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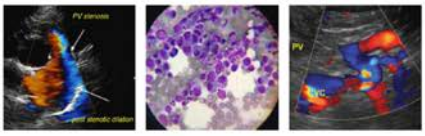

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PATIENT
Roxy Bowman

SPECIES
Feline

BREED
DLH

SEX
Spayed Female

AGE
13 Years

WEIGHT
8.3 Pounds

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

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Cat Care of Rochester Hills

INVOICE
39018

DATE
6/23/22

PRESENTING CLINICAL SIGNS

Weight loss, FPL elevation, chronic vomiting, loss of 2.3 lbs since August, 2021. On Iams dry and boiled chicken (per o canned cat food makes her vomit). Vomiting more undigested food lately. Vomiting through Pepcid given at 5 mg SID. Have not tried Cerenia. Not on any medications or supplements. Abnormal PE/Chem/CBC/UA Results: Last full bw (with thyroid) done on 6-15-22, unremarkable. Spec FPL = 6.5 (mild H), first time an FPL was done. Very mild hypochloremia (likely d/t vomiting). T4 is 2.7, was 2.3, 1.7, 2.4 - no palpable thyroid slip.

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 (3.59 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 is largely obscured by the shadowing gastric content. The cranial portion is visualized and appears normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.40 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 0.42 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. 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 primarily anechoic. The cystic duct appears somewhat prominent and tortuous, measuring 0.24 cm proximally.

Gastrointestinal

The stomach is moderately to severely dilated with fluid and irregular shadowing material, most consistent with normal ingesta and gas. In some areas there appears to be more extensive shadowing, possibly consistent with hairballs or other foreign material. The gas and shadowing material precludes visualization of large areas of the cranial abdomen and parts of the stomach, particularly the pyloric

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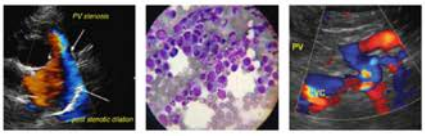

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region is difficult to visualize. The areas of wall that can be seen measured at a normal thickness of <0.36 cm with some variability due to the presence of rugal folds. The distinction of gastric wall layering is adequate with no impression of reduced peristaltic activity. No masses are observed.

Many of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with moderate fluid distension. Wall thickness is normal. There are no focal lesions visualized within the small intestine to suggest an obstructive process. Hypermotility was visualized in the proximal duodenum and some more distal areas.

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 is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild/moderate pancreatitis. The left limb appears particularly prominent.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is an occasional prominent mesenteric lymph node visualized measuring 0.65 cm and 0.45 cm. The omentum appears mildly hyperechoic in the region of the left limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Significantly dilated gastric lumen with gas, ingesta, and shadowing material – correlate these findings with feeding history and abdominal radiographs. If the patient was adequately fasted, considered such differentials as delayed gastric emptying time, ingested foreign material, or gastric outflow tract obstruction (not clearly visualized).
- Fluid dilated small intestine – This could be consistent with a recent meal, ileus, or hypomotility, or multiple partial obstructions due to ingested foreign material.
- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with moderate pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cranial aspect of the abdomen is largely obscured by the distended gas-filled and ingesta-filled stomach. Additionally, much of the more distal small intestine is fluid filled. This could be consistent with diffuse ileus, a recent meal, etc., or possibly with multiple ingested foreign objects, etc. Correlate these findings with abdominal radiographs. Consider a prolonged fast with serial imaging to ensure material is passing. A modified barium swallow may be helpful to be able to follow contrast material passing. If there are concerns, you could consider an exploratory with the intention to obtain GI biopsies and evaluate for any foreign material.

The pancreas does appear prominent and mildly inflamed. This could be consistent with a previous episode of pancreatitis, current mild pancreatitis, or fibrosis and secondary inflammation from the GI

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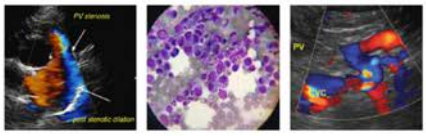

