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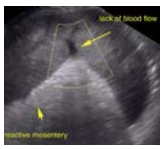
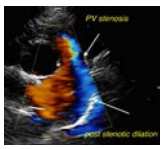
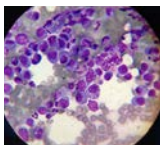
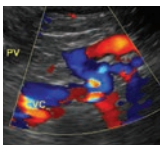

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1-800-838-4268 info@sonopath.com

PATIENT

Opie Kane

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

4.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Callihan – Pacific Crest Mobile VS

HOSPITAL NAME

Pacific Crest Mobile VS

REFERRING VET

Dr. Baker – Animal Emergency Care

INVOICE

39064

DATE

6/28/22

PRESENTING CLINICAL SIGNS

Opie has a long history of soft stools and intermittent diarrhea, but generally manageable with limited ingredient diet (Royal canin). However last weekend was brought home after he had been boarded for a few days, (which is not something new or generally stressful for him) and on returning home had what owner describes as blow-out diarrhea, and he went off his food (which is highly unusual for him). He visited the ER and had lab work done, supportive outpatient care and responded well. He has an unusually dense coat, and per owner vomits up impressive sized bezoars routinely. Opie is 100% indoor, lives w one other adult cat, very stable environment and is an admirably well-attended cat. He looks like a 4 yr old rather than 14yrs.
Abnormal PE/Chem/CBC/UA Results: PE: perfect body and coat condition, no PE abnormalities at all Labs: CBC/Chem/UA normal Echo: done since we had him sedated for abdominal study, very normal appearing heart

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. 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 (3.89 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 0.29 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.

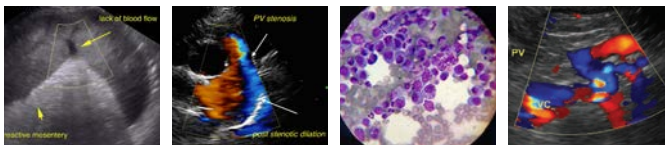
The right adrenal gland is normal in size measuring 0.24 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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.



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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

There is a large area of shadowing material within the gastric lumen. This material has a soft shadow, possibly consistent with hairballs. 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.

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 0.22 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. there is an area of small bowel that appears corrugated, most consistent with focal enteritis.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. The colon appears diffusely dilated with nonformed fecal material and liquid. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is normal and isoechoic to surrounding 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. There are occasional prominent mesenteric lymph nodes visualized. One measures at 0.49 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Moderate/large amount of intraluminal shadowing gastric material – correlate with feeding history and abdominal radiographs. Findings could be consistent with ingesta/ingested material or hairballs.
- Prominent muscularis layer to the small intestine and a focal area of corrugation – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma. The corrugated area of bowel is most consistent with focal enteritis.
- Fluid dilated large bowel – most consistent with the reported diarrhea.
- 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

No focal bowel lesions are observed to identify a cause for the chronic intermittent diarrhea reported. There does appear to be some shadowing material within the gastric lumen. Correlate these findings with a feeding history, radiographs, etc., as this could represent ingested foreign material, hairballs, etc.

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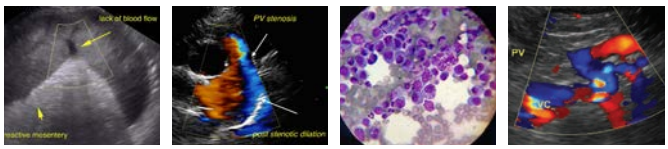

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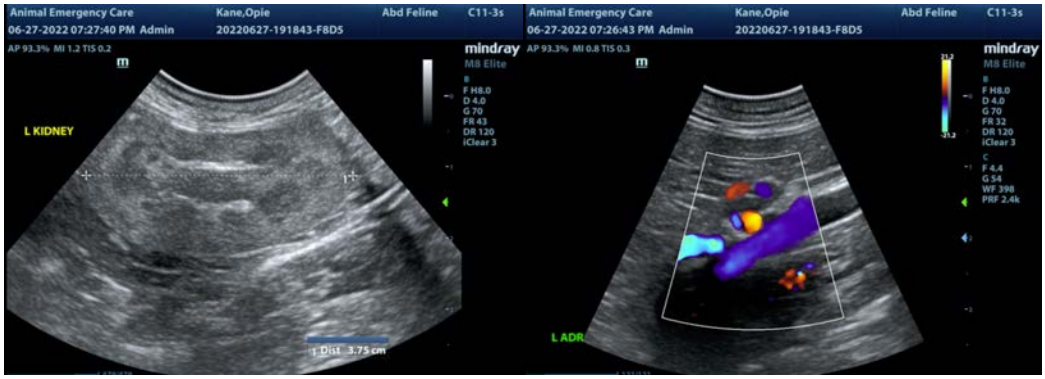
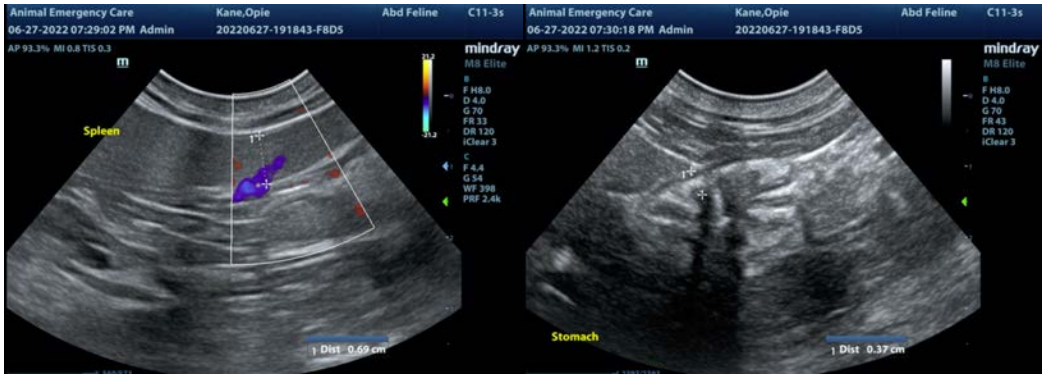
The prominent muscularis layer and prominent mesenteric lymph nodes indicate a level of underlying inflammation. This has historically been controlled with a novel protein diet, but relapses are possible with stress, a possible change of diet (treats?), or age related progression.

