PATIENT

Lincoln Magazine

SPECIES

Feline

BREED

Birman

SEX

Neutered Male

AGE

12 Years

WEIGHT

5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Waterloo West Animal Hospital

REFERRING VET

Dr. Gajadhar

INVOICE

15947

DATE

05/08/26

PRESENTING CLINICAL SIGNS

Findings: - Long term history of chronic intermittent vomiting - IRIS stage 2 renal dysfunction also present - Patient frequently gets hairballs that they bring up in the vomit Current Medications none

Values - elevated pancreatic lipase - elevated cholesterol (not post prandial) Radiographic Findings n/a Primary Question to Be Answered in This Exam Are there signs associated with: - Hairball Foreign body? - Architectural changes associated with inflammatory enteropathy?

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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.69 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 (3.34 cm). Overall echogenicity is slightly hyperechoic with decreased 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 left adrenal gland is normal in size measuring 0.31 cm width. 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 0.32 cm width. 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.

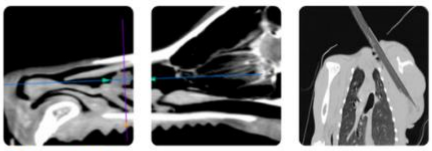
Spleen

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. No focal parenchymal abnormalities are visualized. The spleen measures 0.99 cm.

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



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The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7 cm 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. There is mild soft shadowing material visualized within the pyloric region possibly consistent with some soft ingesta or hair. No evidence of an obstruction is visualized.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal to mild 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. The duodenum measured 0.31 cm in diameter and the jejunum measured 0.26 cm in diameter. Visualized peristalsis appears appropriate. Some sections of small intestine appear mildly 'ropey' with a prominent muscularis layer. These changes are most consistent with inflammatory type change. In the mid abdomen, there is a loop of small intestine which has a small amount of intraluminal shadowing material and some mild fluid distention. This measures at 0.34 cm. A definitive obstruction is not seen. This could represent ingested foreign material, an early obstruction or more likely passing ingesta.

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 in both limbs (left greater than right) 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

- Pancreatic changes most consistent with chronic pancreatic remodeling and chronic pancreatitis.
- Age-related changes visualized associated in both kidneys.
- Segmental prominence of the muscularis layer in 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.
- Soft shadowing visualized within the pylorus, pyloric region and a focal shadowing area visualized within the small intestine- these likely represent passing ingesta/mild ileus. Non-obstructive foreign materials possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Changes visualized associated with the small intestine are relatively mild. Some areas appear mildly 'ropey' with a prominent muscularis layer and there is a small focal area with intraluminal shadowing

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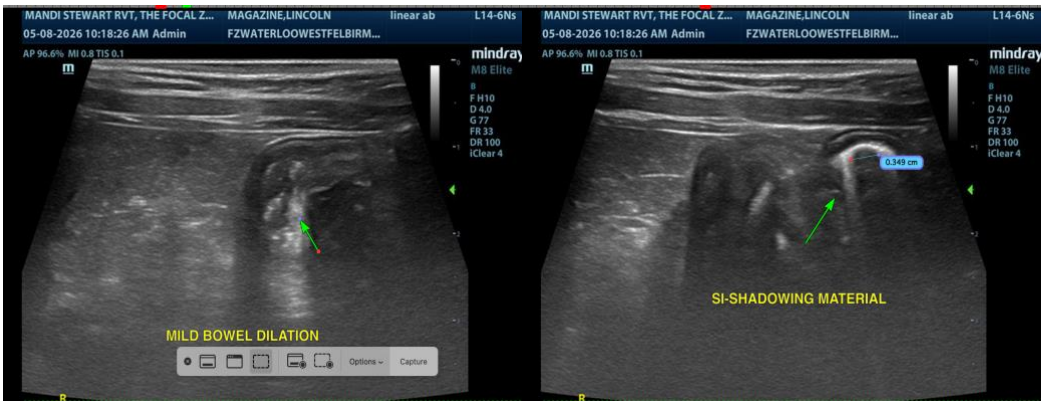
material and fluid distention. No evidence of an overt obstruction is observed, the shadowing strudture isa small with the suspicion of passing ingesta. If symptoms more consistent with a focal obstruction are identified, repeat evaluation of this region could be considered (radiographs +/- ultrasound). Additionally, there's some soft shadowing material visualized within the pylorus which could be ingesta or a small amount of hair. No obstruction is noted as the stomach is primarily empty.

Both limbs of the pancreas are hypoechoic and prominent. The left limb in particular could be consistent with mild chronic pancreatitis. Correlate with a PLI level and consider empirical treatment for pancreatitis.

Consider the following:

- There's a combination hydrolyzed protein/renal diet by Royal Canin which may be a good fit for this individual. If not, a palatable hydrolyzed protein prescription diet could be considered.
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- Correlate findings with a urinalysis and blood pressure to establish a baseline for chronic renal disease.
- Consider chronic hairball remedy.

If symptoms are persistent, ultimately biopsies of the GI tract may be warranted. Additionally, repeat imaging could be considered looking for the progression of today's lesions. If obstructive symptoms are present recommend follow up imaging to reassess.



