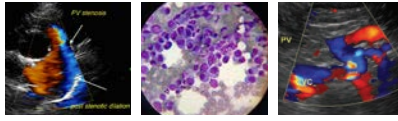


DATE

6/29/22

PATIENT

Roxy Vendenski

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10/7/09

WEIGHT

8.7 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Andi Parkinson RDMS

HOSPITAL NAME

Paradise AH

REFERRING VET

Dr. King

INVOICE

39100

PRESENTING CLINICAL SIGNS

Patient seen a month ago. Owner noted appetite is "slowing down." Full BW sent out, unremarkable. On 6/23, pt. seen at our clinic for not eating, lethargic X 48 hours. Full body radiographs-lungs hyperinflated no other abnormalities. BW (including T4) showed-Hct 36.6%; WBC 4.65 K/microL, Neutropenia 0.42K/microL; thrombocytopenia; rest normal. She was treated with sq fluids, cerenia, famotidine, B12 inj; sent home with entyce and cerenia. Ate small amount after getting entyce, nothing
after that. I saw her on 6/25, just did CBC-Hct 24.6%, WBC 7.8 K/microL (bands present), neutropenia 0.33 K/microL; platelets 81 K/microL, manual 254K/microL with clumps. I sent her to EVC for iv fluids, iv antibiotics and monitoring. She did well there, hospitalized for ~24 hours, started on doxycycline...I think they did a PT which was normal, sent her home on oral doxycycline. She was eating when sent
home and seems to be doing well

Current Medications: doxycycline 20 mg BID PO? (started iv 6/25)
Fortiflora 1 packet SID PO (started 6/26), Entyce SID if needed (given last week, none this).
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 (4.07 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 (4.16 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. 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. There is a small hyperechoic nodule visualized within the liver measuring 0.50 cm x 0.48 cm.

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 <0.36cm 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. Jejunum wall measured 0.46 cm. Visualized peristalsis appears appropriate. There is diffuse moderate to severe thickening of the small intestine with a prominent muscularis layer. Additionally, there is a focal section of bowel where this prominent muscularis layer is expanded. The wall is progressively thickened, and the distinction of the wall layering is greatly reduced. Findings are concerning for an emergent bowel mass.

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 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 clusters of prominent mesenteric lymph nodes measuring 0.61, 0.57, and 0.46 cm. The omentum is hyperechoic around these lesions.

ULTRASONOGRAPHIC FINDINGS

- Generalized small intestinal wall thickening with a prominent muscularis layer in addition to a focal area of thickened bowel with reduced wall layering – 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 focal area of abnormal bowel is concerning for an emerging bowel mass.

