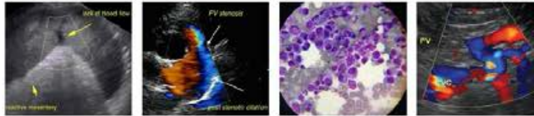


PATIENT
Bubba King

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
12 Years

WEIGHT
10.6 Pounds

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

IMAGING BY
Loetitia Saint-Jacques, LVT

HOSPITAL NAME
North Hills VC

REFERRING VET
Dr. Hartwick

INVOICE
38749

DATE
6/15/22

PRESENTING CLINICAL SIGNS

AliveCor ECG used due to fractious behavior of feline- 50mg gabapentin PO and 0.1ml butorphanol IM used for echo/abdominal scan- unable to scan neck at this time until cardiologist provides a sedation protocol- O states pt has been throwing up. O states pt has been gobbling food and then throwing up. O states pt drinks a lot of water. Owner pointed out an area around pharynx that is a little swollen and requests neck scan- scope may be needed but Dr did not palpate anything abnormal- 5/6 heart murmur at first exam- 3/6 heart murmur on today's exam Abnormal PE/Chem/CBC/UA Results: LABS: BUN 38, Crea 2.1 Temp: 99.90 Respiration: 60.00 Pulse: 200.00

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 (3.99 cm). Overall echogenicity is slightly hyperechoic with poor 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 (3.24 cm). Overall echogenicity is slightly hyperechoic with poor 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.

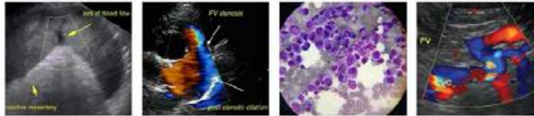
The right adrenal gland is normal in size measuring 0.38 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is normal/borderline large in size (1.02 cm in width 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. There is a small hyperechoic nodule visualized within the parenchyma measuring 0.19 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. There is a hyperechoic cystic structure measuring approximately 2.23 cm x 1.65 cm visualized within the parenchyma.



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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 <0.7cm 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. Duodenum wall measured 0.35 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

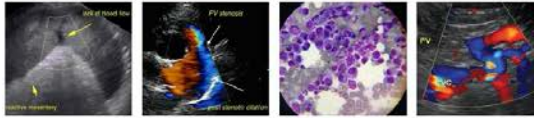
The pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid. Prominent pancreatic duct noted measuring 0.23 cm.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are mildly enlarged mesenteric lymph nodes visualized measuring 0.97 cm and 0.62 cm in diameter. The omentum is generally of normal echogenicity.

PRIMARY FINDINGS

- Prominent, hypoechoic pancreas with prominent pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Hyperechoic cystic lesion in the hepatic parenchyma – most consistent with a benign hepatic cyst. Recommend continued monitoring.
- Subjectively thickened small intestine with prominent muscularis layer – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Mildly enlarged mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.



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SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

- Borderline large spleen with hyperechoic nodule – The spleen appears normal and is likely an appropriate size for this larger cat. The hyperechoic nodule is of uncertain significance. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears somewhat prominent with prominent mesenteric lymph nodes. This could indicate some small intestinal inflammation or less likely neoplastic change. Unfortunately, a prominent muscularis layer can be a common finding in normal older cats, so the significance of this is unclear. Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreatic and small intestinal changes observed.

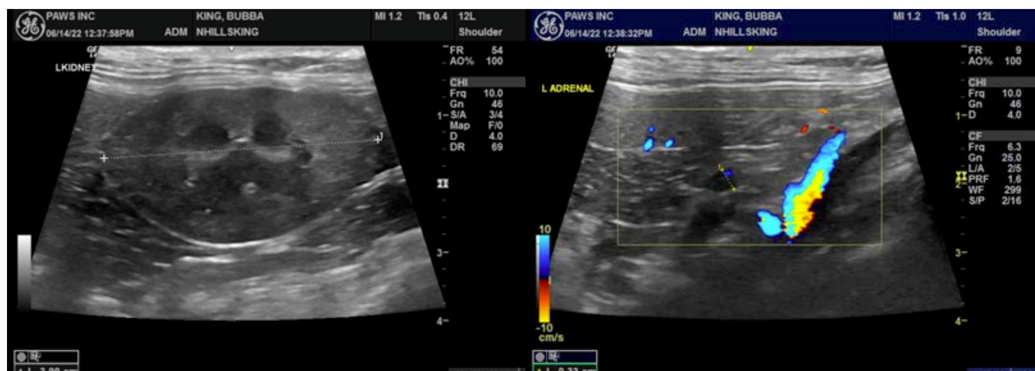
Based on the history, there is concern for a possible cervical lesion. If possible, differentiating between vomiting and regurgitation may be very helpful in trying to determine how significant the changes observed in the gastrointestinal tract are. If a significant cervical lesion is thought likely, then consider either a contrast CT scan or upper GI endoscopy for further evaluation.

