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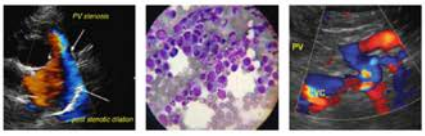

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Milo Hutcherson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years

WEIGHT

14.5 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

Family Pet Practice

INVOICE

39570

DATE

7/15/22

PRESENTING CLINICAL SIGNS

Maropitant 0.65mL SQ Given 7/14/22 Patient History From 7/14/22: Here for vomiting. V started 3 days ago- had a hair ball first then over the past 2 days p has had digested and non digested food. P has been drinking and urinating more. When p goes outside it is supervised on harness on a deck. O thinks p;s abdomen is sore. P won't lay on it all the way.
Abnormal PE/Chem/CBC/UA Results: PE 7/14/22: 1. BAR 5. Scant tartar- no visible oral FB or masses 8. Oily coat, Focal matting of fur on perineum, limited self grooming per O. 9/10. Tense mid mid to cranial abdomen, difficult to palpate deeply. Bladder small to medium sized, not reactive on palpation. O has noticed PU/PD, not straining to urinate. CBC- low monos, otherwise normal Chemistry- Glucose 132 (stress), Cl 105 L (vomiting), Tg elevated (non-fasted sample) T4 3.2- WNL but is above 2.5. may be borderline hyperthyroid, recommend monitoring closely, P did gain weight since last visit- recommend rechecking T4 in 1 month. UA- 1-3 WBC/field, negative for bacteria, neg for crystals felv/fiv- Negative

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 (4.22 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 (4.43 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 0.38 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 0.45 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 proximal bile duct is visualized at 0.42 cm, then tapers to a normal size.

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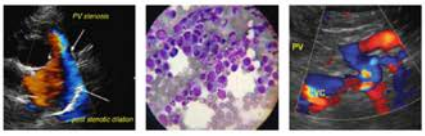

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Gastrointestinal

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. Some areas of the gastric wall appear slightly prominent. Some of these areas measure at 0.55 cm with intact wall layering.

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. Duodenum wall measured 0.29 cm. Jejunum wall measured 0.31 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 mildly 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.

Free Abdomen

There is scant free abdominal fluid. There is a mild lymphadenopathy in the region around the ileocecal junction, where there are clusters of lymph nodes with hyperechoic mesentery.

PRIMARY FINDINGS

- Areas of prominent/subjectively thickened gastric wall – These areas are subjectively thickened and have intact layering. Findings are most consistent with possible gastritis.
- Prominent muscularis layer in 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.
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

SECONDARY FINDINGS

- Mildly prominent, hypoechoic pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mildly prominent proximal bile duct – This tapers down and appears normal distally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The prominent muscularis layer in the small intestine and the clusters of prominent mesenteric lymph nodes, particularly at the ileocecal junction, are most consistent with inflammatory/infiltrative disease. These types of changes can be seen with food allergy/dietary intolerance, dysbiosis, IBD, less likely neoplasia, etc. Additionally, there is some subjective thickening of the gastric wall. If vomiting persists, consider reevaluation of this area.

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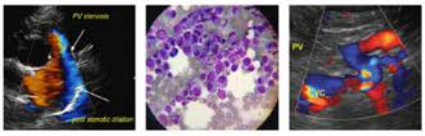

