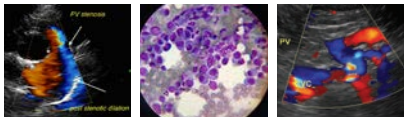
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

5/2/23

PATIENT

Orion Sweeney

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

1/13/18

WEIGHT

16.2 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Timonium AH

REFERRING VET

Dr. Stephens

INVOICE

47026

PRESENTING CLINICAL SIGNS

Decreased appetite since 4/28. No known foreign body ingestion, but will sneak food and potentially foreign objects. One episode diarrhea, one episode vomiting

Current Medications: Cerenia injection and SQ LRS on 5/1.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDSM

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 (4.68 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 (4.9 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

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 is visualized.

Spleen

The spleen is subjectively normal in size (1.0 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 cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild to moderate shadowing ingesta. 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 0.35 cm. Duodenum wall measures 0.32 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. There are prominent mesenteric lymph nodes, examples of which measure at 0.72 cm and 0.65 cm in diameter. The omentum appears generally hyperechoic in the cranial abdomen around the enlarged lymph nodes and in the region of the pancreas.

ULTRASONOGRAPHIC FINDINGS

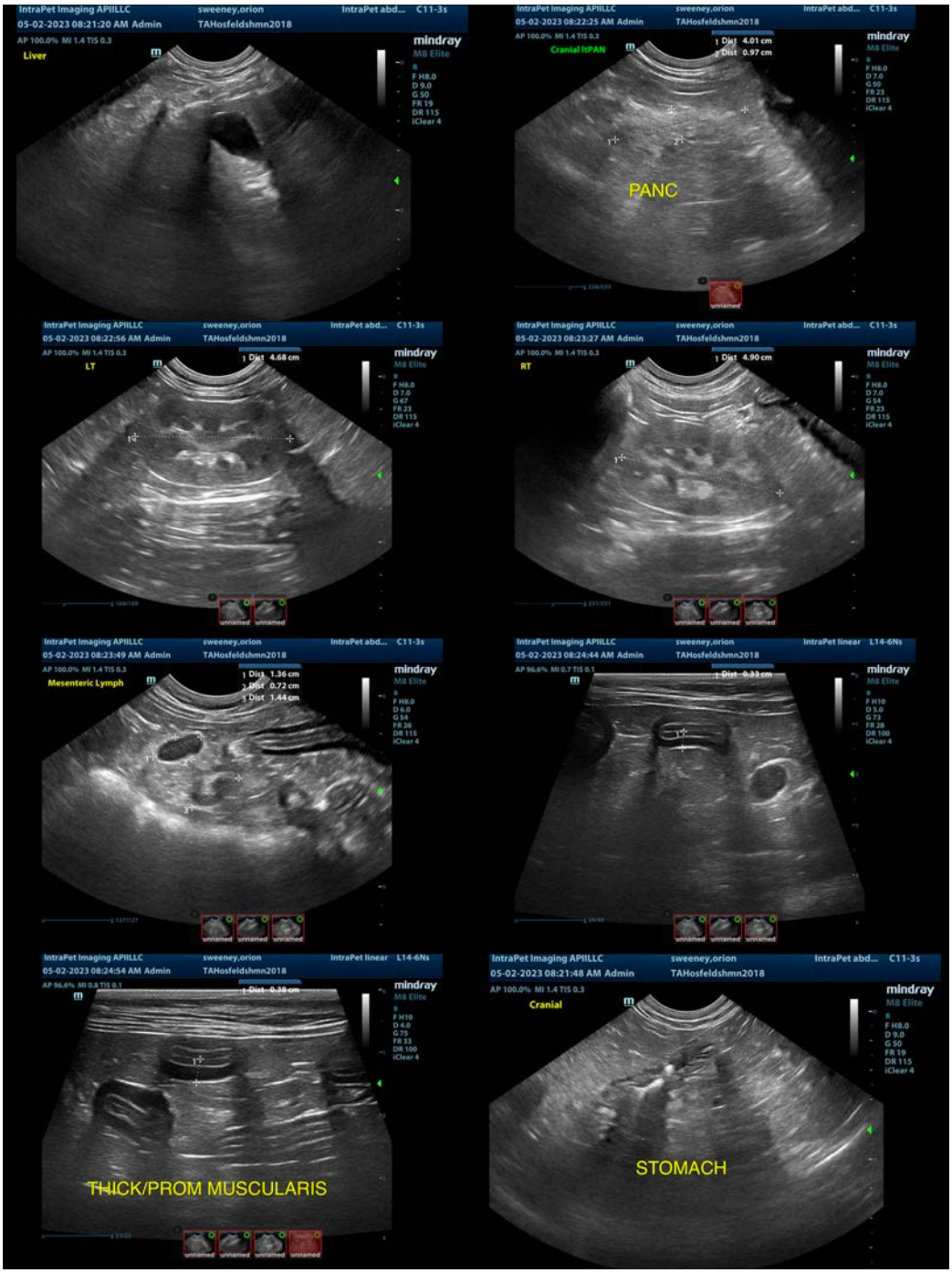
- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Small to moderate amount of shadowing material within the gastric lumen – The stomach does not appear significantly distended and does not appear obstructed. The shadowing material could represent ingesta, medication, ingested foreign material, etc.
- Diffusely thickened small intestine with a prominent muscularis layer – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.
- Enlarged, hypoechoic mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

