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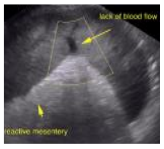
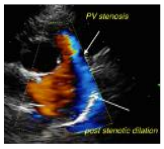
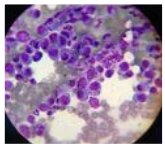
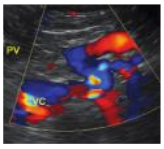

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PATIENT

Rascal Alt

SPECIES

Feline

BREED

DHL

SEX

Neutered Male

AGE

12 Years

WEIGHT

10.1 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Susanne Bush

HOSPITAL NAME

Great Miami VC

REFERRING VET

Susanne Bush

INVOICE

12562

DATE

8/17/21

PRESENTING CLINICAL SIGNS

History: Starting in 2019 Rascal has had intermittent anorexia and hiding behavior. In May 2019 he was not responsive to supportive care, had normal blood work and had concern for intestinal thickening on ultrasound (performed at alt vet). An exploratory was performed and was negative with intestinal biopsies being normal. Since this time he has intermittently had anorexia and increased specCPL. He has previously responded well to cerenia, mirtazipine and prednisolone. He has worsened since March of this year and is currently not eating while on supportive care. He is not on prednisolone currently.

Abnormal PE/Chem/CBC/UA Results: Blood work on 8/13/21 Chem: SDMA 15, Alt 25, TP 6.1, Globulin 2.9, SpecFPL 6.0 CBC: WBC 2.9 (3.9-19), Neutrophils 1.5 (2.6-15.1), Lymph 0.56 (0.85-5.85)

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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.8 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 (3.9 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 region of left adrenal (Cranial to left renal artery) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

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.

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. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

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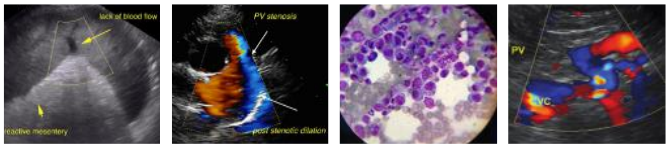

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The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic 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. The jejunum measured 0.2, 0.34 cm in diameter. Visualized peristalsis appears appropriate. The ileum is particularly thick, measuring 0.53 cm at maximal diameter. There is no significant loss of layering visualized.

The ileocecal junction is visualized and exhibits normal intact wall layering. The ileum appears somewhat thickened and just distal at the ileocecal junction is dilated bowel, most consistent with either a dilated/fluid filled cecum or dilated proximal colon. More distal sections of colon are visualized with formed fecal material and 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.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegally. 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

Primary Findings

- Thickened small intestine with a prominent muscularis layer- The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease)
- Fluid dilated cecum or proximal colon- Significance is unclear, could be consistent with inflammation, correlate with abdominal radiographs

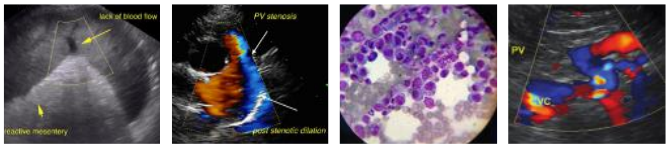
Secondary Findings

- Prominent hypoechoic pancreas- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bowel changes observed are consistent with the symptoms describes. It is unusual to get normal small intestinal biopsies in an animal with GI signs. If not provided, review the previous histopathology in case it is helpful.

- Consider metabolic causes for symptoms describes, including thyroid function testing



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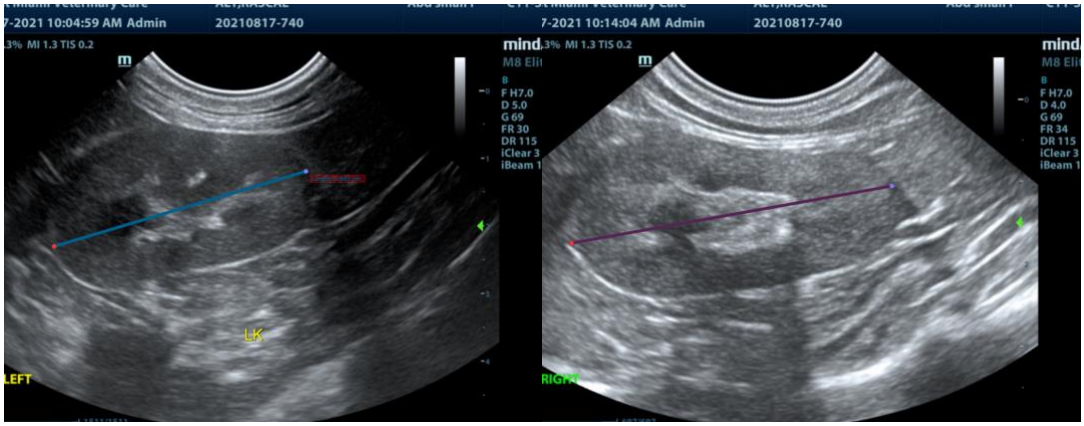
- If metabolic causes are thought unlikely then consider primary GI causes such as GI parasitism, dietary indiscretion, mild pancreatitis, bacterial dysbiosis, food allergy, IDB and less likely, intestinal neoplasia. In older patients with more chronic symptoms, I would most strongly consider food allergy, IBD, and intestinal neoplasia.