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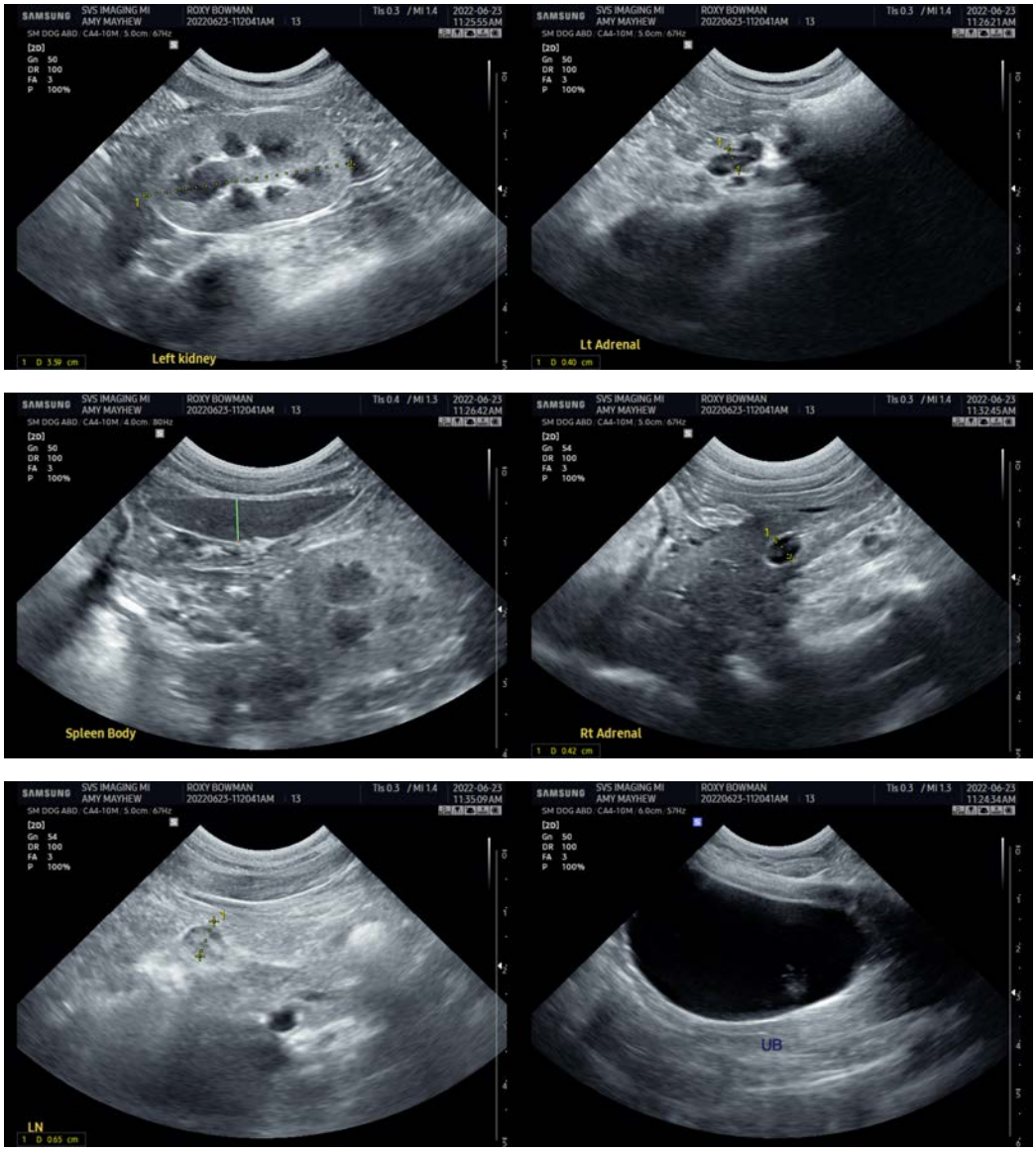
tract.

- Consider a quantitative fPLI to evaluate and follow the pancreas over time.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- If obstructive foreign material is ruled out, then consider empirical treatment for chronic vomiting with a novel protein/hydrolyzed protein prescription diet. Recommend a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- If symptoms persist, consider GI biopsies.



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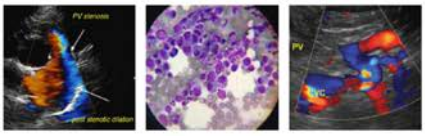

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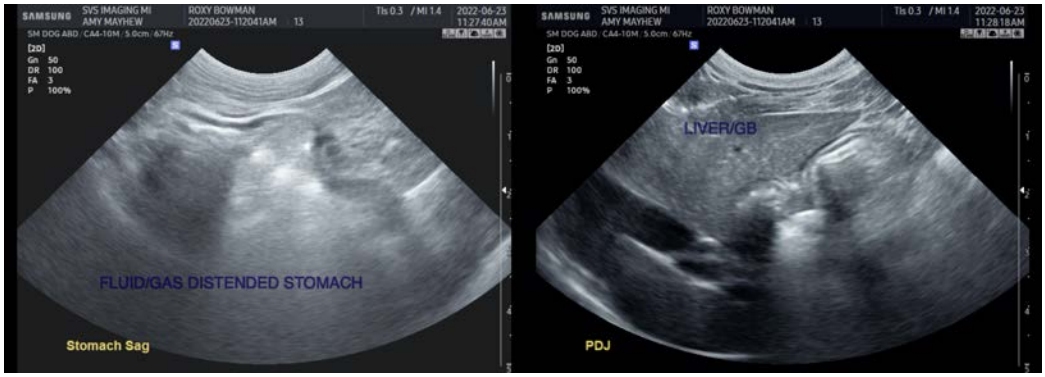

