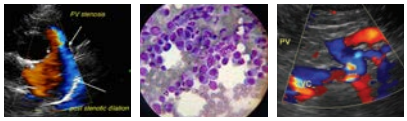
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

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DATE

7/20/23

PATIENT

Monty Siekman

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2/12/14

WEIGHT

8 Pounds

INTERPRETED BY

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

HOSPITAL NAME

AH at Southgate

REFERRING VET

Dr. Alexander

INVOICE

44216

PRESENTING CLINICAL SIGNS

Increased renal values, weight loss, constipation.

Current Medications: Cerenia inj given 7/11/23 when presented for constipation/manual evacuation.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Stephanie Warga RDCS, RVT.

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 (3.36 cm). Overall echogenicity is hyperechoic with poor 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 (3.52 cm) with a 0.47 cm cortical cyst near the cranial pole. Overall echogenicity is hyperechoic with poor 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 0.52 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 0.35 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 (0.58 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.

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 minimally distended. The wall of the gall bladder is mildly prominent/thickened at 0.23 cm. Luminal contents are mild and primarily anechoic. The bile duct appears slightly prominent with some intraluminal debris, measuring 0.38 cm proximally and 0.32 cm at the level of the duodenal papilla.

Gastrointestinal

The stomach contains a large amount of fluid. 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 diffuse moderate to severe 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 measures 0.31 cm. Visualized peristalsis appears appropriate. The small bowel is diffusely severely fluid distended with subjectively mildly thickened small bowel with intact wall layering, and some areas with more prominently thickened hypoechoic walls, which have intact wall layering. These areas of bowel measure at approximately 0.37 cm in thickness.

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 at 0.22 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 diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic kidneys with decreased corticomedullary distinction – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Prominent, hypoechoic pancreas with prominent pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Minimally distended gallbladder with slightly thickened wall and prominent mildly dilated bile duct with intraluminal debris – Findings could be consistent with cholecystitis.
- Severely fluid distended stomach with diffusely fluid dilated small intestine with subjective wall thickening and some focal areas of abnormal appearing bowel – Changes are most consistent with diffuse ileus with concerns for more focal bowel thickening, which could be consistent with inflammatory or neoplastic change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

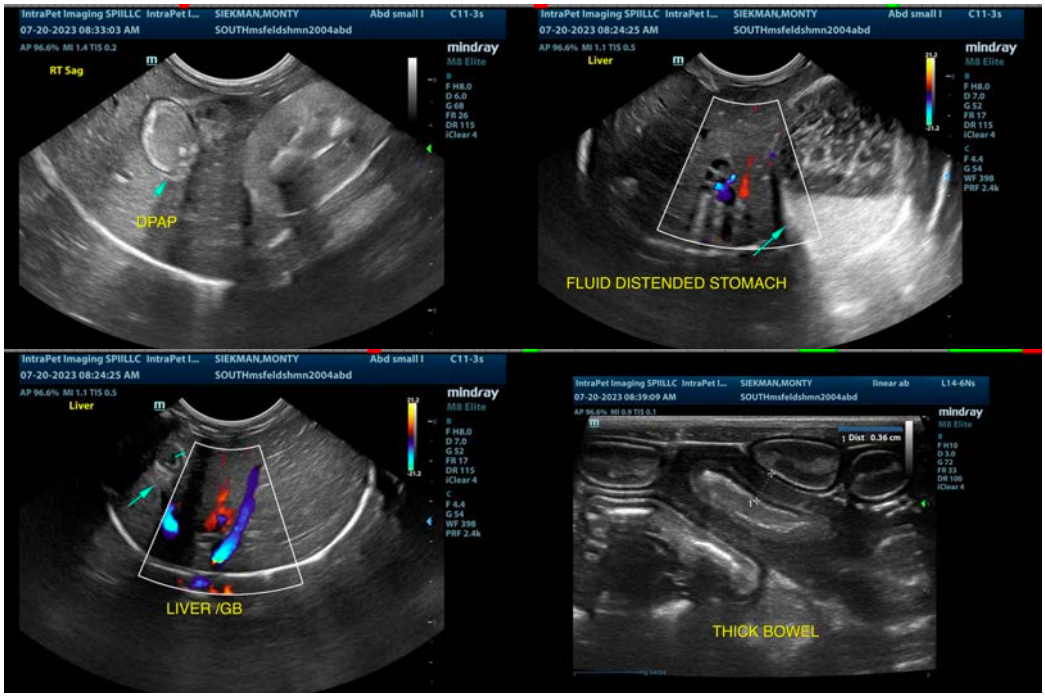
The stomach and the small bowel are severely fluid distended with no obvious obstructive process visualized. Much of the small bowel appears slightly thickened with intact wall layering, but there are some focal areas that appear to have more hypoechoic wall and more severe thickening, possibly suggestive of more focal lesions. Correlate these findings with feeding history. This degree of fluid distention impairs visualization of

