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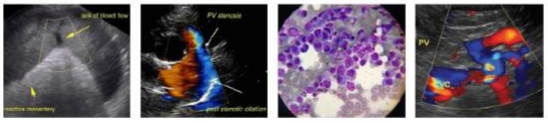

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

**PATIENT**

Buster Duffek

**SPECIES**

Feline

**BREED**

Domestic Long Hair

**SEX**

Neutered Male

**AGE**

10 Years

**WEIGHT**

6.8 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

.oetitia Saint-Jacques, RVT

**HOSPITAL NAME**

.oetitia Saint-Jacques, RVT

**REFERRING VET**

Dr. Peggy Roberts

**INVOICE**

15847

**DATE**

6/1/22

## PRESENTING CLINICAL SIGNS

History: not sedated-DOB approximately 2012, BW 6.8#, MN DLH Acute onset of dragging both hind legs 5/3/22. PE LRL decreased CPs more than RRL. No vertebral pain, no abnormalities apparent on xray. Both rear feet warm. Elevated heart rate, no murmur. Blood work WNL, TT4 3.4. In the past month ambulation has improved. Lost ½ pound.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended with mild primarily severe suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.97 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 (3.95 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 0.43 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 0.33 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 hypoechoic, 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 heterogenous in echotexture with subtle, indistinct focal mottling. 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 gallbladder does not appear thickened and has a smooth mucosal surface. There is a large amount of nonorganized echogenic debris within the lumen. The cystic and common bile ducts are normal/not visible.

### *Gastrointestinal*

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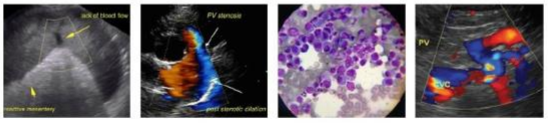

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The stomach is moderately dilated with fluid and irregular shadowing material most consistent with moderate ingesta and gas. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. There is a 1.28 cm shadowing object visualized within the gastric lumen.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal/moderate 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. 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*

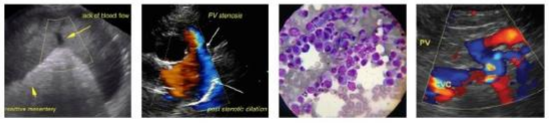
The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

### *Free Abdomen*

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, 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

- Large amount of heavily echogenic debris within the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.
- Hypoechoic “meaty” appearing spleen. This is a nonspecific finding but can sometimes be seen with infiltrative disease. Consider a fine needle aspirate.
- Hypoechoic prominent pancreas. The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Heterogeneous liver. Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Moderate ingesta and fluid within the gastric lumen, as well as a hard shadowing structure. There is no obvious evidence of an obstruction. This shadowing object could be consistent with foreign material, a hair ball, etc. Correlate with abdominal radiographs and feeding history.
- Large amount of debris within the gallbladder. The significance of this is unclear. Correlate with liver values. This is likely an incidental finding.





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- 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

An obvious cause for the pelvic limb paresis is not readily visualized. There is a very large amount of echogenic debris within the urinary bladder. I recommend urinalysis and culture, as there could be some predisposition to infection in a pet with decreased mobility/ability to urinate.

Many of the changes observed are relatively nonspecific. Correlate with blood work findings, physical exam findings, etc. No thrombus was visualized at the aortic trifurcation.

The spleen appeared somewhat hypoechoic and “meaty” If round cell neoplasia is high on your differential list, I recommend a fine needle aspirate of the spleen. Additionally, the pancreas is somewhat hypoechoic and prominent. If there are no signs of active pancreatitis, this could probably be monitored. The liver appears somewhat heterogeneous. If liver enzyme elevations are present, consider a fine needle aspirate.

The significance of the shadowing material within the gastric lumen is uncertain, correlate with feeding history an abdominal radiographs. This could be consistent with ingesta, foreign material, hairballs, etc. An obvious obstruction is not noted.

The small intestine appears generally, mildly fluid dilated with a prominent muscularis layer. This can be seen in some normal older cats, but it can also be associated with generalized small intestinal inflammation. You could consider a GI panel (to Texas A & M) for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.

Consider a consultation with a veterinary neurologist regarding the rear limb paresis reported (provided there is no significant cardiac disease).

