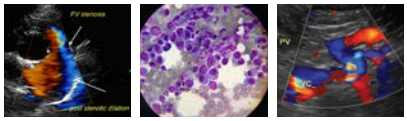
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

7/27/22

PATIENT

Rory Petitt

SPECIES

Feline

BREED

DMH

SEX

Spayed Female

AGE

3/28/08

WEIGHT

6.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Paradise AH

REFERRING VET

Dr. Riehl

INVOICE

39857

PRESENTING CLINICAL SIGNS

Hematuria noted 7/20/2022. Previous history cystotomy 2016--struvite. Maintained on SO/no recurrences of lower urinary tract signs since. Gradual weight loss over past year with increased intermittent vomiting. On PE, irregular/thickening intestines palpated mid-abdomen. Unable to perform rad today

Current Medications: Convenia: 8 mg/kg, Buprenex: 0.15 mL q 8 hr, Gabapentin: 30 mg q 12 hr, Will have 100 mg gabapentin on board, will give 0.3 mL buprenex TM.
Lab Results: UA; hematuria, 8 wBC/hpf. USG=1.050. No crystals
BW pending at time of submission, Submitting culture + growth.
Radiographs: No obvious stones on limited ultrasound of bladder.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 (3.29 cm) with mild pyelectasia at 0.14 cm. There is a small non-obstructive mineralization/nephrolith noted measuring 0.36 cm. Overall echogenicity is normal with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.45 cm) with mild pyelectasia at 0.11 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.36 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 (0.86 cm in width at the level of the hilus), 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.

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 0.19, 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.

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 are visible lymph nodes in the region of the ileocecal junction measuring 0.18 cm and 0.22 cm. The omentum is slightly hyperechoic around these lymph nodes.

