

**DATE**

5/13/22

**PRESENTING CLINICAL SIGNS**

History: H/O intermittent vomiting. Now occurring every 2 weeks.

**PATIENT**

Bandit Zaworski

Current Medications: None.

Lab Results: WNL.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Dex Dom

Stat Report: Not requested.

**SPECIES**

Feline

Imaging Performed By: Andi Parkinson, RDMS.

**BREED**

DSH

**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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

**AGE**

8/3/15

The left kidney has a normal shape and size (3.98 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 (4.09 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 left adrenal gland is normal in size measuring 0.36 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance and shape, but the parenchyma is mildly mineralized. There is no evidence of a mass effect.

**HOSPITAL NAME**

Timonium AH

The right adrenal gland is normal in size measuring 0.42 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance and shape, but the parenchyma is mildly mineralized. There is no evidence of a mass effect.

**REFERRING VET**

Dr. McMichael

**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.

**INVOICE**

15159

**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 gall bladder is bilobed and is moderately distended. The walls of the gall bladder is not thickened and they both have 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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. The duodenum measured as normal (between 0.13-0.38 cm in wall thickness) and the jejunum measured as normal (0.25 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 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***

There is no free fluid. There are occasional visible mesenteric lymph nodes near the mesenteric root. One such lymph node is measured at 0.39 cm and the omentum is of normal echogenicity.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary Findings**

- Hypoechoic prominent pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Prominent mesenteric lymph nodes. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

### **Secondary Findings**

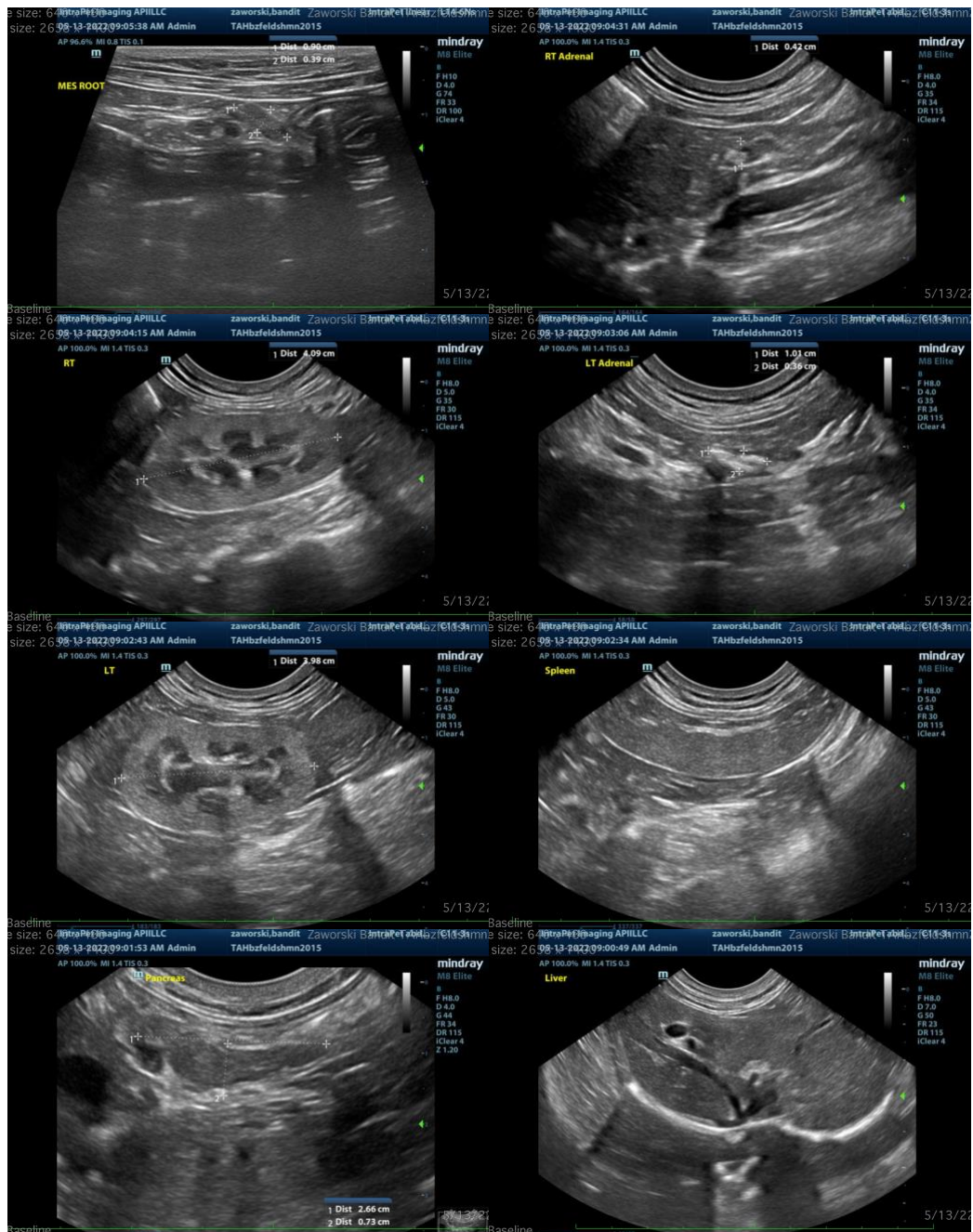
- Mineralization of both adrenal glands. As both glands appear normal in shape and size, this is likely an incidental finding. Continued monitoring is warranted.
- Bilobed gallbladder. This is likely an incidental finding.

