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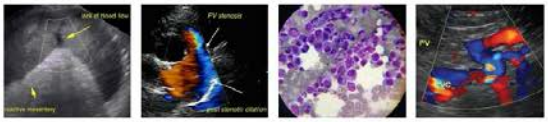

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Cheddar Szumel

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

8 Years

WEIGHT

13.6 Ponds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Alpine AH

REFERRING VET

Dr. Szumel

INVOICE

39824

DATE

7/26/22

PRESENTING CLINICAL SIGNS

sedation- dex/torb History: Has occasionally vomited after eating for the past year; recently is more frequent. Will not vomit if wet food or soaked kibble. Hx severe obesity (was 22# at adoption), has been on RCVD Satiety with gradual appropriate weight loss, now stable for the last few months. Dental work w/ several extractions in June 2022. Physical exam findings: BCS 5.5/9; Abd comfortable with no mass effect. Abnormal CBC values: None Abnormal Chemistry Values: Folate >24, all else normal Abnormal UA Values: Radiograph Findings(email radiographs if available): Included. Reason for Ultrasound: Evaluate for causes for vomiting.

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 (4.34 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 (4.52 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 0.51 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 0.51 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 cystic and common bile ducts are normal/not visible.

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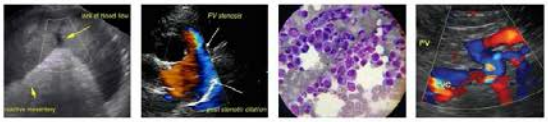

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Gastrointestinal

The stomach contains minimal luminal contents. The wall appears slightly heterogeneous, irregular and thickened in some areas measuring up to 0.67 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate, and the thickening primarily appears to compromise the most superficial mucosal layer. Additionally, a small hypoechoic/cystic appearing lesion is visualized (0.58 cm) involving the deeper portions of the gastric wall. The significance of this lesion is unclear.

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 measured 0.21 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 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 is a diffuse mild mesenteric lymphadenopathy with mesenteric lymph nodes measuring 0.46 and 0.78 cm. An occasional lymph node is cystic, and a lymph node at the ileocecal junction is visualized at 0.47 cm. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Thickened gastric wall – The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.
- Focal hypo/anechoic structure involving the gastric wall – This appears almost cystic in nature. The significance of this lesion is unclear. Recommend continued monitoring.
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastric wall (particularly the mucosal layer) appears somewhat thickened and irregular. This can be difficult to interpret, as the thickening could be artifactual due to rugal folding, or can be seen secondary to gastritis, hyperplasia, less likely neoplastic change, etc. Additionally, there is a hypoechoic/cystic appearing structure involving the gastric wall. The significance of this lesion is unclear, but continued monitoring is warranted. If this lesion appears to be changing, surgical evaluation could be considered.

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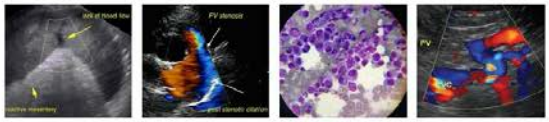

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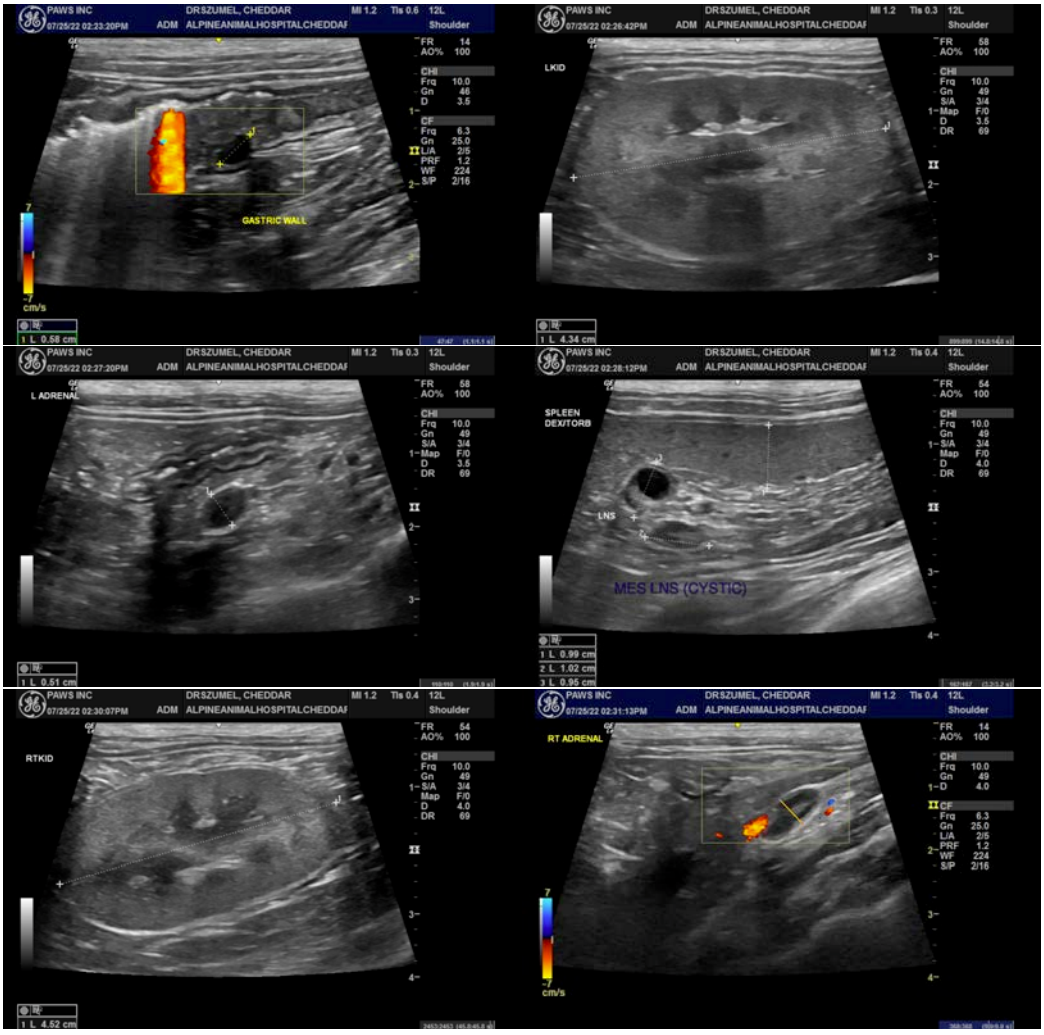
Consider symptomatic treatment for gastritis including a hypoallergenic/novel protein diet +/- treatment for helicobacter and reevaluation of the gastric wall. If chronic vomiting continues, or the wall changes progress, recommend biopsies of the gastrointestinal tract.

