

**IMAGING PERFORMED BY**

SVS Mobile Imaging MI 734-637-7711  
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EDUCATIONAL TELECONSULTATION SERVICES™  
1-800-838-4268 info@sonopath.com SonoPath.com

**PATIENT**

Stitch Campfield

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

9 Years

**WEIGHT**

8.1 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**

Kimball Animal  
Hospital

**INVOICE**

40514

**DATE**

8/16/22

**PRESENTING CLINICAL SIGNS**

Weight loss, and inappetence. Stitch has only ate about 1/2 tsp of food and then she vomits. O also mentioned she seemed to be grinding her jaws and stretching her neck when she tried to swallow. O Also says her meow sound different almost harsh. Last bm was a few days ago but she haven't really kept anything down.

Abnormal PE/Chem/CBC/UA Results: lat/vd abd- marked gas in stomach and small intestines- slight bunching in cranial abdomen but no obvious obstructive pattern, mild rounding of bilateral kidneys

**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 (4.07 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 (3.98 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 0.32 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 XX 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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a mild amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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***Gastrointestinal***

The stomach appears to have a small amount of intraluminal fluid and a large amount of intraluminal gas, creating a large shadow, which impairs full visualization of the stomach. The areas of visible gastric wall appear to have normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers in these regions is adequate and there is no impression of reduced peristaltic activity.

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 0.26 cm. Duodenum wall measured 0.21 cm. Visualized peristalsis appears appropriate. Some of the areas of small intestine appear to have mild corrugation, and a section of the duodenum appears moderately fluid dilated with a lack of progressive motility.

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, 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**

- Mild/moderate gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.
- Large amount of gas visualized within the gastric lumen – This gas impairs full visualization of the stomach. No lesions are observed.
- Prominent muscularis to the small intestine with mild corrugation of the small bowel and mild fluid dilation of the duodenum – These changes are most consistent with gastroenteritis/ileus and small intestinal disease, but proximal gastrointestinal foreign material cannot be excluded as a possibility.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

No prominent focal lesions are visualized on today's exam. Based on the history provided, evaluation of the stomach is desired, but a large amount of intraluminal gas makes this somewhat difficult. No focal small intestinal lesions are observed, although there is some mild corrugation and fluid dilation of the duodenum. If these symptoms are prominent, then I would be most concerned about a chronic gastrointestinal disease. Also consider evaluation for esophageal disease, including thoracic radiographs and possibly a barium swallow. You could consider a GI panel to Texas A&M for a qualitative fPLI, tLI, cobalamin and folate to look for evidence of small intestinal disease, and consider:

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- Novel protein/hydrolyzed protein prescription diet.
- Symptomatic treatment for gastroenteritis.
- Consider obtaining GI biopsies.

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If these symptoms are acute in nature, then I cannot rule out the possibility of a small gastric foreign body, linear foreign body, etc., but no clear evidence of foreign material is visualized. Recommend evaluation for a string under the tongue and evaluation of the caudal nasopharynx/throat region.

