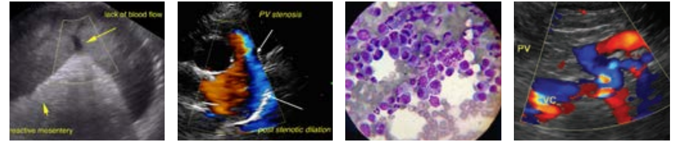


PATIENT

Colin Brookbank

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years

WEIGHT

13.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jessica Bailes

HOSPITAL NAME

All Creatures Great & Small

REFERRING VET

Dr. Jessica Bailes

INVOICE

44753

DATE

8/17/23

PRESENTING CLINICAL SIGNS

Hx of chronic progressive intermittent vomiting and picky appetite. First noted about 1.5 months ago. Abnormal PE/Chem/CBC/UA Results: Minor progressive weight loss, reactive on abdominal palpation, otherwise NSF on PE. Owner reports patient not reactive when she palpates abdomen @ home so could be behavioral. Abdominal rads: NSF; lateral thoracic radiograph: NSF BW/UA: CHEM: WNL - creat = 1.9; SDMA WNL CBC: thrombocytopenia (128K) w/ adequate estimate TT4: WNL @ 2.0 UA: USG = 1.061; 1+ proteinuria (UPC WNL @ 0.0)

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 (4.23 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 (4.59 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 left adrenal gland is normal in size measuring 0.37 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 0.54 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.

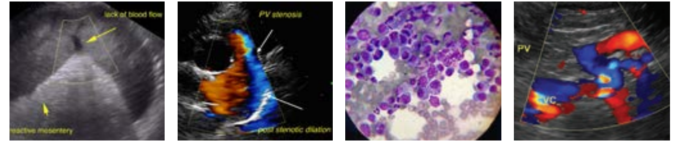
Spleen

The spleen is subjectively normal in size (0.85 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 not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach has moderate fluid distention. 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 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 0.27 cm. Jejunum wall measures 0.30 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 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 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

- Prominent, hypoechoic left and right limbs of the pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

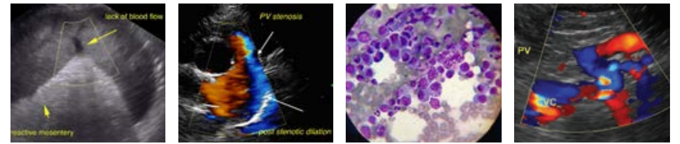
- Moderate fluid distention of the stomach and proximal duodenum – Correlate with feeding history and abdominal radiographs. If the patient was adequately fasted, consider such differentials as delayed gastric emptying, a pyloric outflow tract obstruction, etc. (none observed).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the gastrointestinal tract to explain the chronic vomiting reported. The stomach is moderately distended with fluid and ingesta, and the proximal duodenum has some fluid visualized within it. There is no obvious intraluminal material or wall lesions to explain this. Correlate with feeding history and abdominal radiographs, as this could represent ileus.

Additionally, the pancreas is somewhat prominent with minimal surrounding reactive mesentery. These changes are most consistent with previous episodes of pancreatic inflammation, although mild chronic inflammation cannot be ruled out. Correlate with a quantitative fPLI level. Consider serial imaging (radiographs +/- ultrasound), particularly if the stomach does not empty with fasting, as ingested foreign material cannot be definitively ruled out.

Unfortunately, there are many causes for chronic vomiting that cannot be definitively diagnosed by