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

There is a mild diffuse mesenteric lymphadenopathy present. These lymph nodes are borderline in size for fine needle aspirates, but this could be attempted on one of the larger, more superficial lymph nodes visualized.



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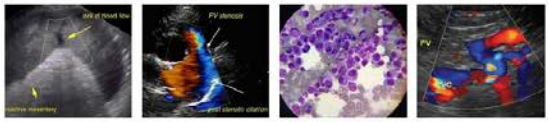

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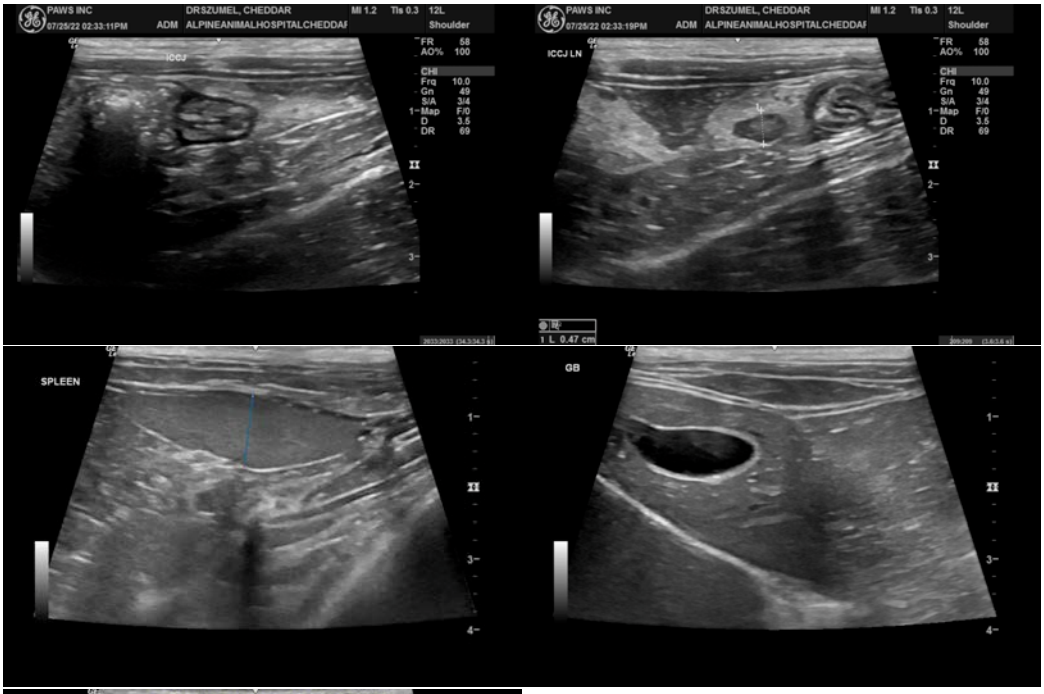

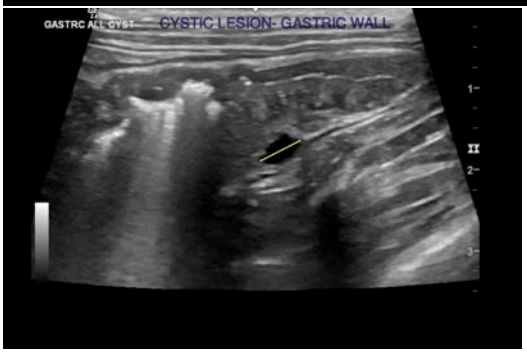

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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