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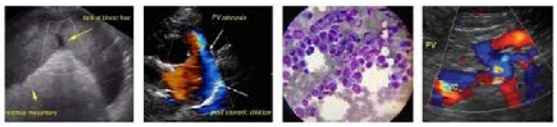

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Posie Major

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10.5 Years

WEIGHT

4.63 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Grand River VH

REFERRING VET

Dr. Day

INVOICE

43159

DATE

6/14/23

PRESENTING CLINICAL SIGNS

Quiet, not eating well, vomiting. Normal litterbox habits. Long history of allergies. Tense abdomen on exam and possible dental resorptive lesions. Has been on Prednisolone, Mirtazipine, Convenia and transdermal Codeine. Still seems off.

Abnormal PE/Chem/CBC/UA Results: Bloodwork NSF

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 (3.67 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 is normal in size (3.9 cm) but slightly irregular in shape (likely due to previous infarct). 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 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 right adrenal gland is normal in size measuring 0.43 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 (0.83 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.

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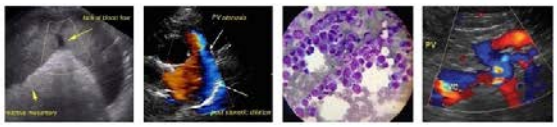

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Gastrointestinal

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. Duodenum wall measures 0.33 cm. Jejunum wall measures 0.26 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 large and hypoechoic to surrounding mesentery. There are occasional hypoechoic nodules visualized associated with the parenchyma, most consistent with lymphoid hyperplasia. There is evidence of regional mesenteric inflammation. Consistent with moderate pancreatitis.

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.

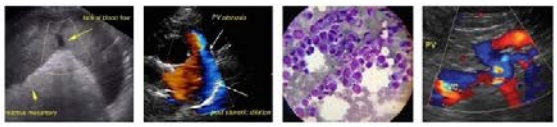
ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled, hypoechoic pancreas with occasional hypoechoic nodules and minimal surrounding inflammation – Findings are most consistent with either mild chronic pancreatitis or previous episodes of pancreatic inflammation as well as lymphoid hyperplasia.
- Prominent muscularis layer to the small intestine – The small intestinal wall changes could be consistent with an underlying inflammatory process. These types of changes can sometimes be seen in normal older cats. Correlate with clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious source for the symptoms described is not visualized. The pancreas does appear prominent in both the left and right limbs, and there are some hypoechoic associated with it. These changes could be consistent with mild active pancreatitis, and the nodules are most consistent with lymphoid hyperplasia, although underlying neoplastic disease cannot be definitively ruled out. Correlate these findings with a quantitative fPLI. If symptoms are persistent, the nodules could be reevaluated with ultrasound, or a fine needle aspirate could be considered. Consider empirical treatment for pancreatic inflammation.

The muscularis layer is somewhat prominent associated with the small bowel. This could be consistent with a chronic enteropathy. If metabolic disease is thought unlikely, then primary gastrointestinal disease is possible.