If primary gastrointestinal disease is considered likely, then you could consider:

- Novel protein/hydrolyzed protein prescription diet.
- Consider obtaining fine needle aspirate from a mesenteric lymph node.
- Aforementioned GI panel.
- Chronic probiotic therapy.
- Symptomatic treatment for pancreatitis/gastroenteritis.
- If symptoms persist, consider obtaining GI biopsies.

There are changes observed in the kidneys consistent with chronic progressive disease. Recommend urinalysis, culture and blood pressure evaluation.

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



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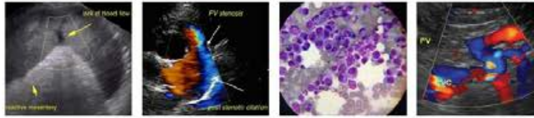

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

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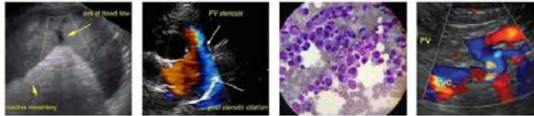

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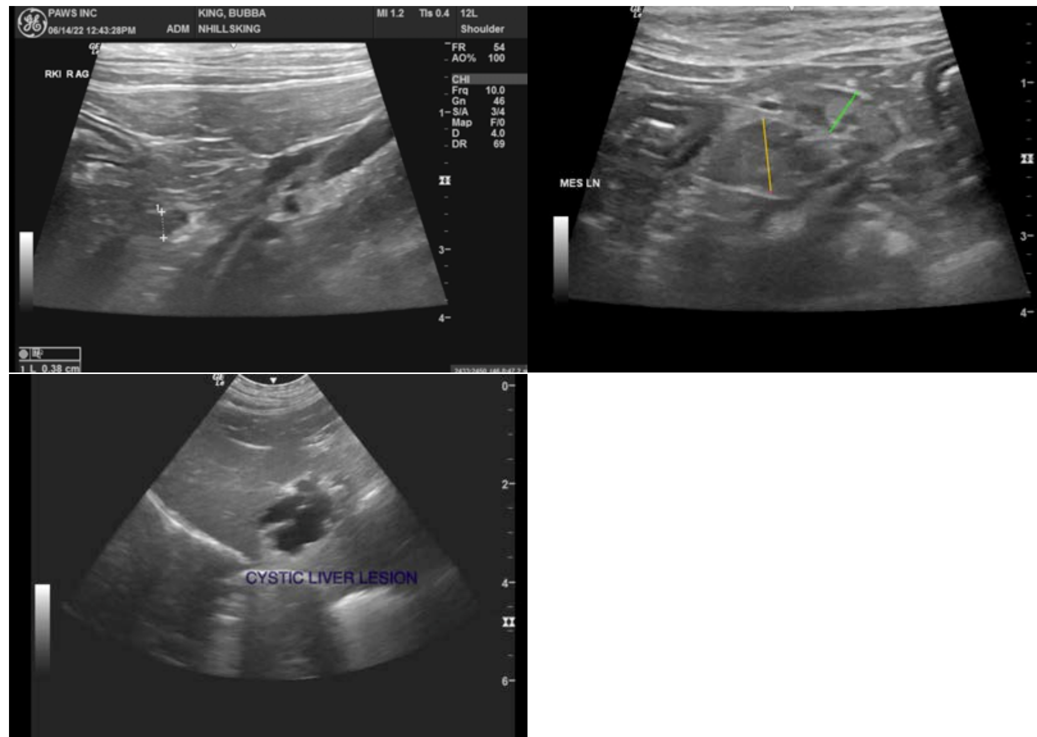

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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