

**DATE PRESENTING CLINICAL SIGNS**

5/13/22

**PATIENT**

Paige Kamanitz

History: 5 years of vomiting. Presented 11/2021 -5 years of vomiting off & on. Normal Chem/CBC/T4 Sept 2021. On Ultramino. Nov 2021-Started prednisolone 5mg BID x 14 days, then tapered over several weeks to 2.5mg EOD. Did VERY well- 1-2 episodes of vomiting first 4 months on pred, but past 6 weeks- vomiting has occurred a few times , and 2 times in the past 6 days.

**SPECIES**

Feline

Current Medications: prednisolone 2.5mg- M, W, Fr, Sat (past 2 months).

Lab Results: See attached.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

**BREED**

DSH

Imaging Performed By: Andi Parkinson, RDMS.

**SEX**

Spayed Female

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****AGE**

1/9/16

**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.

**WEIGHT**

8.6 Pounds

The left kidney has a normal shape and size (3.6 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)

The right kidney has a normal shape and size (4.08 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.

**HOSPITAL NAME**

Timonium AH

**Adrenal Glands**

The region of left adrenal (Cranial to left renal artery) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

**REFERRING VET**

Dr. Kauder

**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**

15166

**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 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 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 (0.17 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***

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**

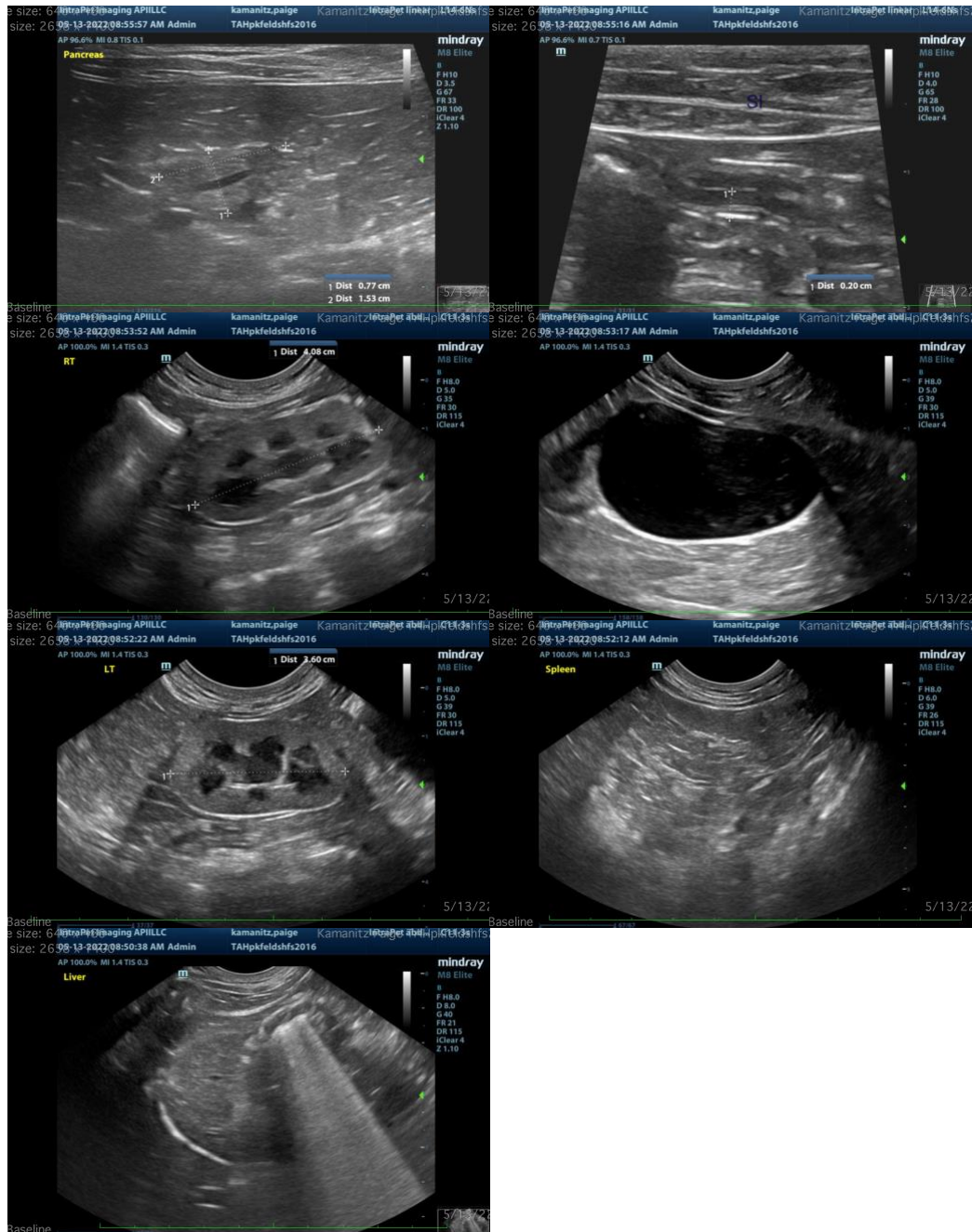
- Mildly hypoechoic prominent pancreas. The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mildly echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture

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

Today's scan is largely normal for this 6-year-old cat. No large focal lesions associated with the gastrointestinal tract are visualized. The pancreas is somewhat prominent but does not appear overtly inflamed. These findings could be consistent with mild pancreatitis or previous episodes of pancreatitis. Based on the history, this cat has been vomiting for most of its life, but recently has had an uptick in vomiting. This could be due to recent pancreatic inflammation, a change in the diet (ingredients in the prescription diet, etc.), progression of disease or concurrent health issues.

- I recommend a GI panel (to Texas A & M) for a qualitative fPLI, TLI, cobalamin and folate to look for evidence of pancreatic inflammation and/or small intestinal disease.
- You could consider a diet change to a different hydrolyzed protein or novel protein prescription diet.

- Consider symptomatic therapy for acute gastroenteritis/pancreatitis.
- If symptoms persist, consider 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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