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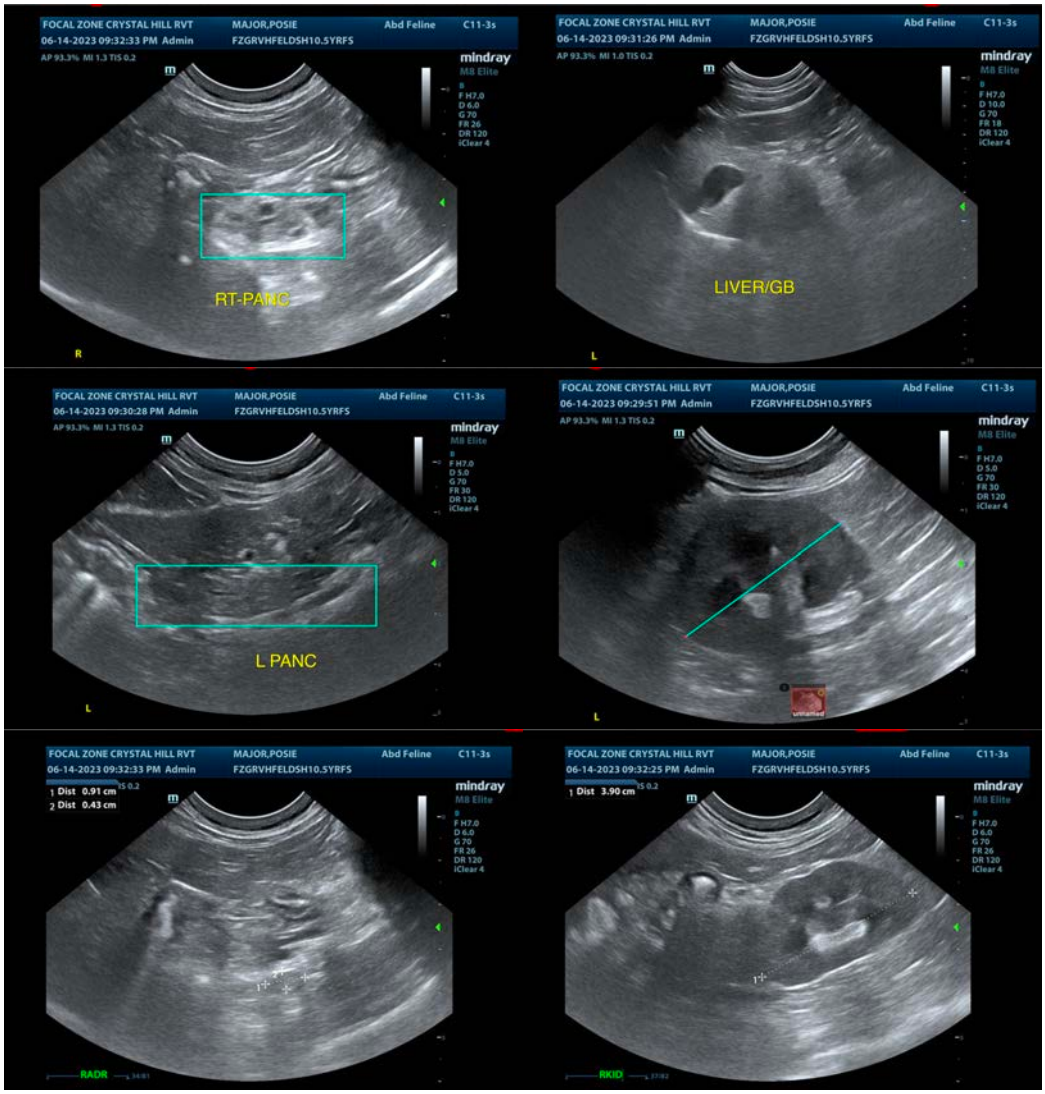
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- If symptoms persist and a primary enteropathy is strongly suspected, consider obtaining GI biopsies.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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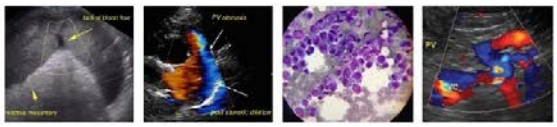

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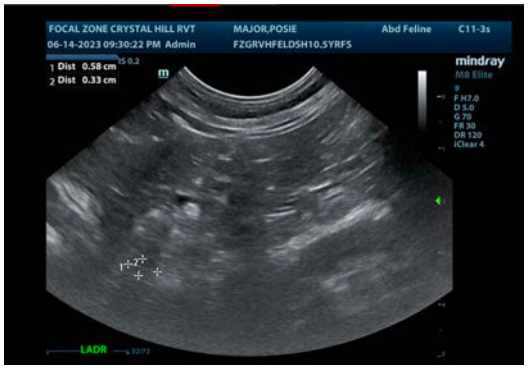

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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