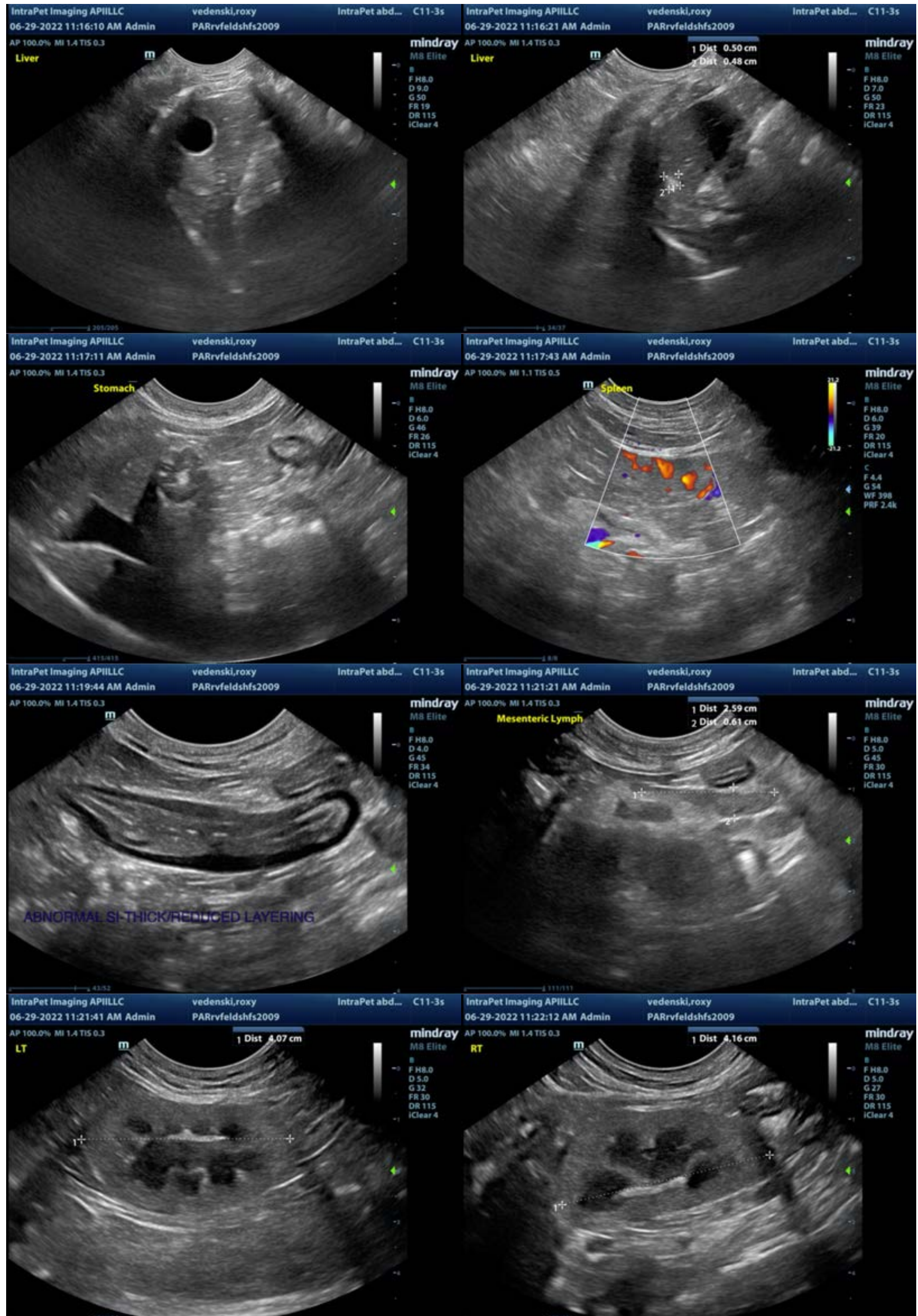
- Moderate mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

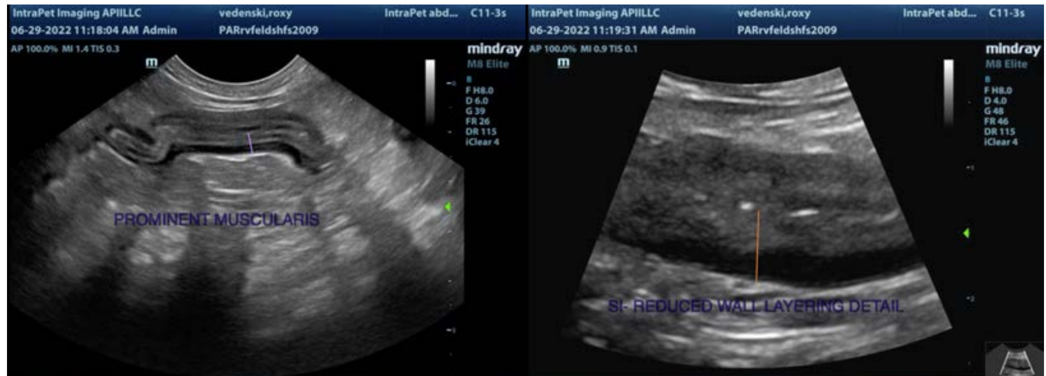
- Hyperechoic nodule in the liver – This trends towards a more benign appearance, but consider a fine needle aspirate.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears significantly diffusely thickened with a prominent muscularis layer, and there is a section of small bowel with continued thickening and decreased distinction of wall layering, consistent with a possible emerging bowel mass. Additionally, there are some clusters of prominent mesenteric lymph nodes. Consider a fine needle aspirate of the abnormal section of bowel and/or a mesenteric lymph node. If cytologic diagnosis is not possible, then consider obtaining GI biopsies.

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





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.

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