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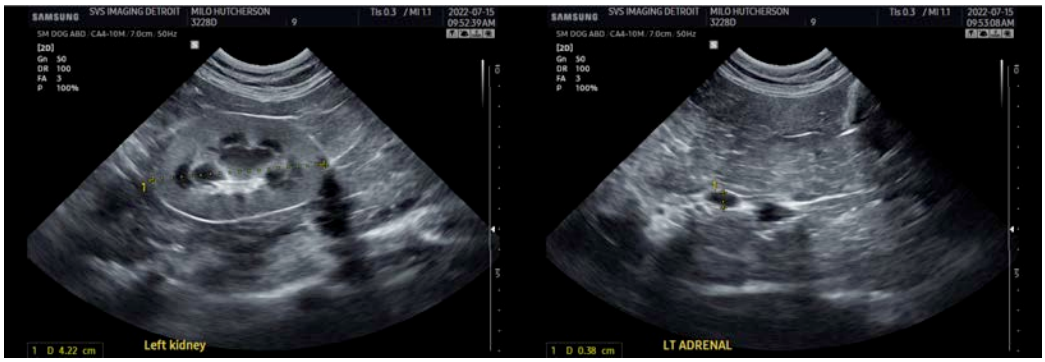
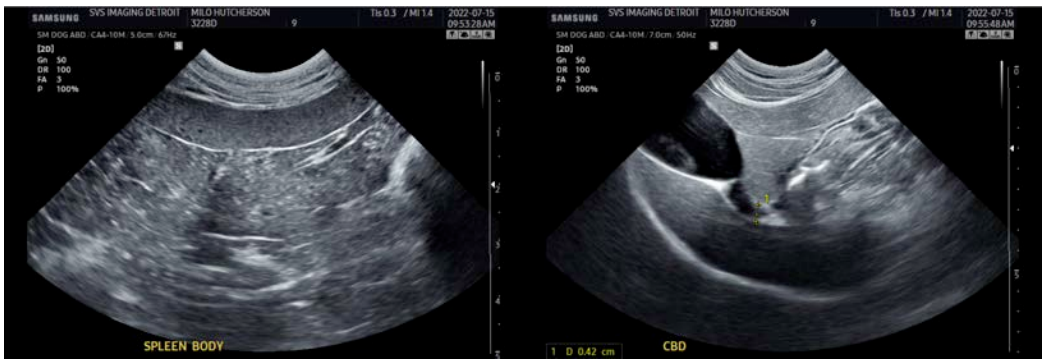
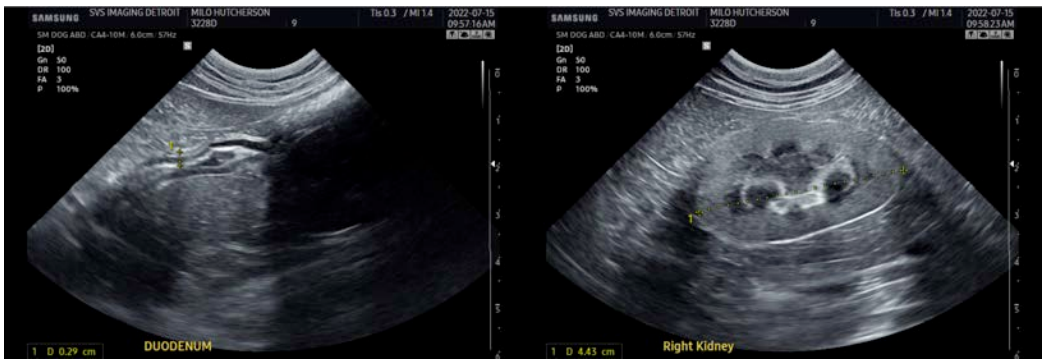
- Recommend a GI panel with quantitative fPLI, TLI, cobalamin and folate to Texas A&M for further evaluation of the pancreas and small intestine.
- Recommend chronic probiotic therapy.
- Recommend a hydrolyzed protein/novel protein diet.
- If GI signs are persist, consider reimaging and obtaining GI biopsies (+/- mesenteric lymph nodes).

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







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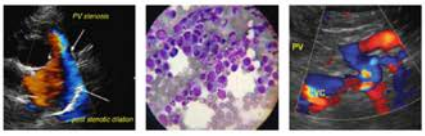