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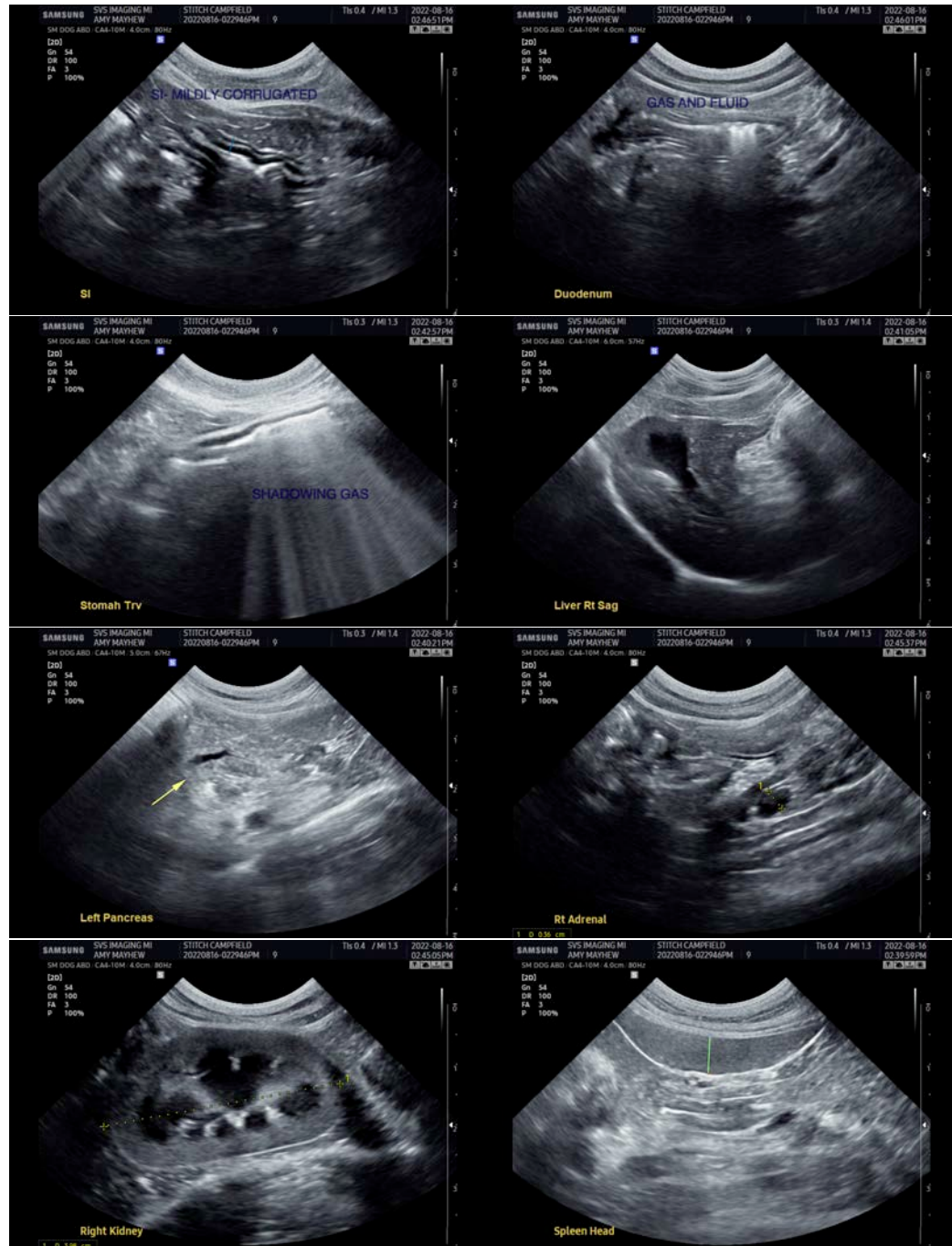
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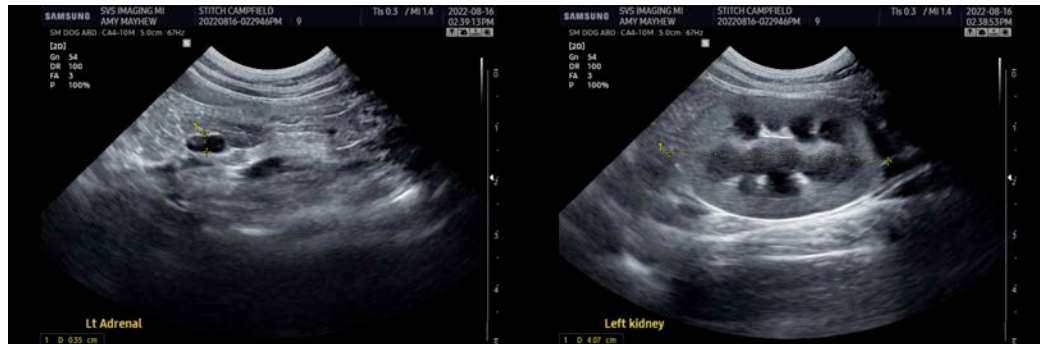
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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