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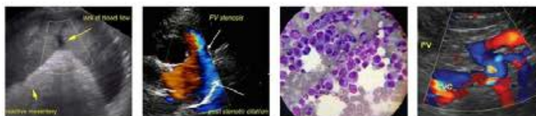


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT
Cobi Mack

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
10 Years

WEIGHT
16 Pounds

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

IMAGING PERFORMED BY
Loetitia Saint-Jacques, LVT

HOSPITAL NAME
Donner Truckee VH

REFERRING VET
Dr. Greg H.

INVOICE
43587

DATE
6/29/23

PRESENTING CLINICAL SIGNS

Sedated dex/torb for AUS 06-23-2023 :Check chronic fecal accidents and recent vomiting. Patient has had intermittent fecal accidents outside of the litter box for the last 5 months. Time between episodes can be weeks and stool is usually normal, but when episodes do occur, patient has discomfort upon having the bowel movement. The stool was soft during episode last night and patient did vomit. He has vomited 3 times in the last wk, but does not have chronic vomiting. Owner switch from chicken to turkey based diet when signs first started. Good appetite/energy. No C/S/D. No major historical problems/current medications reported. Indoor only and up to date on Rabies vaccine per owner 06-28-2023:Owner reported that patient is doing well overall with good app/energy and no further vomiting, but he has had more fecal accidents outside of the litter box. Owner does not perceive and hind end pain or mobility issues. Owner has not added another litter box to the household. Discussed novel vs hydrolyzed protein diet trial and AUS as next steps if adding a litter box does not help the fecal accidents. Owner would like to be proactive and pursue AUS.

Abnormal PE/Chem/CBC/UA Results: CBC/chem/T4/FT4ED: Mild hyperalbuminemia, rest WNL. Consistent with dehydration.

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 (4.57 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 has a normal shape and size (4.76 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.

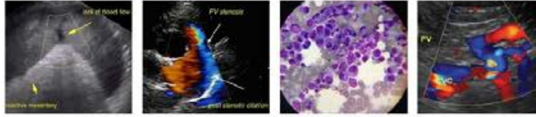
Adrenal Glands

The left adrenal gland is normal in size measuring 0.42 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 0.26 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 borderline large (1.24 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.



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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.

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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measures 0.20 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. Colon wall measures 0.11 cm.

Pancreas

The pancreas is prominent and mottled 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.

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.

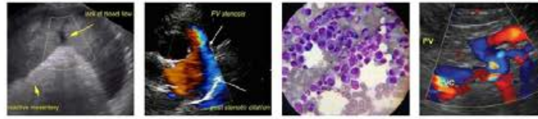
ULTRASONOGRAPHIC FINDINGS

- Borderline large spleen – The spleen appears normal in shape and echogenicity. I suspect this is normal for a 16 lb cat.

- Prominent, mottled left limb of the pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan is relatively normal. No focal lesions are visualized associated with the colon or small bowel to explain the vomiting or inappropriate eliminations described. Unfortunately, ultrasound can be insensitive in picking up evidence of colonic disease, and there are many causes for vomiting that cannot be diagnosed by ultrasound alone.



