girth but NSF

PATIENT

Boo Curry

Current Medications: None.

Lab Results: Superchem/CBC 12/22/22 WNL. BUN and Creat high normal BUN 30 (14-36), creat 1.8 (0.6-2.4), T4 1.3, Free T4 42.6 (10-50)

SPECIES

Feline

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: STAT requested.

BREED

DSH

Imaging Performed By: Rachel Brillhart, RDMS.

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

5/1/13

The left kidney has a normal shape and size (4.95 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.

WEIGHT

19 Pounds

The right kidney has a normal shape and size (4.31 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.

INTERPRETED BY

Kathleen Sennello DVM,
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(Small Animal Internal
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Adrenal Glands

The left adrenal gland is normal 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.

HOSPITAL NAME

Jacksonville AH

The right adrenal gland is normal in size measuring 0.51 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.

REFERRING VET

Dr. Thai

Spleen

The spleen is subjectively normal in size (0.83 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.

INVOICE

46461

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 cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. The stomach wall is slightly prominent, measuring up to 0.48 cm in thickness. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. There is some hyperechoic mesentery around the stomach, most consistent with inflammation/gastritis.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Jejunum wall measures 0.31 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 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

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.

Other

A brief view of the heart is evaluated with no obvious pathology involving the area of the right auricle. Scant pleural effusion is visualized. Consider a full cardiac evaluation to evaluate cardiac function.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Subjectively prominent stomach wall with surrounding hyperechoic mesentery – Findings are most consistent with inflammatory changes/gastritis.
- Prominent muscularis layer to the small intestine – 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach wall appears slightly prominent with intact wall layering, and there is some surrounding hyperechoic mesentery consistent with inflammation. This would be most consistent with gastritis. No obvious intraluminal foreign material is visualized, but this cannot be definitively ruled out. Correlate with abdominal radiographs.

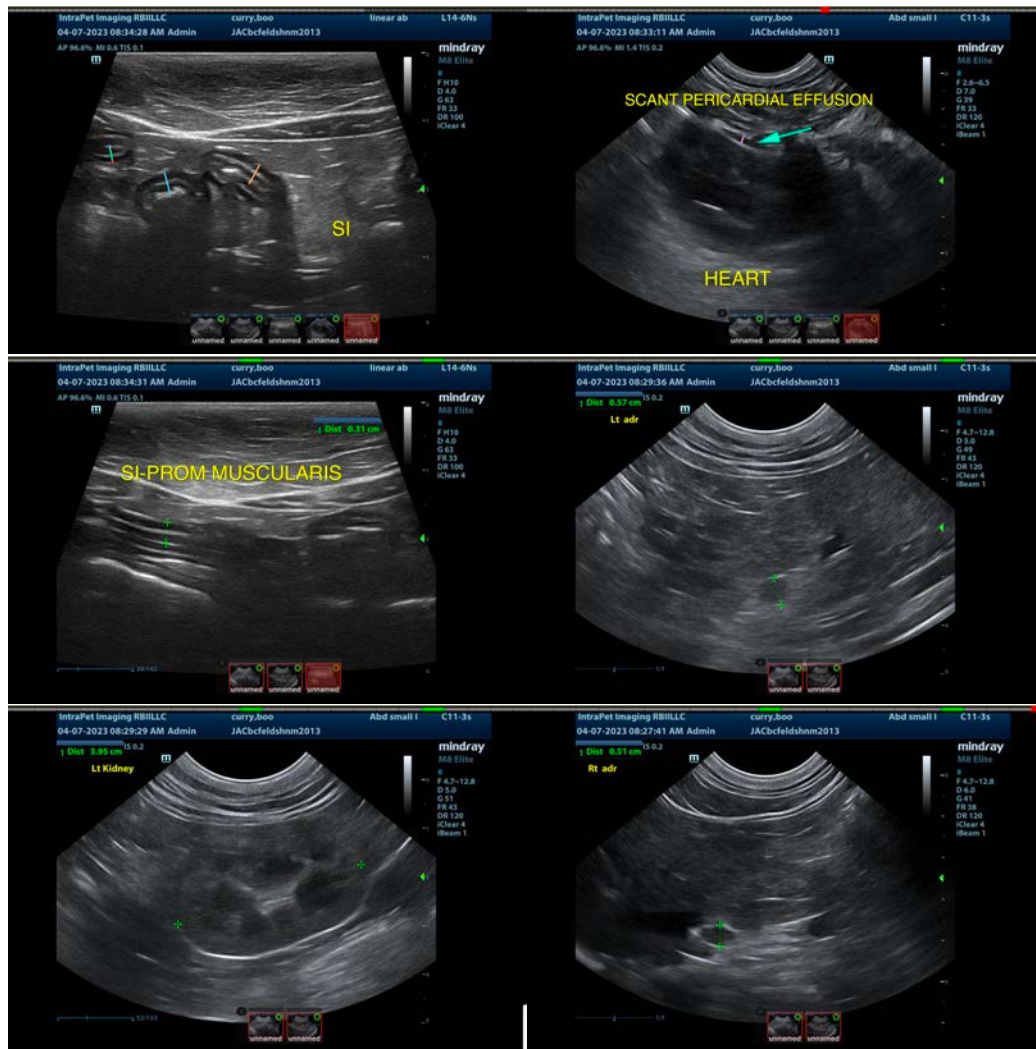
The changes visualized in the pancreas are most consistent with previous episodes of pancreatitis, but mild active pancreatitis cannot be definitively ruled out. Correlate findings with a quantitative fPLI level.

