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DATE PRESENTING CLINICAL SIGNS

8/31/22 Chronic vomiting, straining to urinate.

PATIENT Current Medications: None listed.

Anya Polasko

Lab Results: See attached.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Gabapentin PO, Demdomitor/Torbugesic IM.

Stat Report: Not requested.

SPECIES

Feline

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

BREED

DSH

SEX

Spayed Female

AGE

7/26/12

WEIGHT

12.4 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Stephanie Warga
RDMS, RVT

HOSPITAL NAME

Cat Hospital at Towson

REFERRING VET

Dr. Slaughter

INVOICE

40908

Urinary System

The urinary bladder is moderately distended with mildly echogenic urine. The Bladder wall appears mildly thickened and prominent, measuring approximately 0.20 cm. There is a small pile of echogenic debris visible in the dependent portion of the urinary bladder. The 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. Findings are consistent with cystitis.

The left kidney has a normal shape and size (3.89 cm) with pyelectasia at 0.37 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.91 cm) with pyelectasia at 0.26 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.27 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 0.37 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 (1.0 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.

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 relatively uniform diameter with minimal 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. Jejunum wall measures 0.23 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 mottled 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. Occasional visible mesenteric lymph nodes are noted, measuring 0.25, 0.27 cm. The omentum is of normal echogenicity.

Other

There is a heterogeneous subcutaneous mass effect imaged measuring approximately 0.77 cm x 2.0 cm.

PRIMARY FINDINGS

- Mildly thickened urinary bladder wall with echogenic debris – most consistent with cystitis. Recommend urinalysis and culture.
- Bilateral pyelectasia – Pyelectasia of the kidney(s) could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

SECONDARY FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Visible mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Subcutaneous hypoechoic tissue/mass effect – Correlate with physical exam. Consider a fine needle aspirate if appropriate.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

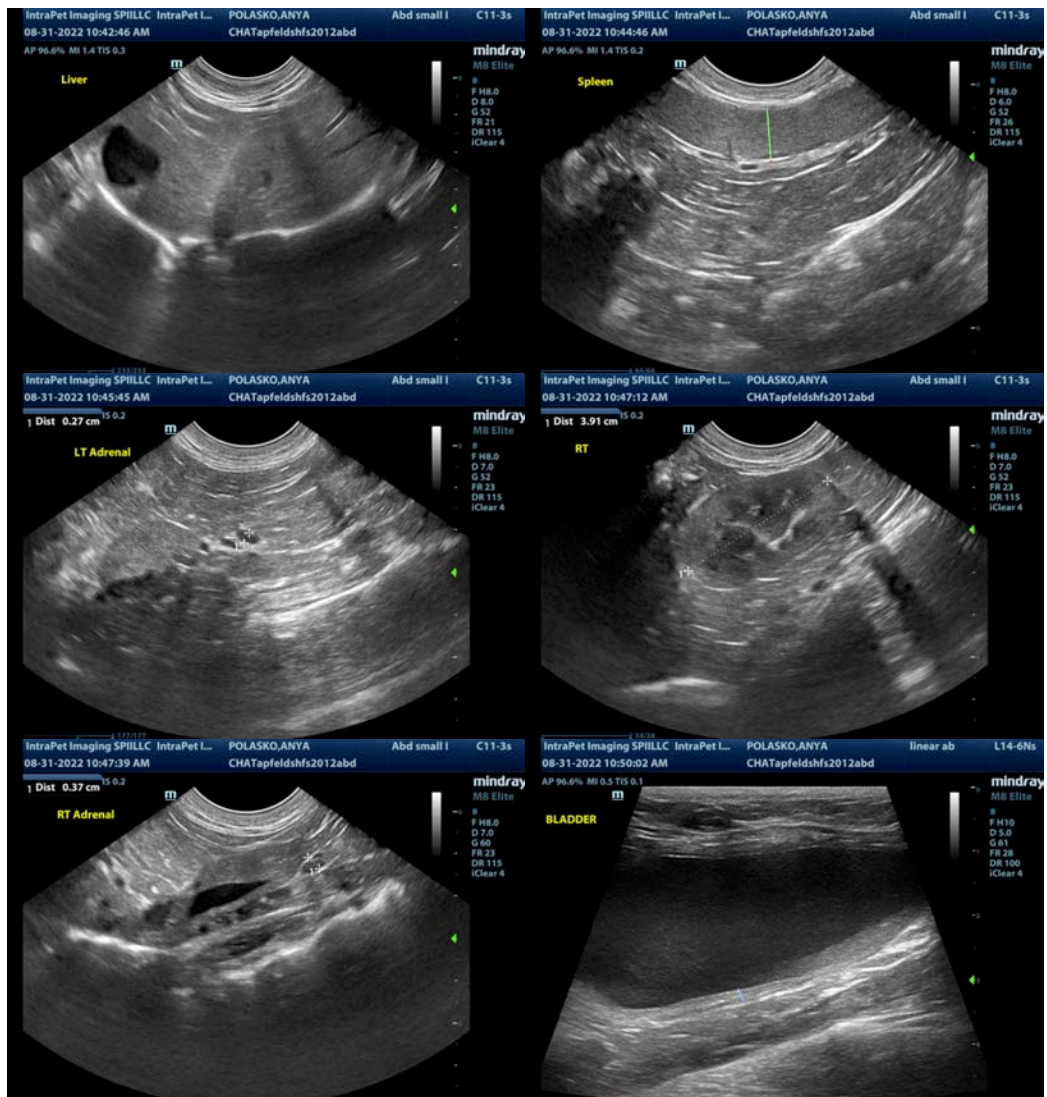
The changes in the urinary bladder are most consistent with cystitis. There is mild pyelectasia noted in both kidneys, so if a urinary tract infection is diagnosed, there could be concurrent pyelonephritis.