- Consider a novel protein/hydrolyzed protein prescription diet (already doing this).
- Recommend a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Recommend symptomatic therapy for acute gastroenteritis/diarrhea.
- Recommend chronic probiotic therapy.
- If symptoms persist, consider obtaining GI biopsies.
- If hairballs are clinically suspected, recommend hairball remedy and continued monitoring of the intraluminal gastric material.





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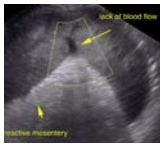
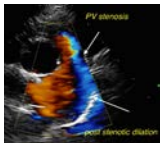
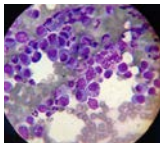
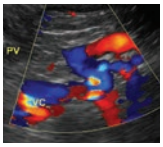

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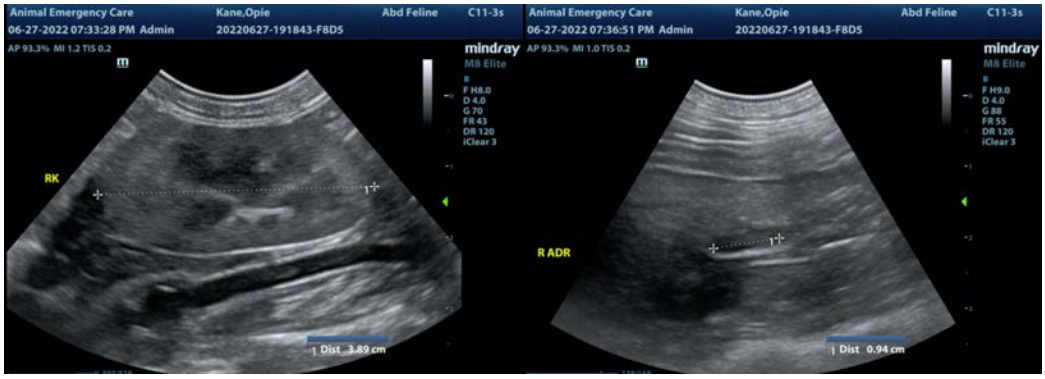

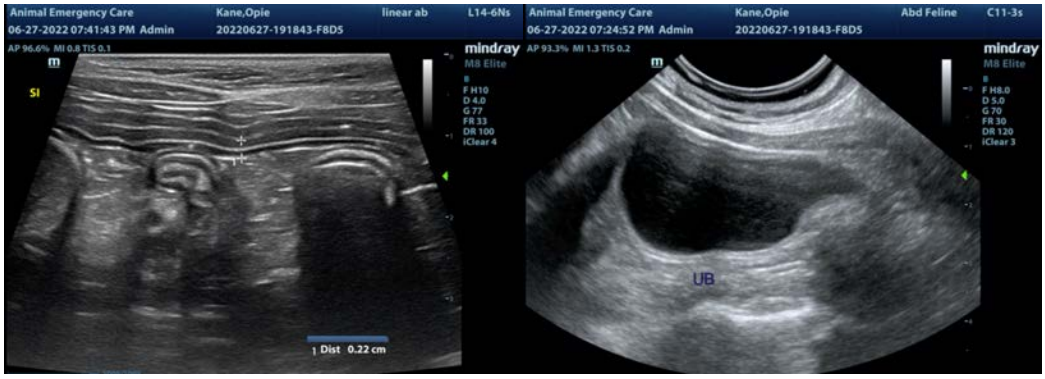

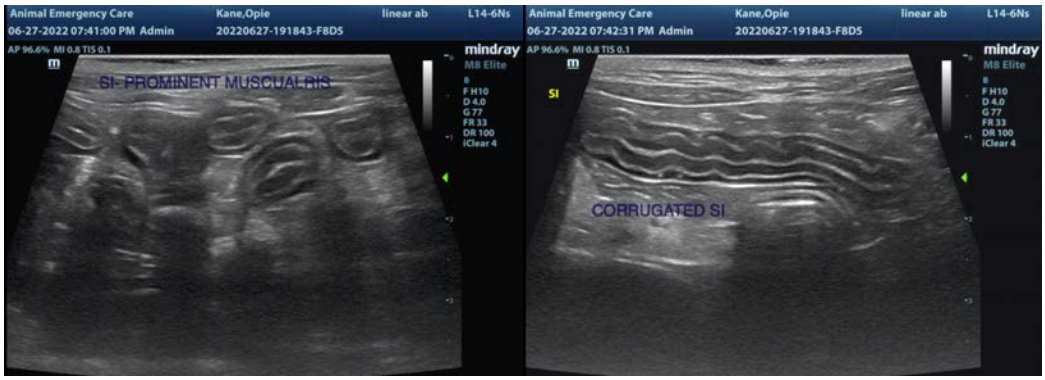

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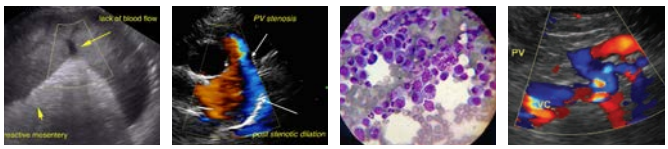

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com