

**DATE PRESENTING CLINICAL SIGNS**

6/9/22 Chronic diarrhea ongoing for 3 weeks. No improvement on diigel, metronidazole and propectalin.

PATIENT

Boris Ziegler

Current Medications: Prednisolone 6/7 5mg SID, Panacur 6/7, Tylosin 6/7. Failed to improve on Metronidazole and diigel doses started 5/23 at another hospital.

Lab Results: Pending.

Radiographs: Possible cd colon stricture.

Date of Previous IntraPet Ultrasound: No previous.

SPECIES

Feline

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

BREED

DSH

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.

SEX

Neutered Male

The left kidney has a normal shape and size (4.59 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.

AGE

6/5/14

WEIGHT

15 Pounds

The right kidney has a normal shape and size (4.89 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.

INTERPRETED BY

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

Adrenal Glands

The left adrenal gland is normal in size measuring 0.35 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.

IMAGING PERFORMED BY

Andi Parkinson RDMS

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.

HOSPITAL NAME

Eastern AH

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.

REFERRING VET

Dr. Sole

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.

INVOICE

38571

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 0.27 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 0.18 cm.

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

- Prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Prominent, hypoechoic pancreas with prominent pancreatic duct – 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

The lesions observed on today's scan were relatively mild and non-specific. Given the chronic history of diarrhea, it is possible that the prominent muscularis layer in the small intestine represents an inflammatory condition.

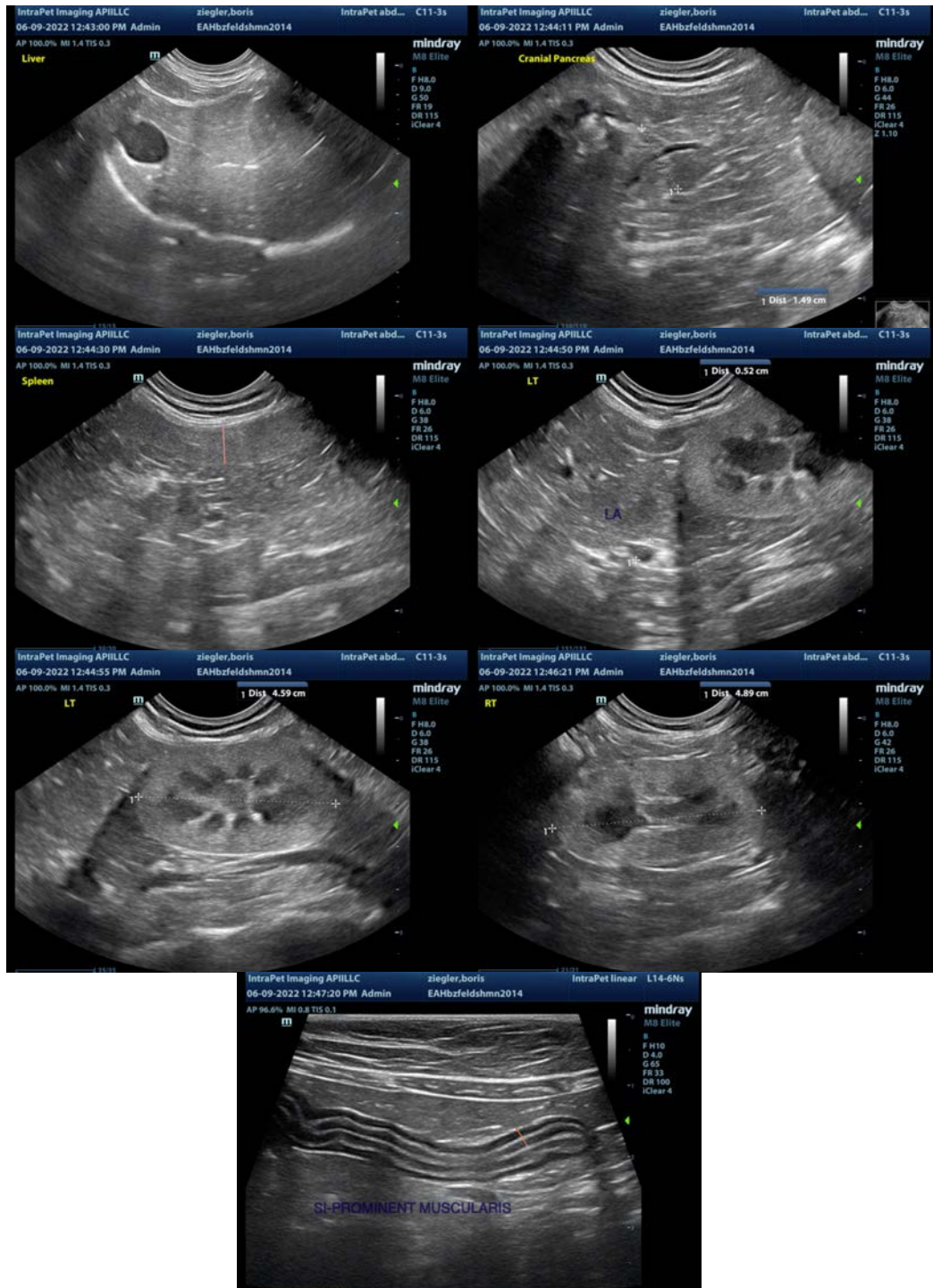
- Consider metabolic causes for diarrhea such as hyperthyroidism, liver disease, Addison's disease, etc.

If metabolic causes seem unlikely based on test results, then consider primary gastrointestinal causes. These would include dietary intolerance/food allergy, GI parasitism, dysbiosis, IBD, and less likely intestinal neoplasia.

- Consider a novel protein/hydrolyzed protein prescription diet as well as chronic probiotic therapy.
- Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further

evaluate the pancreas and small intestine.

- If symptomatic therapy and a diet change is not successful, then consider obtaining GI biopsies to obtain more information regarding the GI tract.



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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