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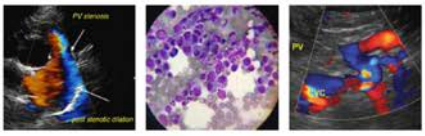

SonoPath
Clinical Sonography & Telecytology
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**PATIENT**

Maya Baker

**SPECIES**

Feline

**BREED**

DMH

**SEX**

Spayed Female

**AGE**

15 Years 10 Months

**WEIGHT**

7.9 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**

Wixom Family Pet Practice

**INVOICE**

40696

**DATE**

8/24/22

## PRESENTING CLINICAL SIGNS

Current Medications: Fortiflora in food SID Patient History: Chronic vomiting, mostly fluid, very rarely food; recently developed diarrhea as well and has some mild weight loss. Had an episode of increased vomiting last fall and she recovered with treatment. Blood work on 10.28.21 revealed mild pre renal azotemia with BUN 35.5 (15-32 mg/dL), Globulins 5.2 (2.8-4.8 g/dL), and mild stress hyperglycemia. USG 1.048. Owner unable to repeat blood/urine at this time. Treated on 8.10.22 with subcutaneous fluids, injectable maropitant, oral metronidazole and fortiflora and cat is not improving.

Abnormal PE/Chem/CBC/UA Results: Thick tartar over upper arcade, mild to moderate gingivitis; some alopecia and erythema at base of ears and some scabbing over dorsal neck (doesn't really bother her per owner, has been an ongoing issue); small intestines feel uniformly thickened, no masses/FB palpated, soft, non-painful

## 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 (3.58 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 (4.14 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 0.43 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 0.38 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 (0.74 cm in width at the level of the hilus), 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.

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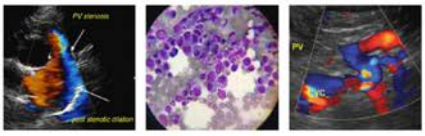

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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The common bile duct appears somewhat prominent, measuring 0.3 cm.

### *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. Duodenum wall measured 0.36 cm. Jejunum wall measured 0.31 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. Prominent pancreatic duct noted at 0.22 cm.

### *Free Abdomen*

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a diffuse mesenteric lymphadenopathy with mesenteric lymph nodes measuring 0.45, 0.44, and 0.54 cm. Additionally, there is a cluster of enlarged lymph nodes near the ileocecal junction measuring 0.49, 0.31, 0.39 cm, and surrounded by hyperechoic mesentery.

## ULTRASONOGRAPHIC FINDINGS

- Significantly thickened muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Mild/moderate mesenteric 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

No focal lesions involving the gastrointestinal tract are visualized. There is diffuse thickening and a very prominent muscularis layer to the small intestine. This is likely an indicator of underlying small intestinal disease. Consider such differentials as food allergy/dietary intolerance, GI parasitism, pancreatitis, dysbiosis, IBD, and less likely intestinal neoplasia.

- Recommend current bloodwork to evaluate current renal function, albumin levels, etc.
- Consider a hydrolyzed protein/novel protein diet.

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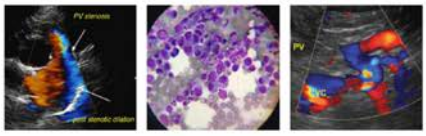

