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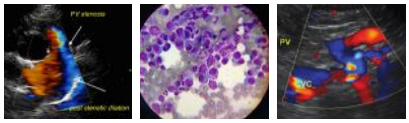
IntraPet.com



SonoPath
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DATE

5/17/22

PATIENT

Kayla Mitchell

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10/29/08

WEIGHT

12.4 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Stephanie Pearce RDCS, RVT

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Levine

INVOICE

37678

PRESENTING CLINICAL SIGNS

Presented for anorexia and vomiting after returning from the Pet ER. Presented to ER for trouble breathing. Initially diagnosed with asthma here and started on pred. About 3 weeks later taken to ER for vomiting and trouble breathing. On exam diagnosed with CHF and had emergency echo. CVCA said pet was not in CHF and had asthma. Pet sent home on Clamamox 125 mg bid, Ondansetron, probiotics, Mirtaz gel and theophylline. Pred resumed. O phoned last week noting Kayla had not been eating well and had vomited up a small blood clot. Stopped pred and added pepcid and sucralfate. Still not eating and vomiting with diarrhea. 5/10. Given sq fluids, cerenia, metronidazole. D/C clavamox, ondansetron, sucralfate. Still not eating and gulping, licking lips a lot but no recent vomiting.

Current Medications: Cerenia 24 mg 1/4T sid, Metronidazole 250 mg 1/4T BID, probiotic sid, famotidine 10 mg 1/2 T bid.
Lab Results: Fairly unremarkable. CVCA echo normal.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 (3.77 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.

The right kidney has a normal shape and size (3.8 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.38 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 0.37 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 (0.73 cm in height at the level of the hilus), 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 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 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 measured 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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild to moderate pancreatitis.

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

- Hypoechoic, prominent pancreas with surrounding hyperechoic mesentery – The pancreatic changes are most consistent with mild/moderate pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

- Prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

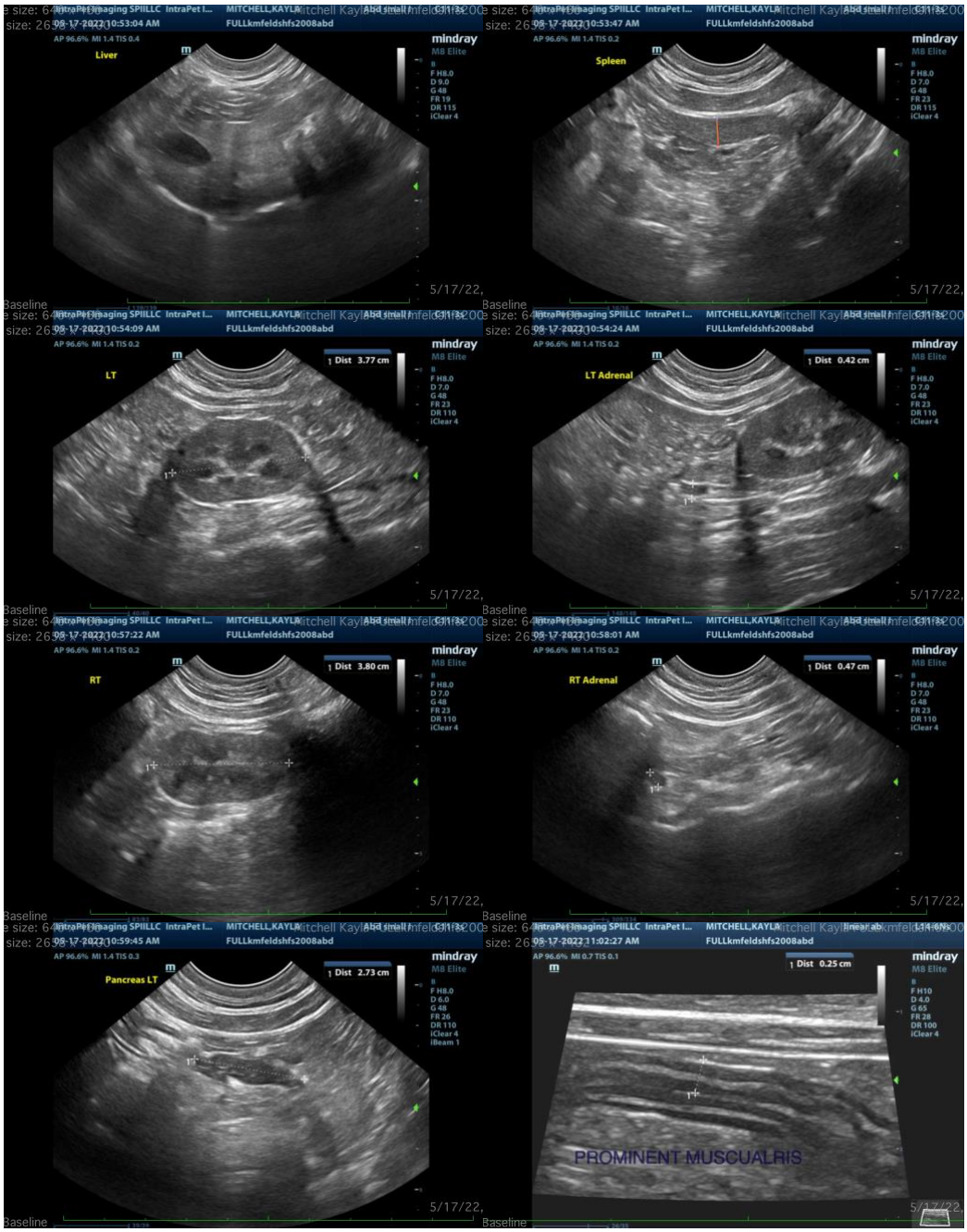
The pancreas appears prominent and hypoechoic with mildly to moderately prominent/hyperechoic mesentery surrounding the pancreas. Given the possible vomiting and drooling, this could be consistent with acute pancreatitis. Correlate these findings with the results of a quantitative fPLI, TLI, cobalamin and folate (GI panel to Texas A&M) to further evaluate the pancreatic and small intestinal changes observed.

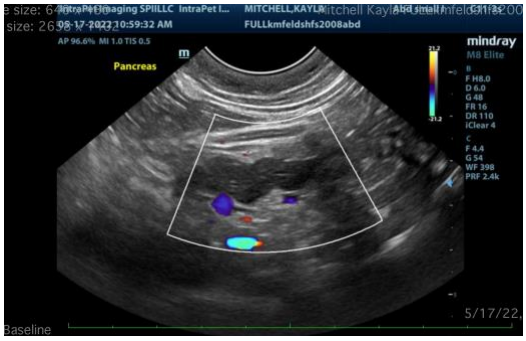
The changes observed in the small intestine are mild and relatively non-specific. You could consider a novel protein/hydrolyzed protein prescription diet and symptomatic treatment for acute pancreatitis.

The respiratory signs reported are atypical, and the chest radiographs appear “busy” and are difficult to interpret. Largely, I suspect a moderate amount of fat around the cardiac silhouette. If not already done,

consider a radiologist interpretation of 3-view thoracic radiographs.

Additional thoughts could include aspiration pneumonia secondary to vomiting (although there is little radiographic evidence to support this), esophageal disease, etc. If this patient continues to not eat, then a temporary feeding tube should be considered to try and prevent secondary hepatic disease, etc. If symptoms are not improving, serial imaging, lab work, etc. may be necessary, as well as a BAL +/- CT scan of the thorax and upper GI endoscopy.





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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com