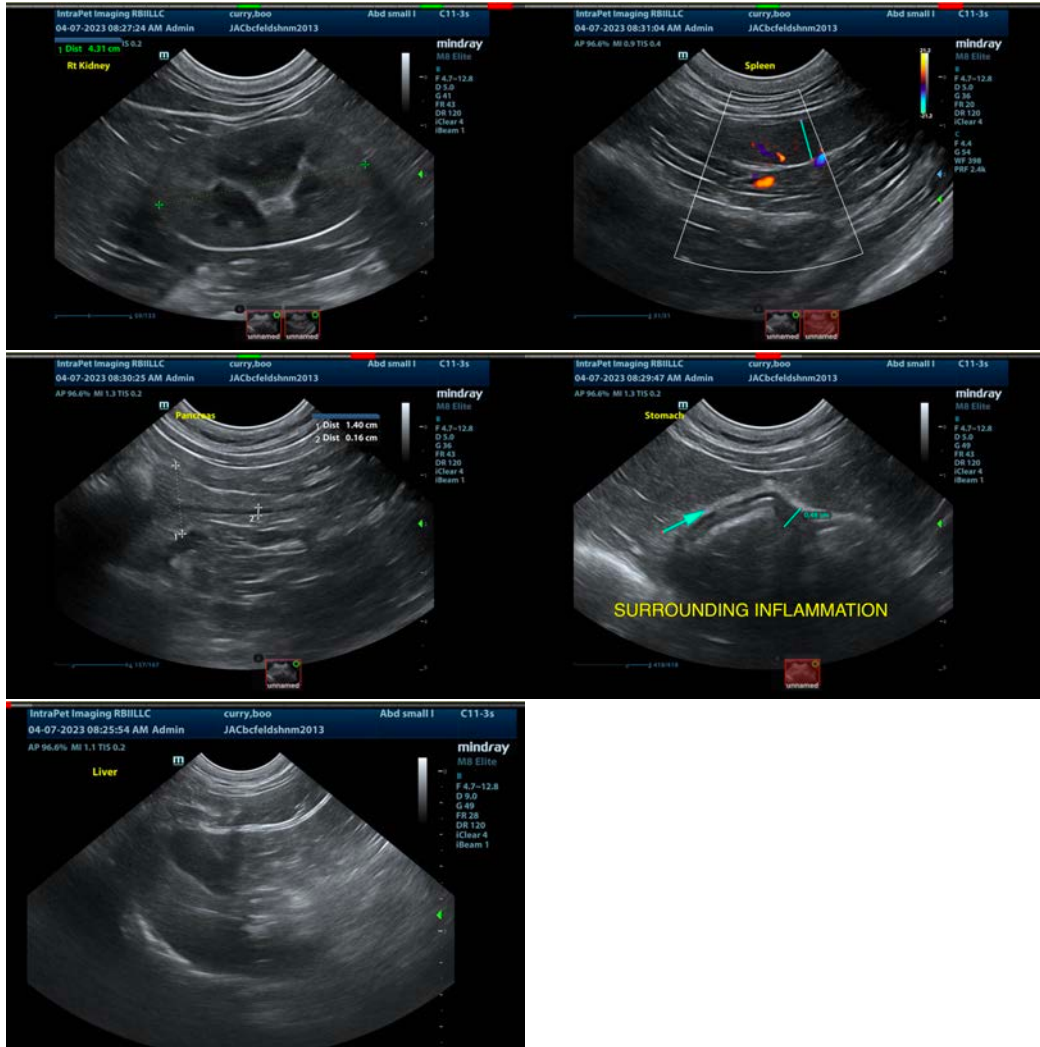
The small intestine appears somewhat “ropey” with a prominent muscularis layer. This can be associated with inflammatory type changes.

Consider such differentials as food allergy/dietary intolerance, GI parasitism, chronic pancreatitis, IBD and less likely neoplasia, etc..

- 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, consider obtaining GI biopsies.

It is possible that the collapse episode was due to a vagal episode when vomiting. The surrounding gastric inflammation indicates gastritis, some of which may be exacerbated by the vomiting itself. There is a scant amount of pericardial effusion visualized. To be safe, I would recommend a blood pressure evaluation and cardiac ultrasound, as well as 3-view thoracic radiographs.





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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