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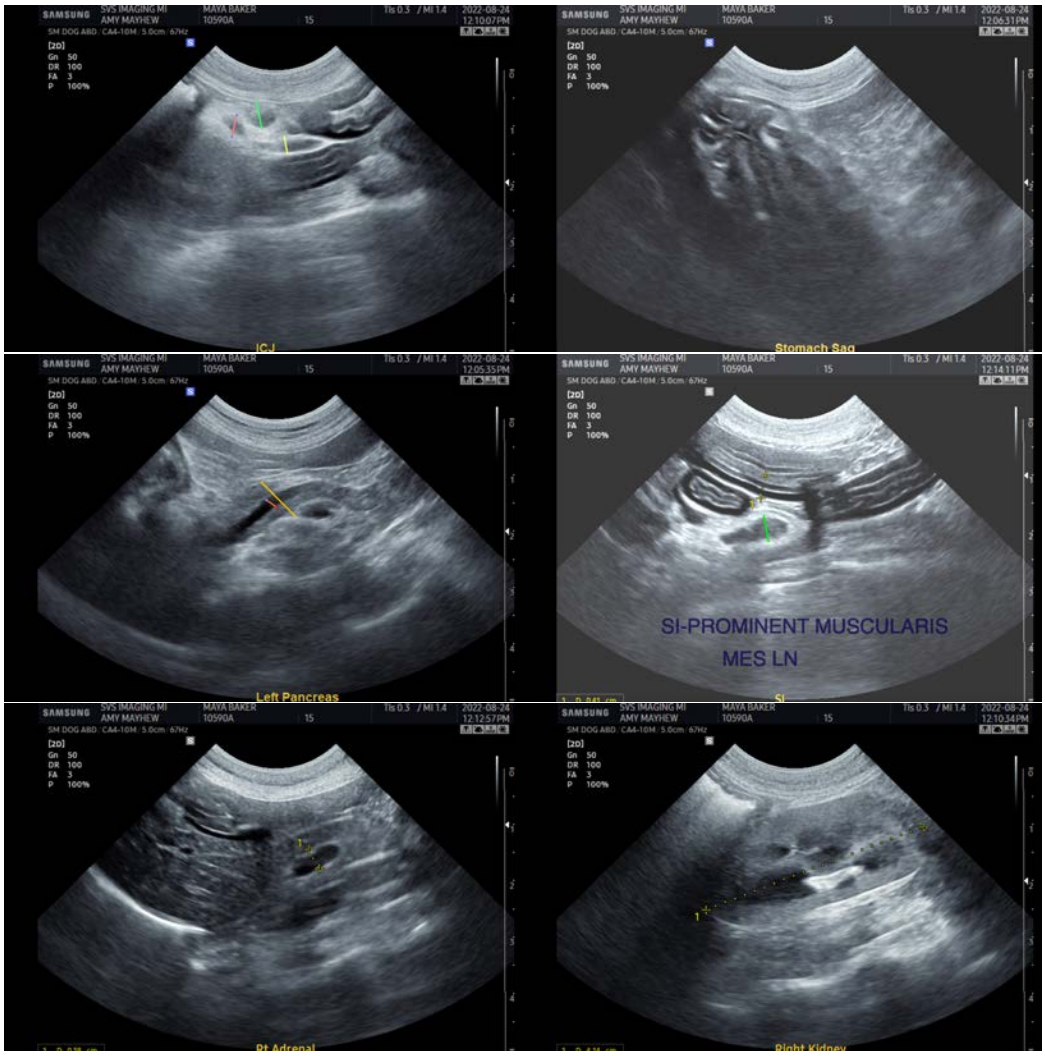
- Continue chronic probiotic therapy.
- Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Recommend treatment for mild pancreatitis.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- If symptoms persist despite these measures, consider obtaining GI biopsies.



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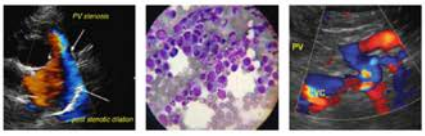

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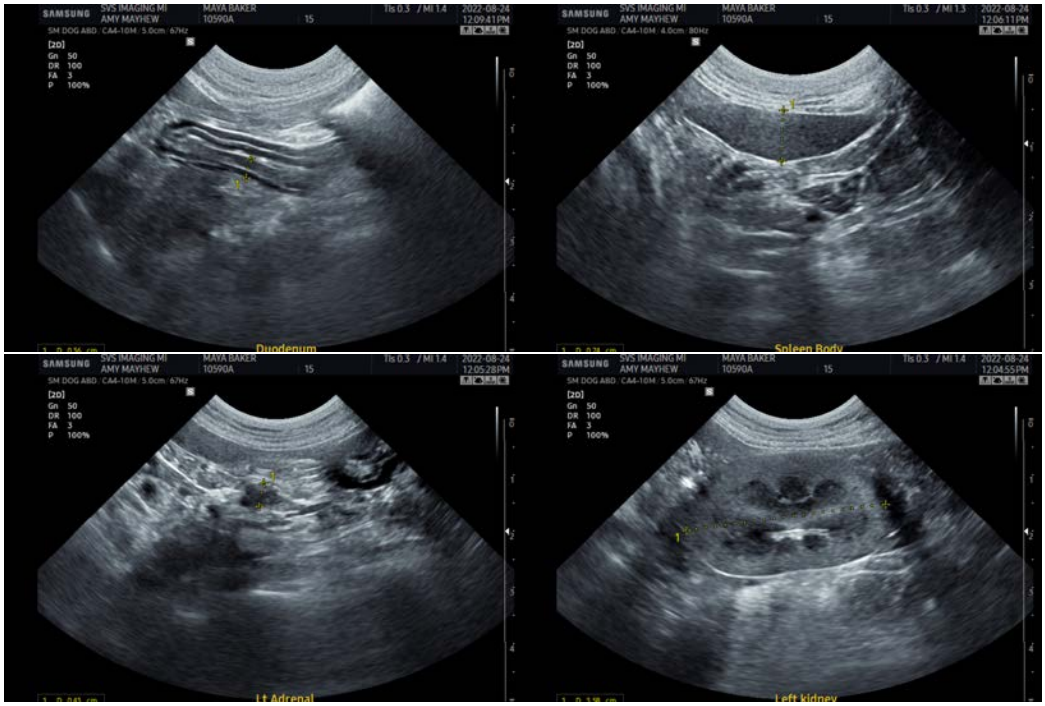


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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