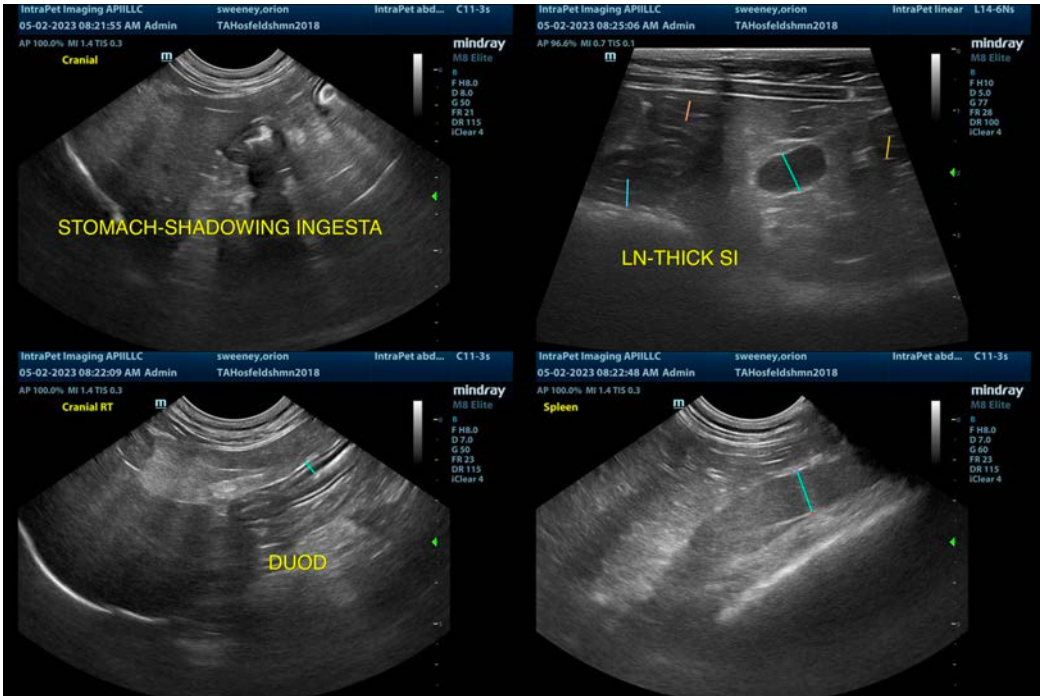
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened with a prominent muscularis layer. These changes are somewhat non-specific but concerning for possible inflammatory or less likely infiltrative disease. There is some shadowing material visualized within the gastric lumen. the nature of this material is unknown, but the stomach does not appear overtly obstructed. Additionally, there are some prominent mesenteric lymph nodes in the cranial abdomen, and the pancreas is mottled. These changes could be consistent with mild current inflammation or with previous episodes of inflammation. Options moving forward would include:

- Consider medical management with a novel protein/hydrolyzed protein prescription diet, nausea meds, pain meds, etc., empirically treating possible pancreatitis/acute gastroenteritis. Additionally, I would follow with abdominal radiographs, looking for the persistence of material in the stomach and a GI panel to Texas A&M, looking to evaluate a qualitative fPLI and look for changes consistent with chronic gastrointestinal disease.

- If the medical route is not successful or helpful, you could consider obtaining GI biopsies. If surgical biopsies are obtained, consider additionally sampling a mesenteric lymph node and evaluating the stomach for foreign material.





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