

**DATE**

8/17/21

**PRESENTING CLINICAL SIGNS**

Several month history of vomiting, weight loss, and rare diarrhea. Vomits almost daily, slight improvement since switching to purina sensitive skin and stomach diet.

Lab Results: low TP, globulins.

**PATIENT**

Date of Previous IntraPet Ultrasound: No previous

Sedation: declined

Stat Report: not requested

Wedgie Coppage

**SPECIES**

Feline

**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.

**BREED**

Domestic Shorthair

The left kidney has a normal shape and size (4.05 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.

**SEX**

Neutered male

**AGE**

2011

The right kidney has a normal shape and size (4.03 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.

**WEIGHT**

9.7 lbs

**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.

**INTERPRETED BY**

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

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.

**HOSPITAL NAME**

Hickory VH

**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.

**REFERRING VET**

Dr. McCourt

**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.

**INVOICE**

91309

**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. The jejunum measured 0.37 cm. Visualized peristalsis appears appropriate. There is a focal segment of bowel approximately 1.8 cm in length, which is thickened with a wall thickness of 0.71 cm with complete loss of layering. This is most consistent with the focal bowel mass. The surrounding mesentery and lymph nodes are all enlarged/hyperechoic.

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 prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. The pancreatic duct measured 0.46 cm. 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 moderate lymphadenomegaly present (mesenteric lymph nodes are enlarged particularly in the area of the bowel mass). The lymph nodes measured 1.5 x 1.0 cm and 0.65 cm. There was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is generally normal in echogenicity, but increased in the area of the bowel mass.

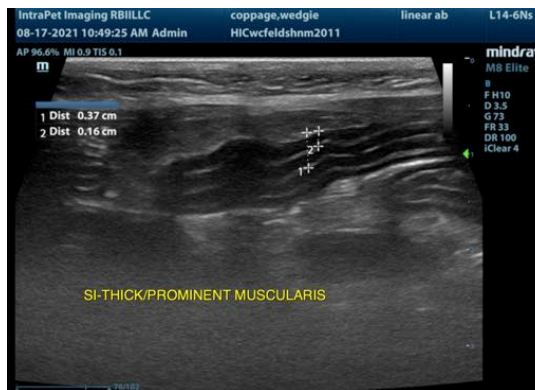
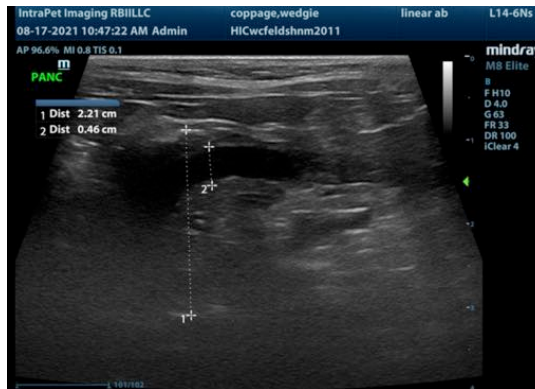
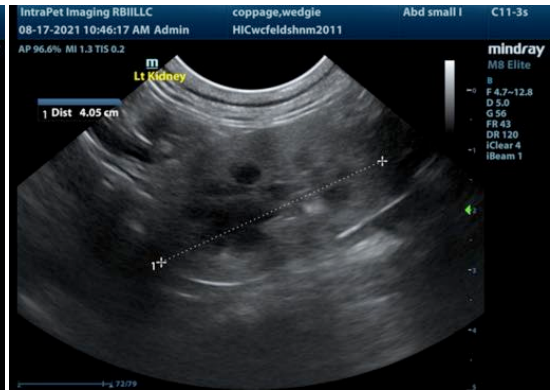
## **ULTRASONOGRAPHIC FINDINGS**

