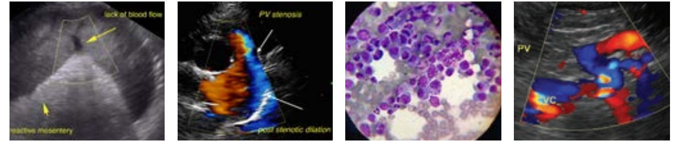

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1-800-838-4268 info@sonopath.com

PATIENT

Drake Them

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

9 Years

WEIGHT

18 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Mandy Foley

HOSPITAL NAME

All Creatures Great & Small Vet Clinic

REFERRING VET

Dr. Jessia Bailes

INVOICE

43847

DATE

7/6/23

PRESENTING CLINICAL SIGNS

Hx of chronic intermittent vomiting. Used to be about once/week; no vomiting about every 1-2 days.

Abnormal PE/Chem/CBC/UA Results: Overweight, otherwise NSF on PE BW/urinalysis results unremarkable: SC: Creat 1.9. SDMA 10. Phosph 4.0. All other UR. CBC: UR UA: USG 1.067. IS. T4: 1.3.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.86 cm). Overall echogenicity is normal with adequate 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 (3.81 cm). Overall echogenicity is normal with adequate 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

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 is visualized.

Spleen

The spleen is subjectively normal in size (0.75 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.

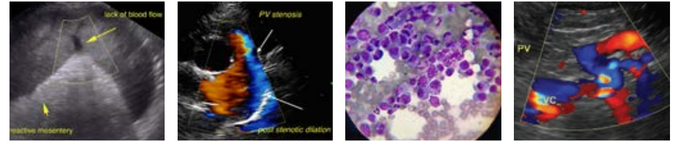
Liver

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 moderately distended. The wall of the gall bladder is slightly prominent and hyperechoic, measuring 0.14 cm. Luminal contents are mild and primarily anechoic. The bile duct appears slightly prominent and tortuous and 0.26 cm with no evidence of an obstructive process.

Gastrointestinal

The stomach contains mild/moderate 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.



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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to moderate 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. Duodenum wall measures 0.21 cm. Jejunum wall measures 0.18 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 right limb of the pancreas is mildly prominent and mottled 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

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

- Echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

- Mildly mottled right limb of the pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

- Prominent gallbladder wall with a prominent tortuous bile duct – These changes are mild and could be consistent with previous cholecystitis.

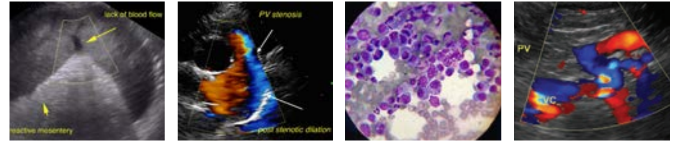
- Moderately fluid distended stomach – Findings could be consistent with a non-fasted patient, delayed gastric emptying, a partial outflow tract obstruction (none observed), etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized with the gastrointestinal tract to explain the vomiting reported. The stomach does appear to have some fluid within it, as does some of the small bowel, but there is no overt thickening or mass effects visualized. Unfortunately, I cannot definitively rule out the possibility of ingested foreign material, a thickening/mass effect not visualized, etc., but this seems less likely.

The right limb of the pancreas is slightly prominent with no obvious inflammatory changes. This is most consistent with previous episodes of pancreatic inflammation. Correlate with a quantitative fPLI level.

The gallbladder wall is hyperechoic and slightly prominent, and the bile duct is slightly tortuous. I suspect this is an incidental finding at this time but continued monitoring for liver enzyme elevations/signs of cholecystitis are warranted.