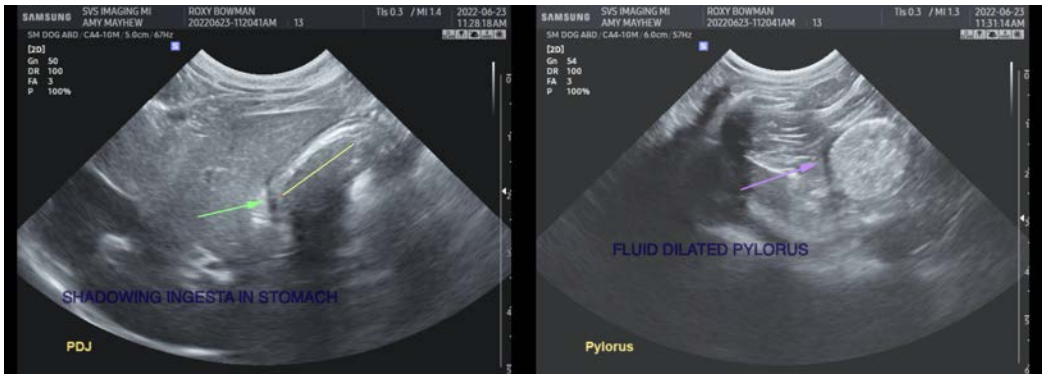

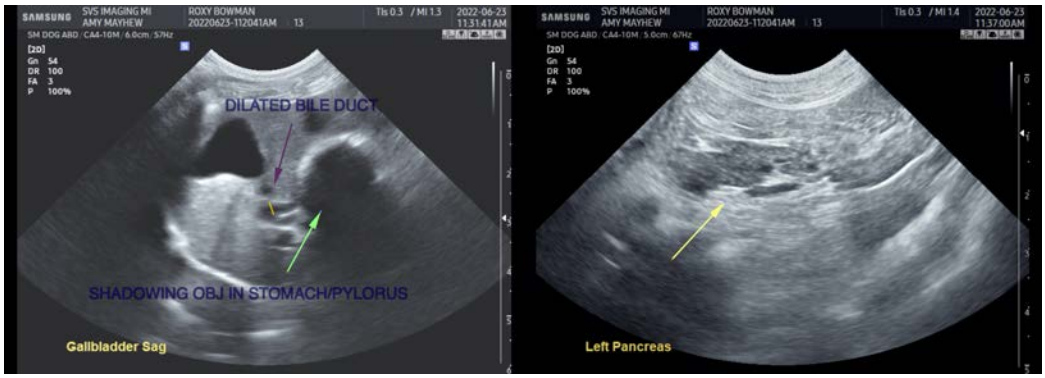

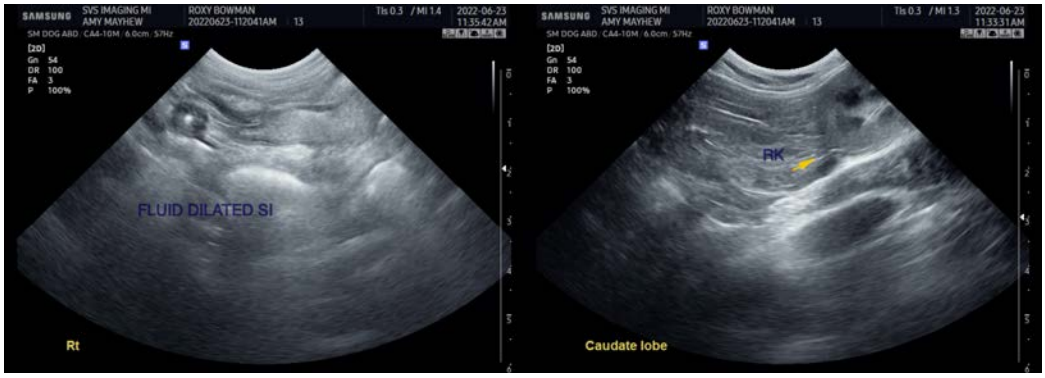

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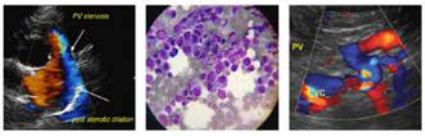

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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