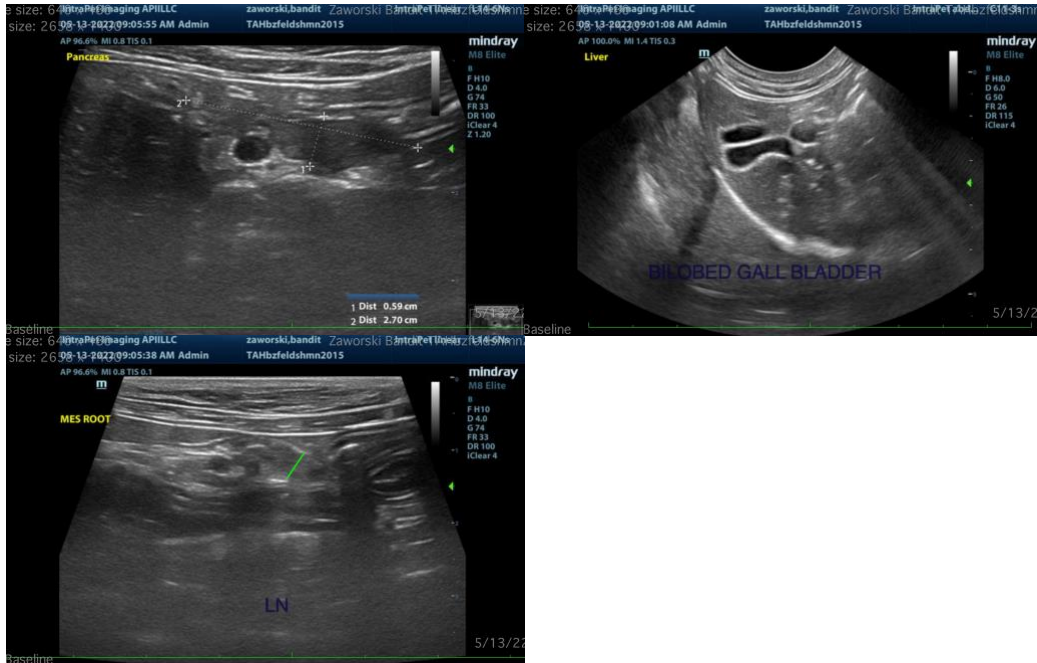
## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Today's scan is relatively normal. The pancreas does appear prominent and hypoechoic, but there is minimal surrounding inflammation. This could be consistent with current mild pancreatitis or a previous episode of pancreatitis. If blood work and other metabolic causes for vomiting are thought unlikely, then consider primary GI causes, such as food allergy/dietary intolerance, GI parasites, dietary indiscretion, IBD and less likely intestinal neoplasia. As these symptoms reported are relatively mild, I would start with a

dietary change and possibly a GI panel to Texas A & M (a qualitative fPLI, TLI, cobalamin and folate to further evaluate the GI tract and pancreas) to get a baseline for follow-up. If symptoms progress despite these measures, I would consider possible reevaluation and obtaining GI biopsies.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.





**The information and recommendations provided are based on the images presented by the referring veterinarian. 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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