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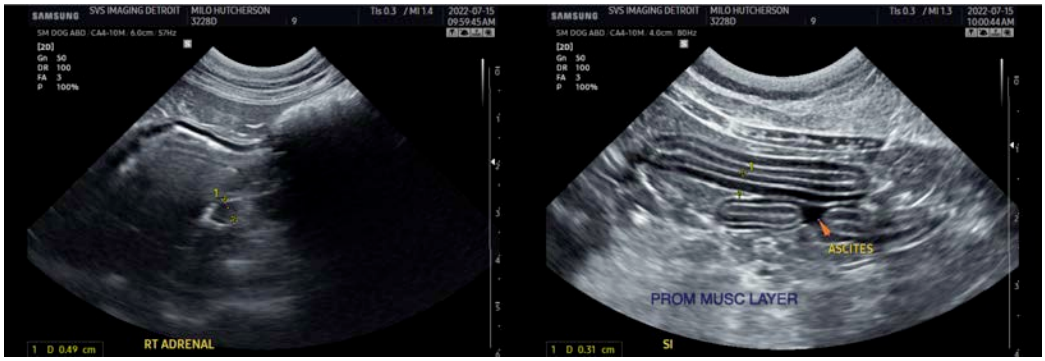

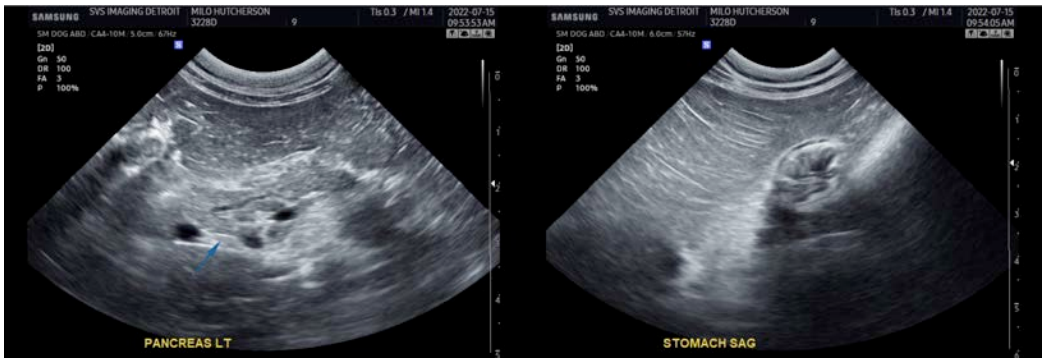

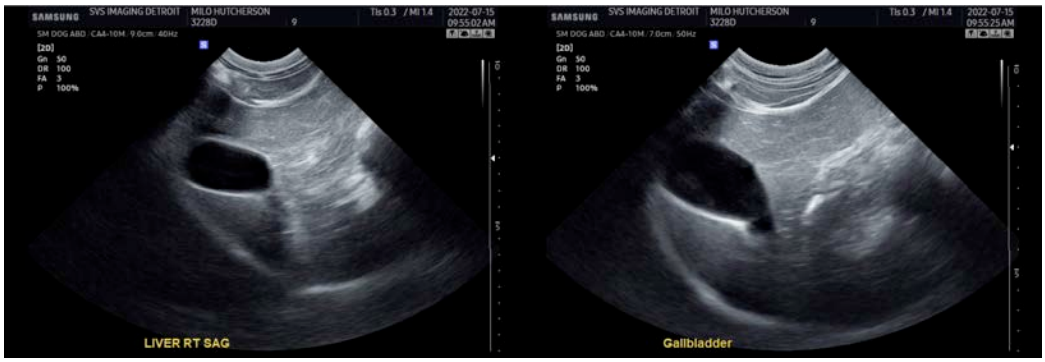

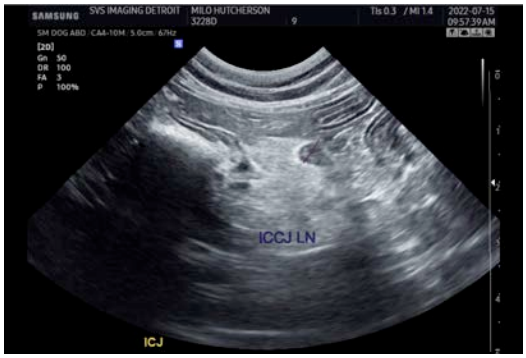

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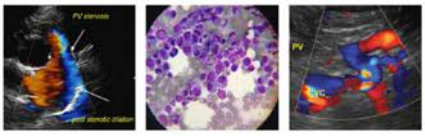

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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