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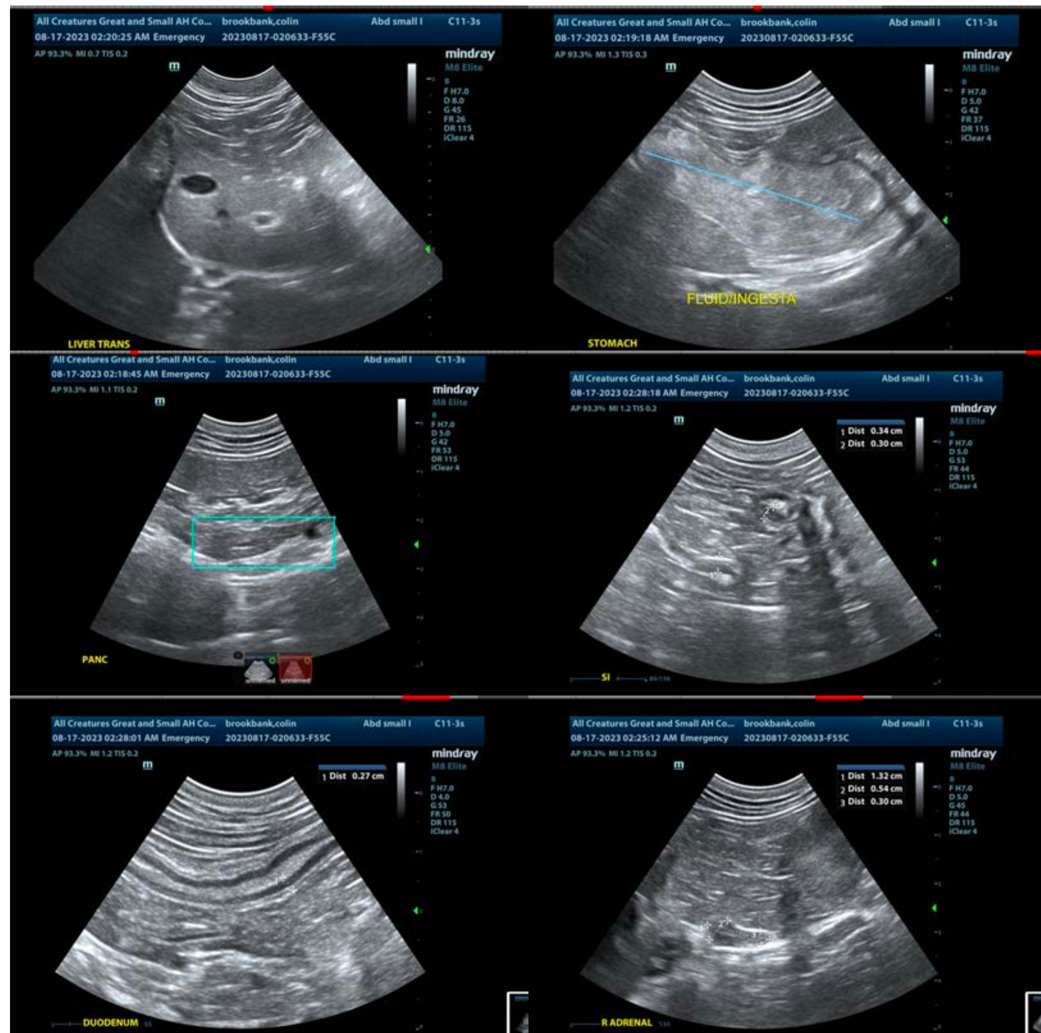
ultrasound alone.

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 despite taking these measures, consider obtaining GI biopsies.

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



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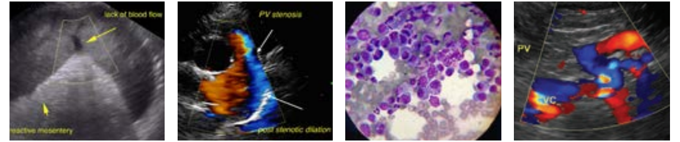

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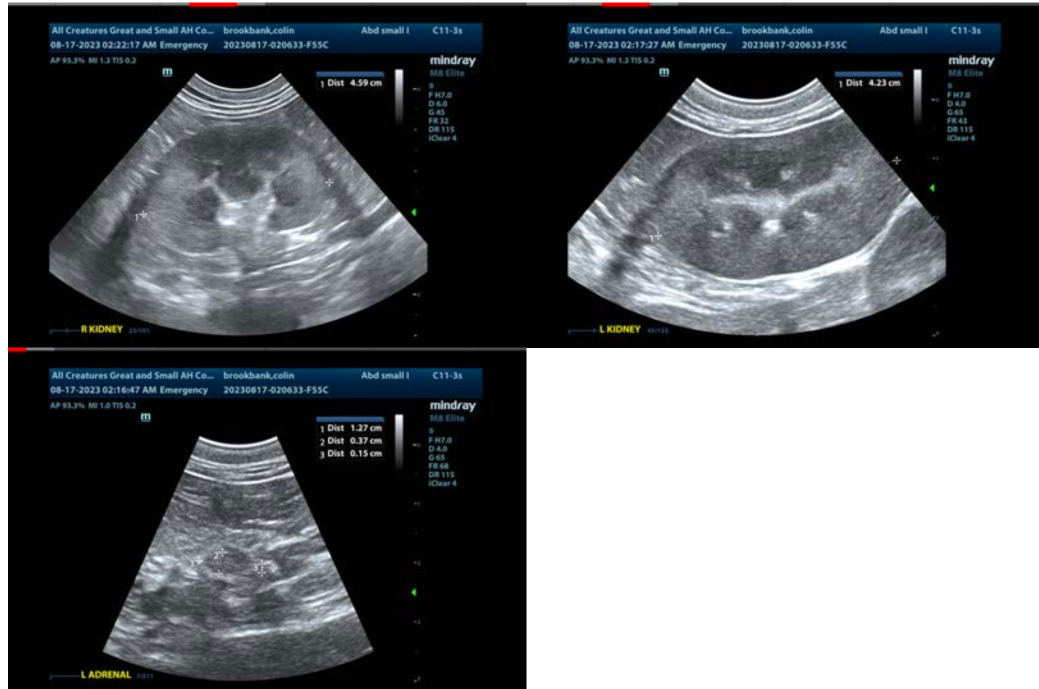

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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