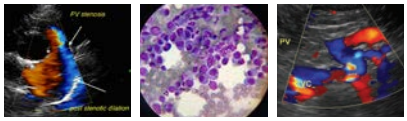
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

5/26/22

PATIENT

Sunny Deremer

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6/1/10

WEIGHT

8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Stephanie Pearce RDCS, RVT

HOSPITAL NAME

Alexander AH

REFERRING VET

Dr. Alexander

INVOICE

38022

PRESENTING CLINICAL SIGNS

Murmur grade 3-4/6 since 2017. Weight loss of 1lb over last 6 months. BM out of litter off and on past year. Odd neurologic twitching/petite seizure episodes since 2018.

Current Medications: Gabapentin 250mg/mL 1/2mL BID.
Lab Results: 5/9/22 SChem/CBC/T4 normal. 5/9/22 Snap Pro BNP abnormal. 5/10/22 fecal negative.
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 (3.76 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 (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.

Adrenal Glands

The left 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 (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, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There are occasional hyperechoic foci seen within the spleen. These do not deviate the splenic capsule.

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 0.28 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 a section of focal colonic wall thickening in the distal portion of the colon. This area extends approximately 2.14 cm in length with a wall thickness of 0.34 cm. In this area, there is reduction in the detail of wall layering, surrounding inflammation, and a localized lymphadenopathy.

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. Prominent pancreatic duct noted.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is an enlarged colonic lymph node in the caudal abdomen measuring 1.28 cm x 1.1 cm. Additionally, there is a prominent mesenteric lymph node visualized measuring 0.61 cm. The omentum is of increased echogenicity around the abnormal colon.

PRIMARY FINDINGS

- Focal area of colon wall thickening and surrounding inflammation – most consistent with focal inflammation (colitis) or focal infiltrative disease (lymphoma, carcinoma, adenoma, etc.).
- Focal colonic lymphadenopathy – There is a prominent colonic lymph node. Recommend fine needle aspirate.
- Prominent muscularis layer of 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.
- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

SECONDARY FINDINGS

- Occasional hyperechoic foci in the spleen – These lesions trend towards a more benign appearance, but an underlying neoplastic process cannot be excluded.

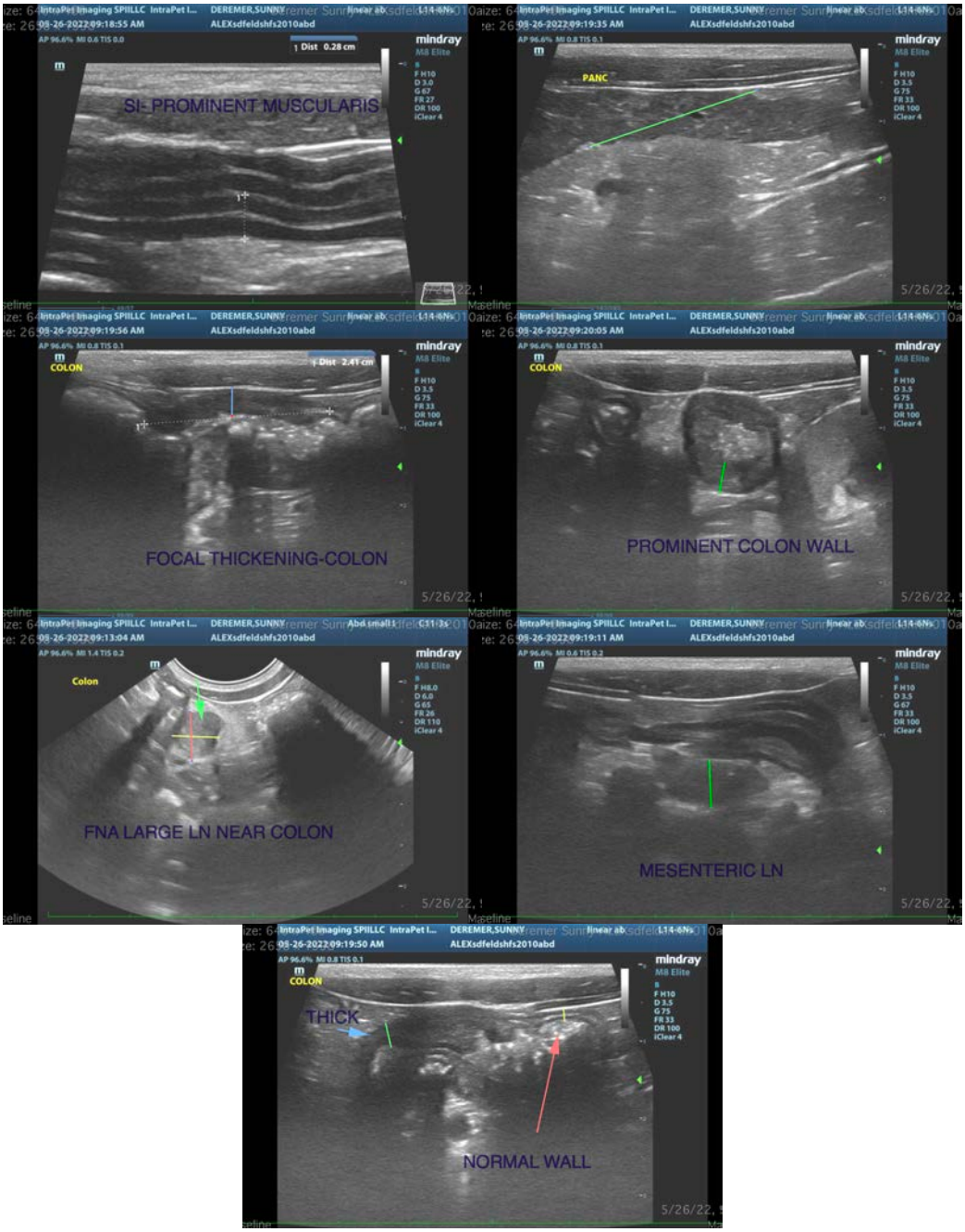
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a focal area of colonic wall thickening surrounded by inflammation and a prominent mesenteric lymph node. Correlate with a good sedated rectal exam and consider a fine needle aspirate of the local colonic lymph node (see image), as there is concern for possible localized inflammation or infiltrative disease. Correlate with radiographs in this area, looking for any evidence of foreign material, extraluminal gas, etc.

There is a prominent muscularis layer to the small intestine. This can be seen with inflammatory disease. It can also be seen in some normal older cats. If chronic small intestinal disease is suspected, consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate. This will help to further evaluate the pancreatic changes and the small intestinal changes observed.

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

Consider implementing therapy for pancreatitis/gastroenteritis while pursuing diagnostics regarding the focal colon wall thickening. In the very least, recheck this area with ultrasound in the next two weeks.



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.

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