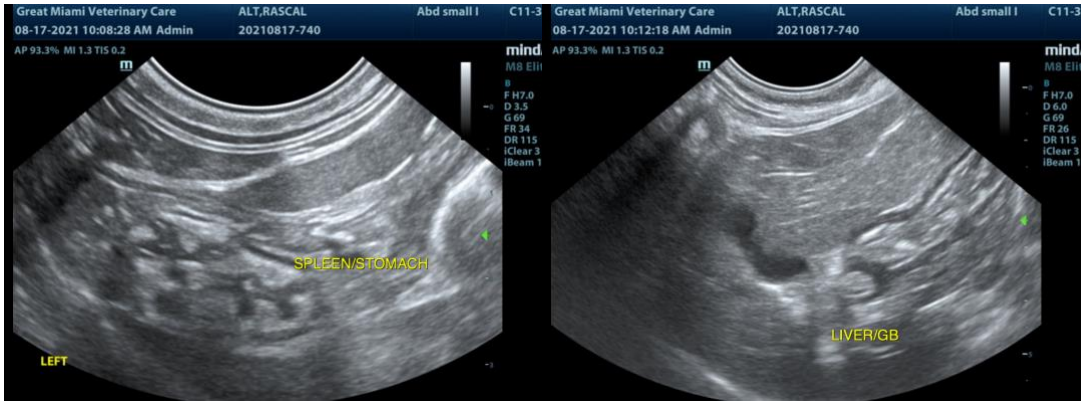
-recommend diet trial with a novel protein/hydrolyzed prescription diet

-Recommend GI panel for evaluation of B12 levels etc. (start empirical B12 while waiting for results)

-If symptoms are progressing consider obtaining GI biopsies

The changes at the ileocecal junction are of questionable significance. If there is large bowel diarrhea present, consider colitis/typhlitis, correlate with abdominal radiographs. Even if previous GI biopsies are normal, this could have progressed or there could be a food allergy present which can sometimes cause minimal changes on biopsy.





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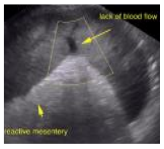
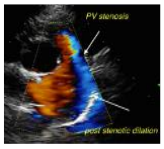
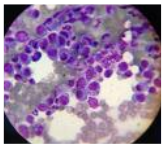
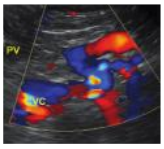

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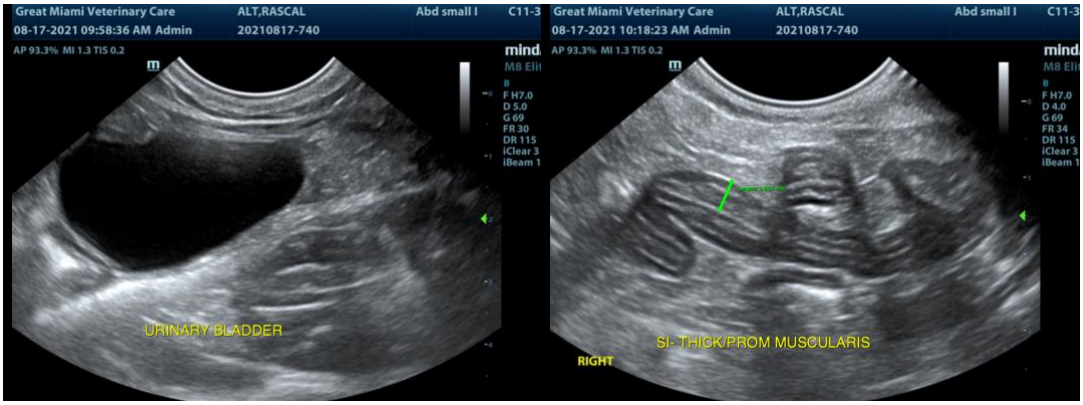

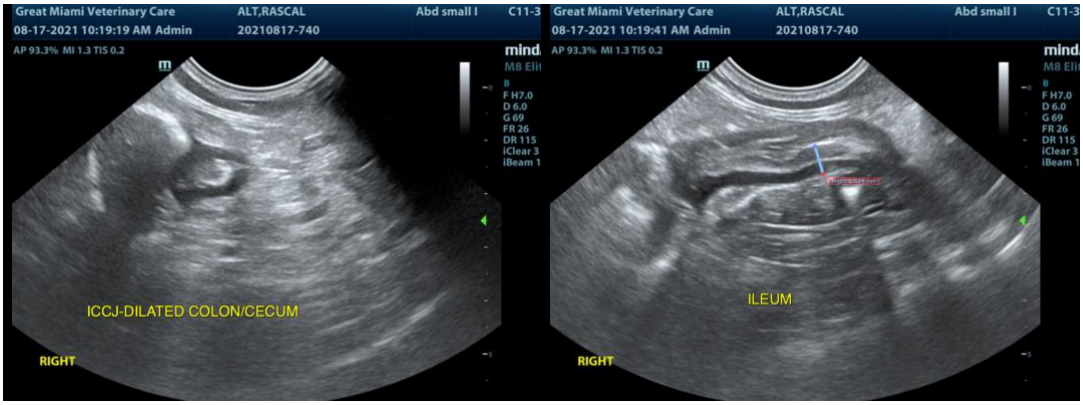

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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