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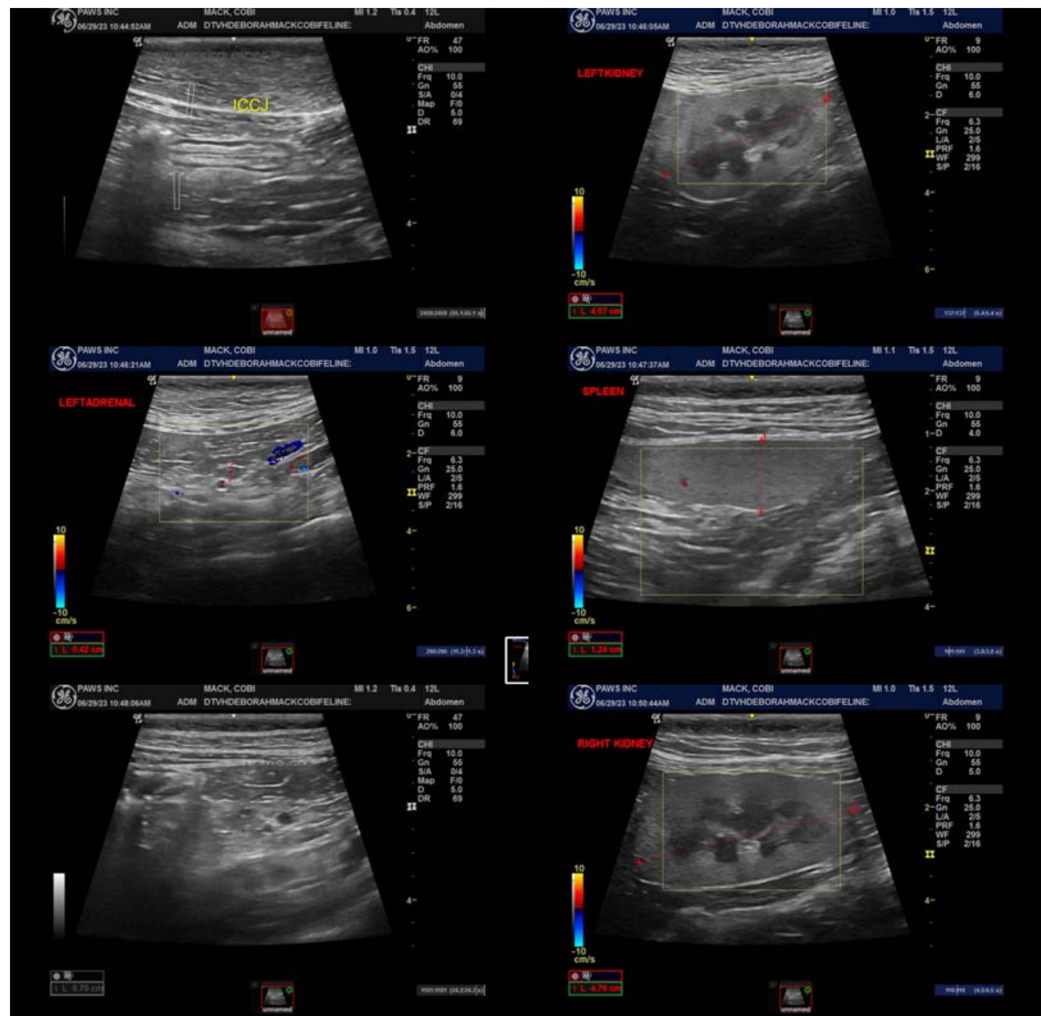
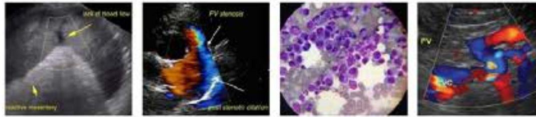
Consider such differentials as food allergy/dietary intolerance, GI parasitism, pancreatitis, dysbiosis, recurrent dietary indiscretion, IBD and less likely neoplasia, etc….

- 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.

The above recommendations are primarily for vomiting (gastric or small bowel disease). If large bowel disease is suspected based on the fecal accidents, the dietary changes and probiotics would be reasonable to consider. If the patient would tolerate it, you could consider a digital rectal exam, palpating for any irregularities, additionally looking for lumbar pain, pain upon raising the tail, etc. These types of episodes could be behavioral due to urgency (colitis, neurologic, etc.). If colitis is suspected, a colonoscopy could be considered.





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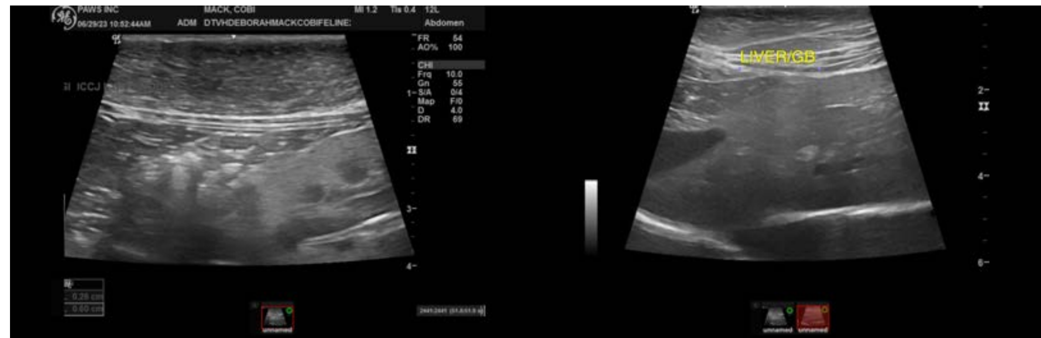

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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