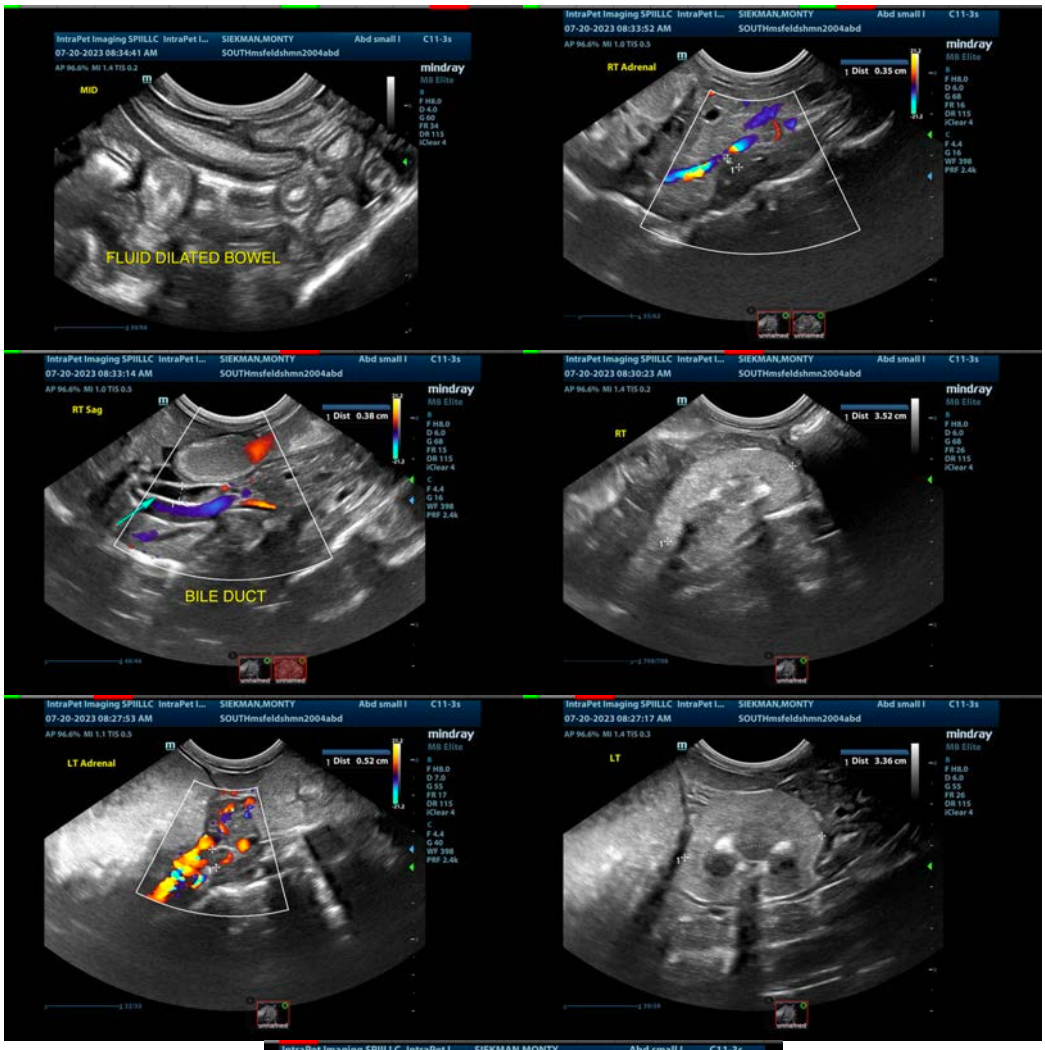
other abdominal structure. Diffuse ileus could result from severe diffuse gastrointestinal disease, multiple partial obstructions, etc. Consider a low-dose promotility medication and continued monitoring of the GI tract while pursuing additional diagnostics. Unless this resolved on its own, I suspect surgical biopsies of the GI tract may be necessary to further evaluate.

- 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.
- Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

The gallbladder appears minimally distended with a subjectively thickened wall, and the bile duct appears slightly distended with some intraluminal debris. Correlate these findings with bloodwork. If there are liver enzyme elevations present, you could consider treatment for cholecystitis with Ursodiol +/- antibiotics, etc. Additionally, the pancreas is prominent. It I difficult to discern if the surrounding reactive mesentery is secondary to the diffuse gastrointestinal disease present or if the pancreas itself is inflamed. Correlate these findings with a quantitative fPLI level and consider empirical treatment for pancreatitis.

The changes observed in the kidneys are consistent with chronic progressive renal disease. Recommend blood pressure, urinalysis and culture as a baseline.

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RT Adrenal
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RT Sag
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BILE DUCT
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RT
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LT
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Pancreas LT
1 Dist 1.21 cm
2 Dist 0.22 cm

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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