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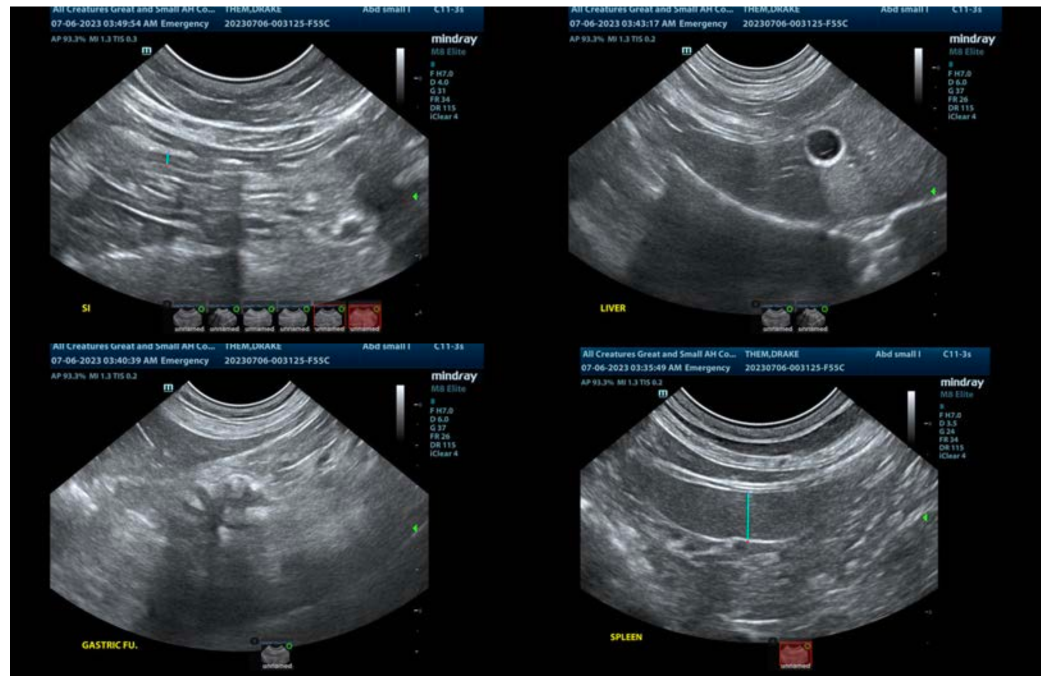
Unfortunately, there are many causes for vomiting that cannot be definitively diagnosed by ultrasound alone.

Consider such differentials as food allergy/dietary intolerance, GI parasitism, chronic pancreatitis, IBD and less likely neoplasia, etc.. .

- 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.
- If symptoms are persistent and primary gastrointestinal disease is thought extremely likely, then consider obtaining GI biopsies.

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



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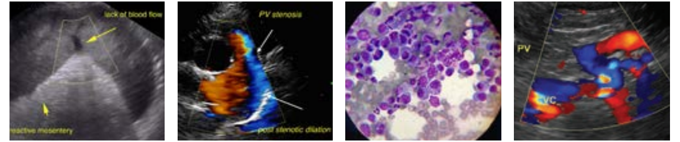

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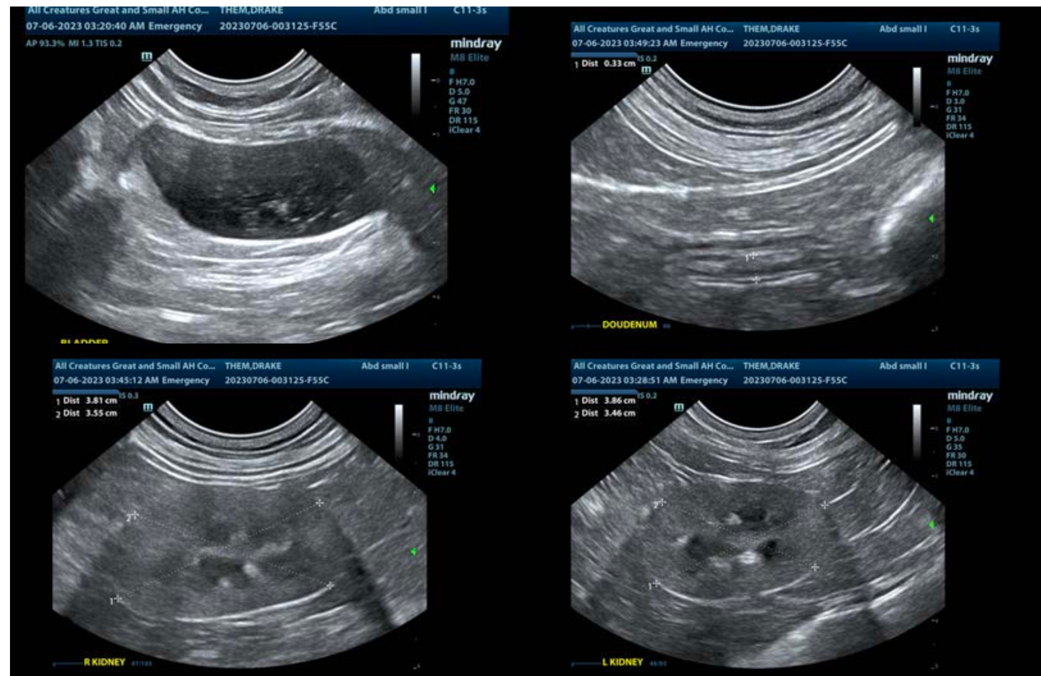

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com