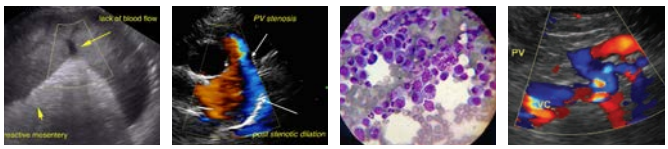
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™
1-800-838-4268 info@sonopath.com

**PATIENT**
Emu Jin

**SPECIES**
Feline

**BREED**
Bengal Cat

**SEX**
Spayed Female

**AGE**
12 Years

**WEIGHT**
N/A

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

**IMAGING PERFORMED BY**
Kelly Vazquez

**HOSPITAL NAME**
Glen Rock VH

**REFERRING VET**
Dr. Scott Stekler

**INVOICE**
38007

**DATE**
5/26/22

## PRESENTING CLINICAL SIGNS

History of weight loss and decreased appetite. Current meds: Flagyl 62.5 mgs EOD, prednisolone 5 mgs SID, B12 shots.

## 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 (3.85 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 (3.77 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.

### *Adrenal Glands*

The left adrenal gland is normal in size measuring 0.33 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 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.

### *Spleen*

The spleen is subjectively normal in size (0.85 cm 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*

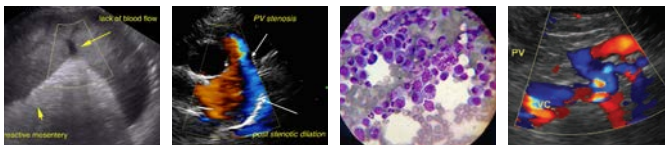
The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

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 is moderately fluid distended. 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 mild to moderate 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



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normal (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) Visualized peristalsis appears appropriate. The proximal duodenum and some areas of small intestine appear somewhat fluid dilated. In some areas, there is subtle soft shadowing from the bowel lumen, possibly due to the passage of hair, ingesta, etc.(?). Additionally, there appears to be focal inflammation in the cranial abdomen.

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 slightly hyperechoic in the region of the pancreas.

## ULTRASONOGRAPHIC FINDINGS

- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Fluid distended gastric lumen – this could be consistent with gastric ileus, a recent meal, or a partial outflow tract obstruction (none clearly visualized).
- Diffuse mild fluid dilation of the small intestine with some areas exhibiting soft shadowing – suggestive of the passing of ingesta, hair, etc.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas appears somewhat prominent on today's scan, but this could be consistent with mild current pancreatic inflammation or previous episodes of inflammation. Additionally, the stomach is distended with fluid. If the patient was adequately fasted, this could represent delayed gastric emptying, partial outflow tract obstruction, etc. Correlate with abdominal radiographs. In some areas of mildly fluid dilated bowel, there is soft shadowing, which could be consistent with passing of hairballs, ingesta, etc.

- Recommend a novel protein/hydrolyzed protein prescription diet.
- Recommend hairball therapy.
- Recommend a GI panel with quantitative fPLi, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- If there is a lack of response to symptomatic therapy for pancreatitis/gastroenteritis and a dietary change with hairball therapy, then consider obtaining GI biopsies.

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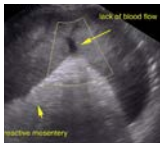
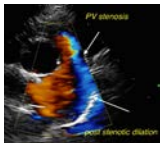
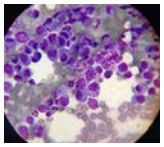
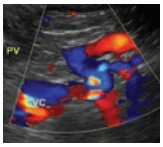

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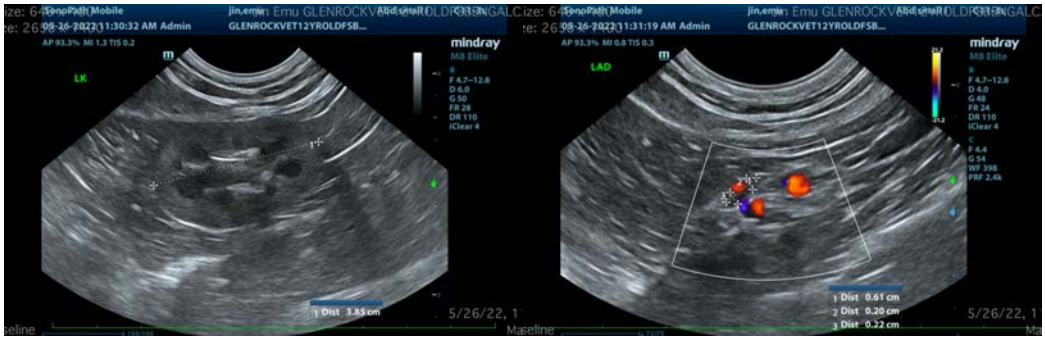