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

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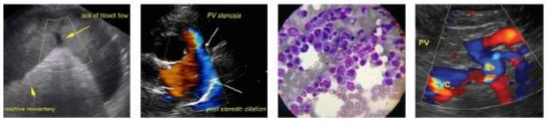

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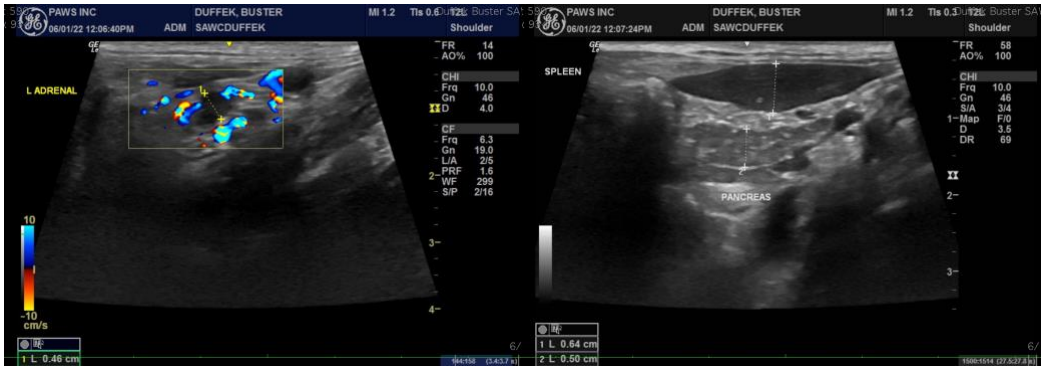



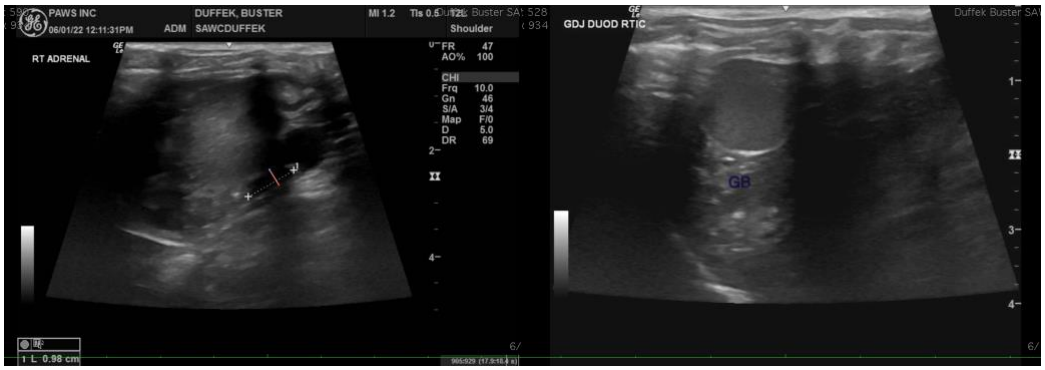


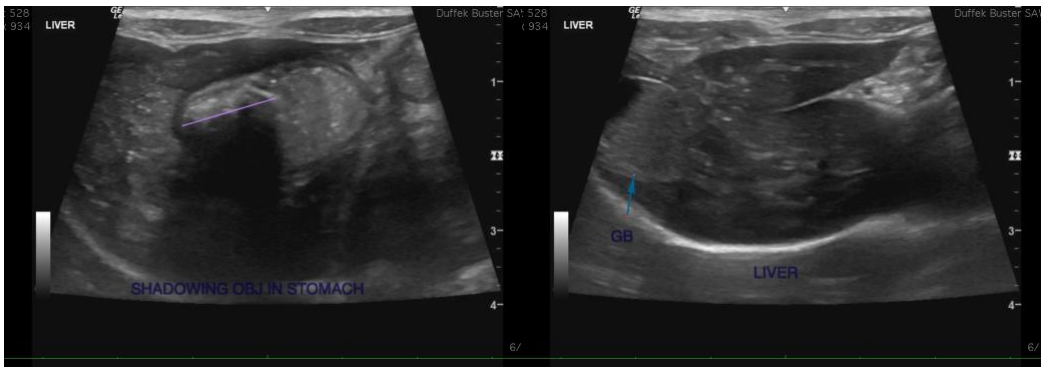


The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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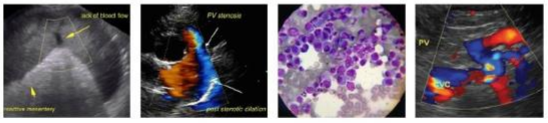

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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kathleen.sennello@sonopath.com