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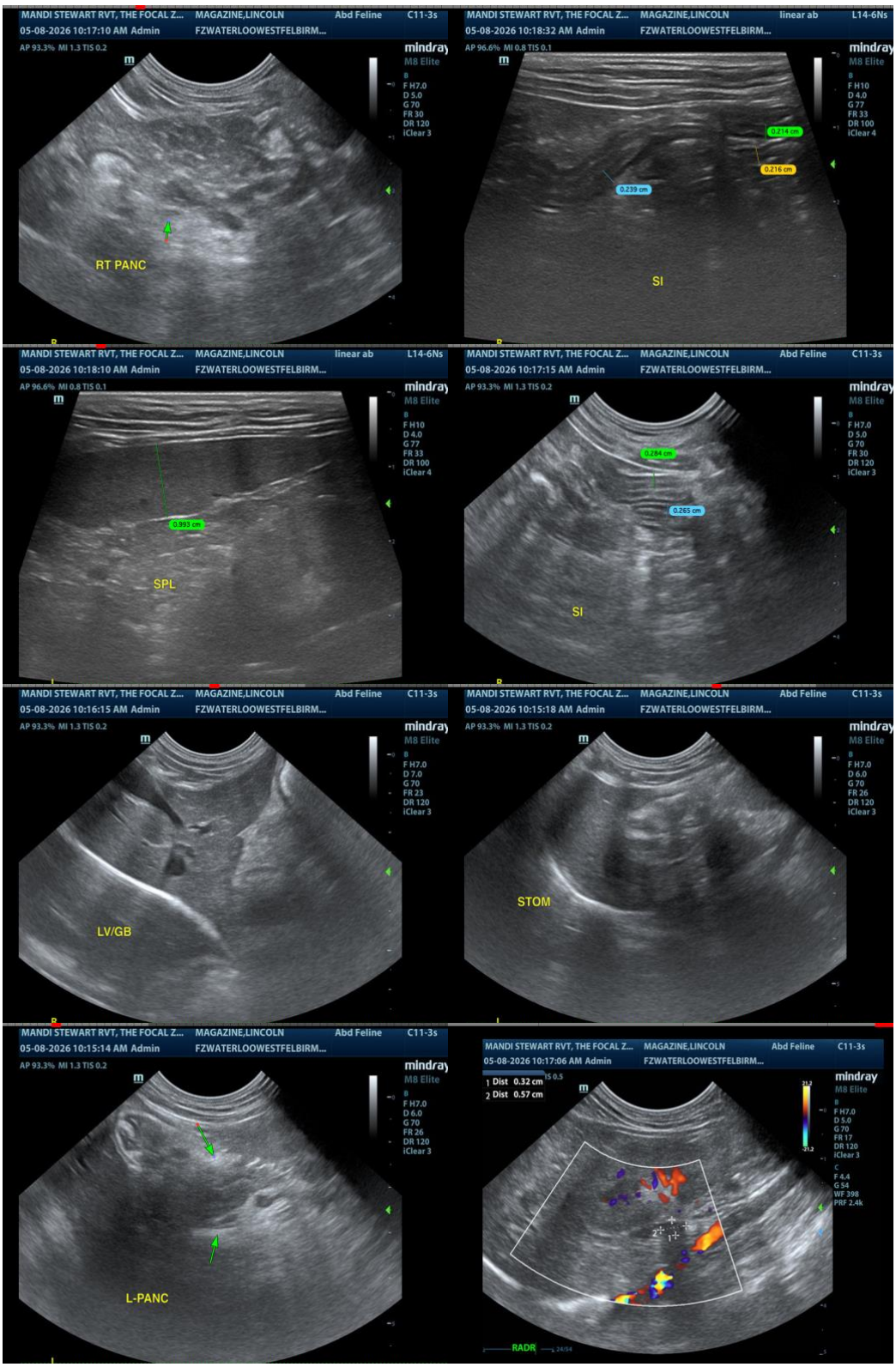

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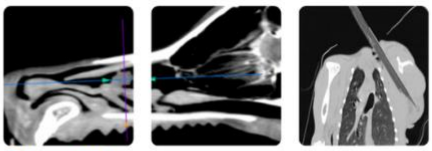

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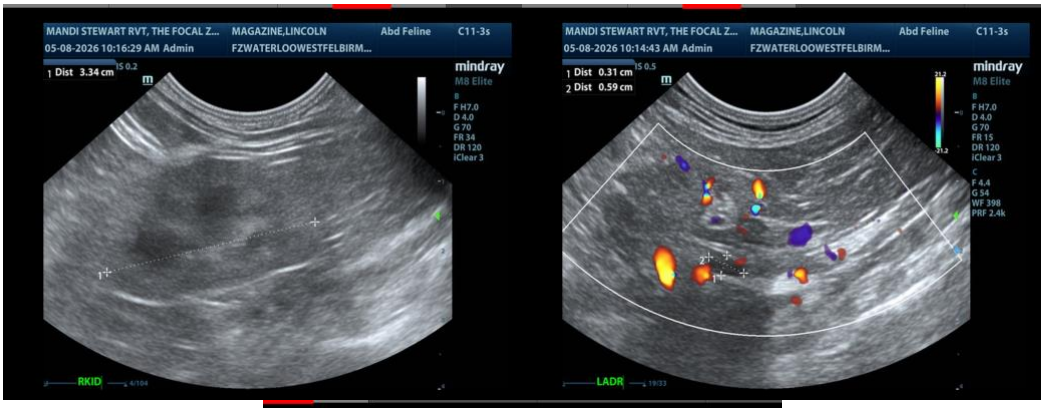

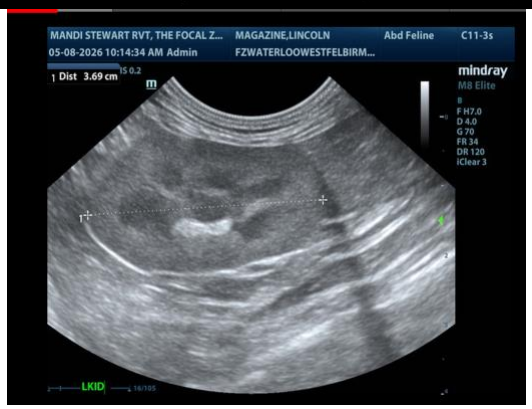

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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