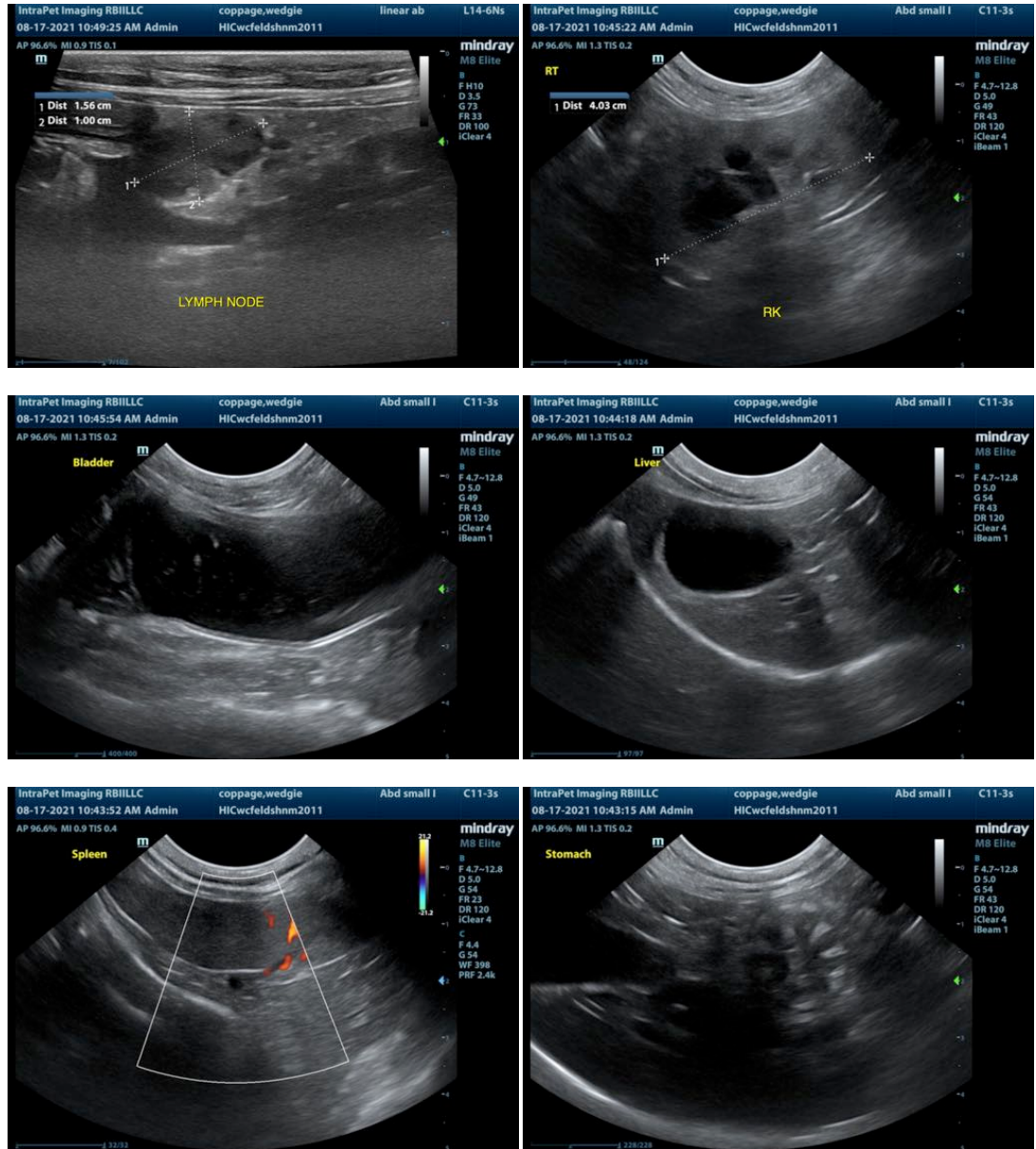
### **PRIMARY FINDINGS:**

- Focal loss of layering and bowel thickening. This is most consistent with a bowel mass. Differentials favor a neoplastic process; however, focal inflammation and edema are possible.
- Prominent, mottled pancreas with dilated pancreatic duct. The pancreatic changes are most consistent with (mild) pancreatitis/pancreatic infiltration. I recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider FNA if not improving.
- Mild, diffuse small intestinal wall thickening with prominent muscularis layer. The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Moderate 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 focal bowel mass and lymphadenomegaly are very concerning for possible neoplastic process (round cell neoplasia, carcinoma, other). I recommend FNA of the mesenteric lymph node and thickened section of bowel possible. Consider a GI panel to obtain a quantitative fPLI and B12 folate level to better assess the general health of the bowel and to look for concurrent pancreatitis. I recommend three view thoracic radiographs. If FNA are not diagnostic then consider surgery to obtain biopsies of lymph node, small intestine (mass and more normal looking bowel) +/- pancreas.





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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