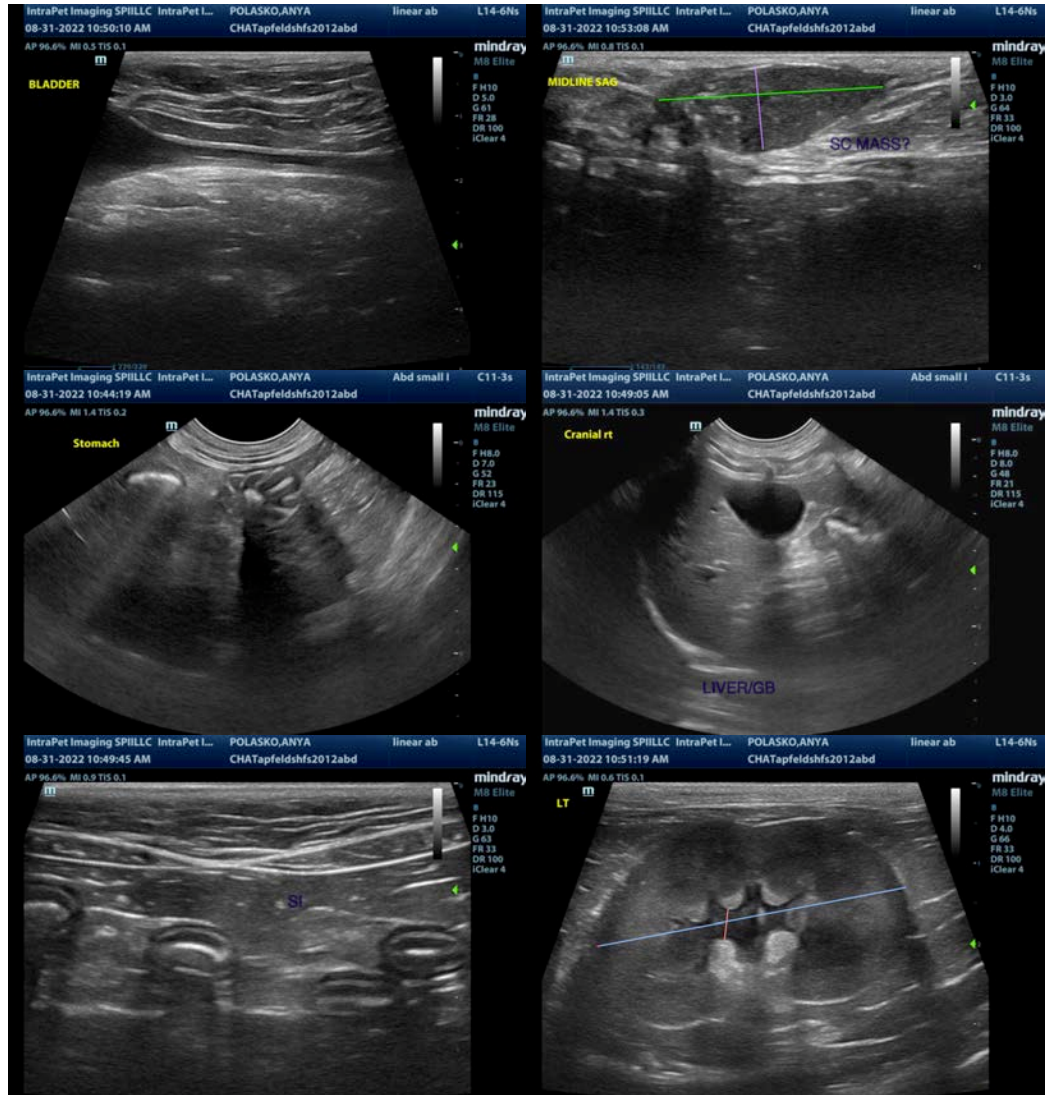
No focal lesions are visualized to explain the vomiting noted. It is not uncommon to have GI signs with minimal significant lesions, as there are many causes of vomiting that cannot be diagnosed by ultrasound

alone.

In older patients with more chronic symptoms, I would most strongly consider differentials such as food allergy, IBD, and intestinal neoplasia (but also consider dysbiosis, chronic pancreatitis etc..)

- 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)- this will provide additional information regarding possible pancreatic and small intestinal disease.
- If symptoms are progressing consider obtaining GI biopsies





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.

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