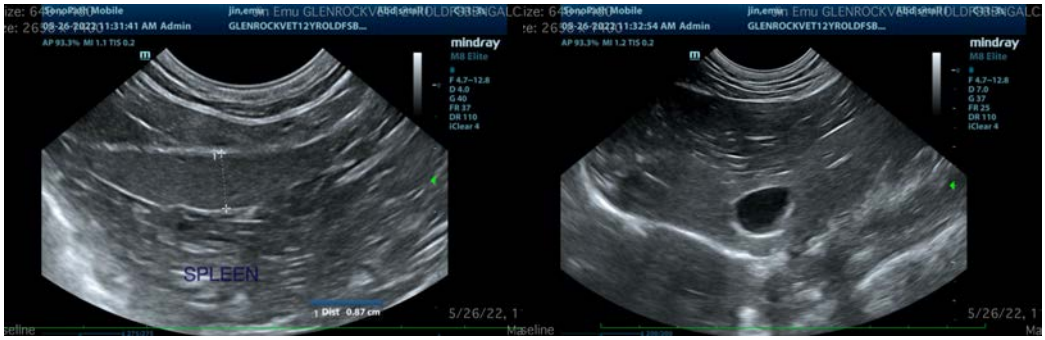


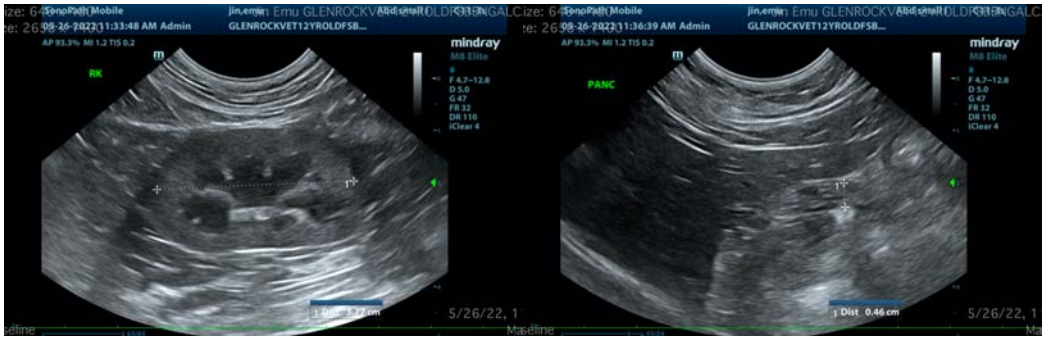


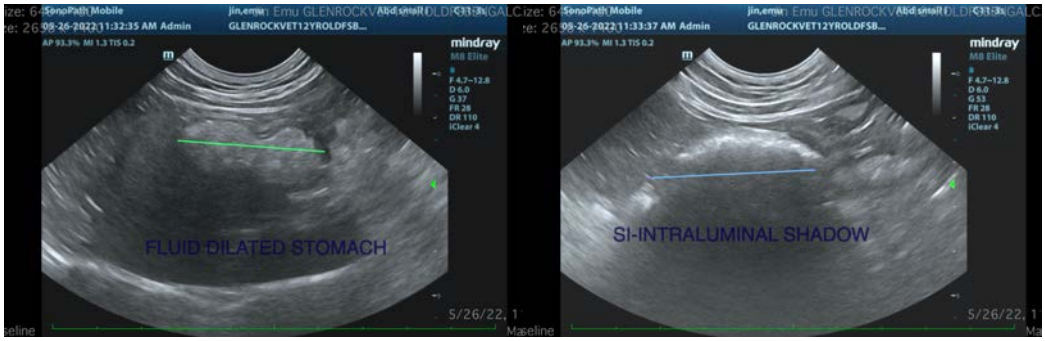


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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