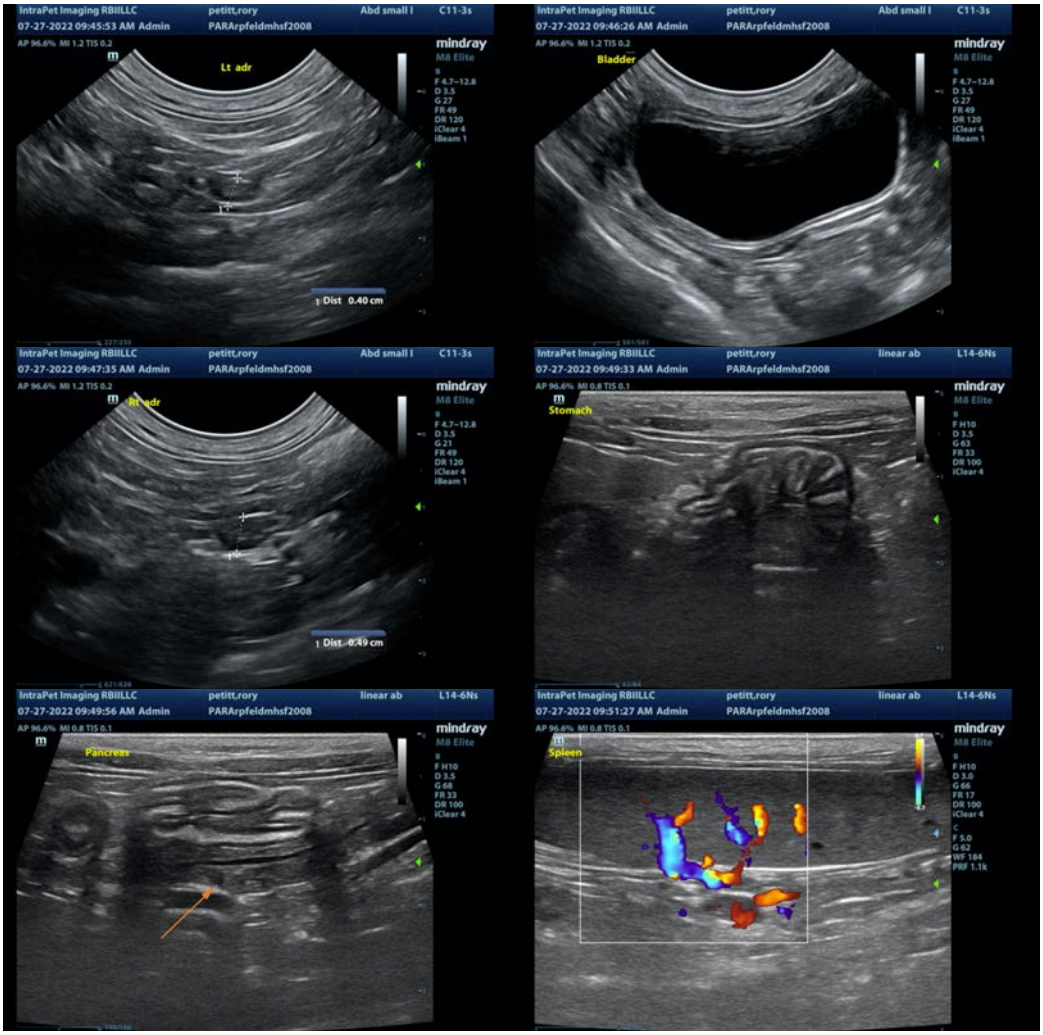
ULTRASONOGRAPHIC FINDINGS

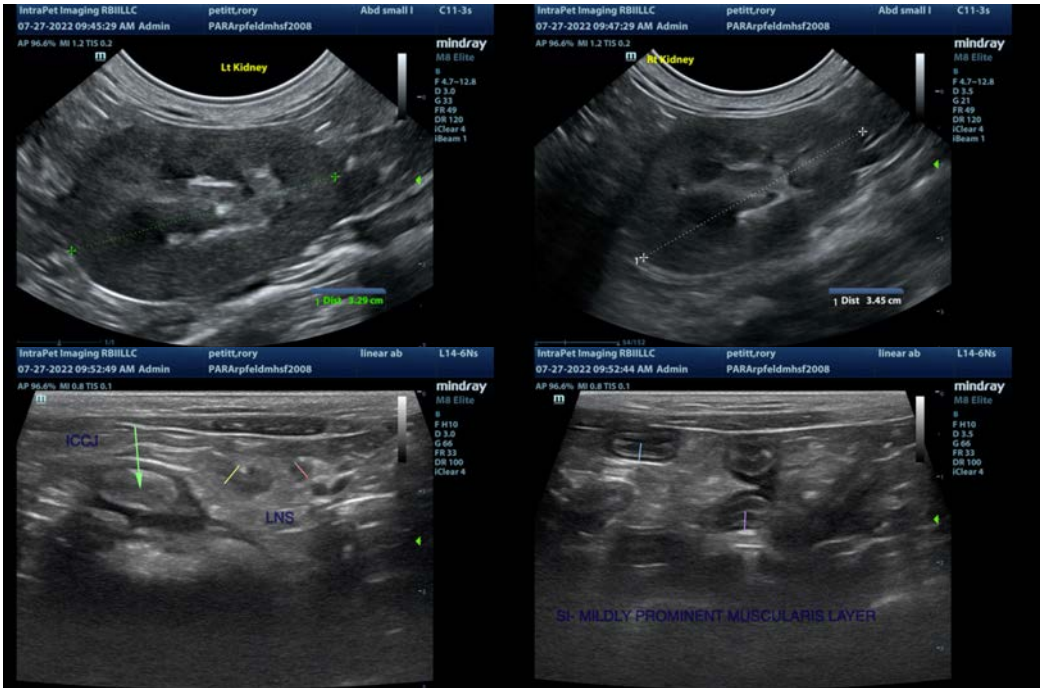
- Decreased corticomedullary distinction in both kidneys with very mild pyelectasia – The bilateral renal findings are consistent with age-related change.
- Mildly prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Visible lymph nodes in the region of the ileocecal junction – 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 lesions observed on today's scan are very mild and could be within normal limits for this individual. There is no obvious source for the hematuria noted. Recommend urinalysis and culture (I believe this was already done) and blood pressure evaluation due to the changes observed in the kidneys. In some views of the small intestine, the muscularis layer appears slightly prominent. This can be a normal finding in some older cats, but can also be an indicator of inflammatory type changes. Based on the vomiting reported, underlying gastrointestinal disease could be a possibility. Consider such differentials as dietary intolerance/food allergy, chronic pancreatitis, dysbiosis, IBD, and less likely intestinal neoplasia.

- Recommend a novel protein/hydrolyzed protein prescription diet.
- Recommend a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Consider chronic probiotic therapy.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- If GI signs persist despite supportive care and a diet change, then consider reimaging and obtaining GI biopsies.





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