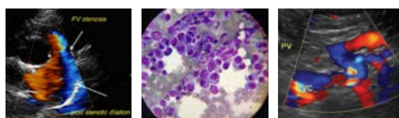
IMAGING PERFORMED BY

IntraPet.com



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DATE
8/9/22

PATIENT
Leonitas Dewald

SPECIES
Feline

BREED
Tabby

SEX
Neutered Male

AGE
1/1/11

WEIGHT
9.4 Pounds

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

IMAGING PERFORMED BY
Andi Parkinson RDMS

HOSPITAL NAME
Perry Hall AH

REFERRING VET
Dr. Breidenbaugh

INVOICE
40269

PRESENTING CLINICAL SIGNS

Weight loss, ravenous appetite, occasional projectile vomiting, occasional sneezing, normal energy. Faint head tilt to right, ceruminous debris AU and dental disease were the only findings on PE.

Current Medications: None.
Lab Results: CBC: mild decrease RBC (6.69), mild monocytosis (0.55k).
CHEM: mild decreased cholesterol (72). UA: cysto, usg 1.025, pH 5.5, trace protein.
T4: 2.1 WNL (increase from 1/2022 from 1.4).
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 is slightly irregular, but normal in size at 4.44 cm. There is a small 0.28 cm non-obstructive nephrolith visualized, and an irregularity in the renal capsule, likely due to previous infarct. 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 or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.55 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. There is a moderate amount of non-organized echogenic debris. The proximal bile duct appears slightly prominent and dilated at 0.35 cm with mucoid material visualized within the lumen.

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. Jejunum wall measured 0.22 cm. Visualized peristalsis appears appropriate. There is a solid focal jejunal mass visualized measuring 1.2 cm x 0.83 cm. There is no evidence of a significant obstructive pattern visualized.

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. Prominent pancreatic duct noted.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are prominent mesenteric lymph nodes visualized near the root of the mesentery, measuring 0.38, 0.40 cm, and the omentum is of increased echogenicity around the bowel mass and enlarged lymph nodes.

PRIMARY FINDINGS

- Moderate gallbladder debris with a mildly dilated proximal bile duct with intraluminal debris – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).

- Prominent muscularis layer to the small intestine with a focal jejunal bowel mass – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma. The focal bowel mass could represent a benign or neoplastic process. Recommend a fine needle aspirate.

- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

SECONDARY FINDINGS

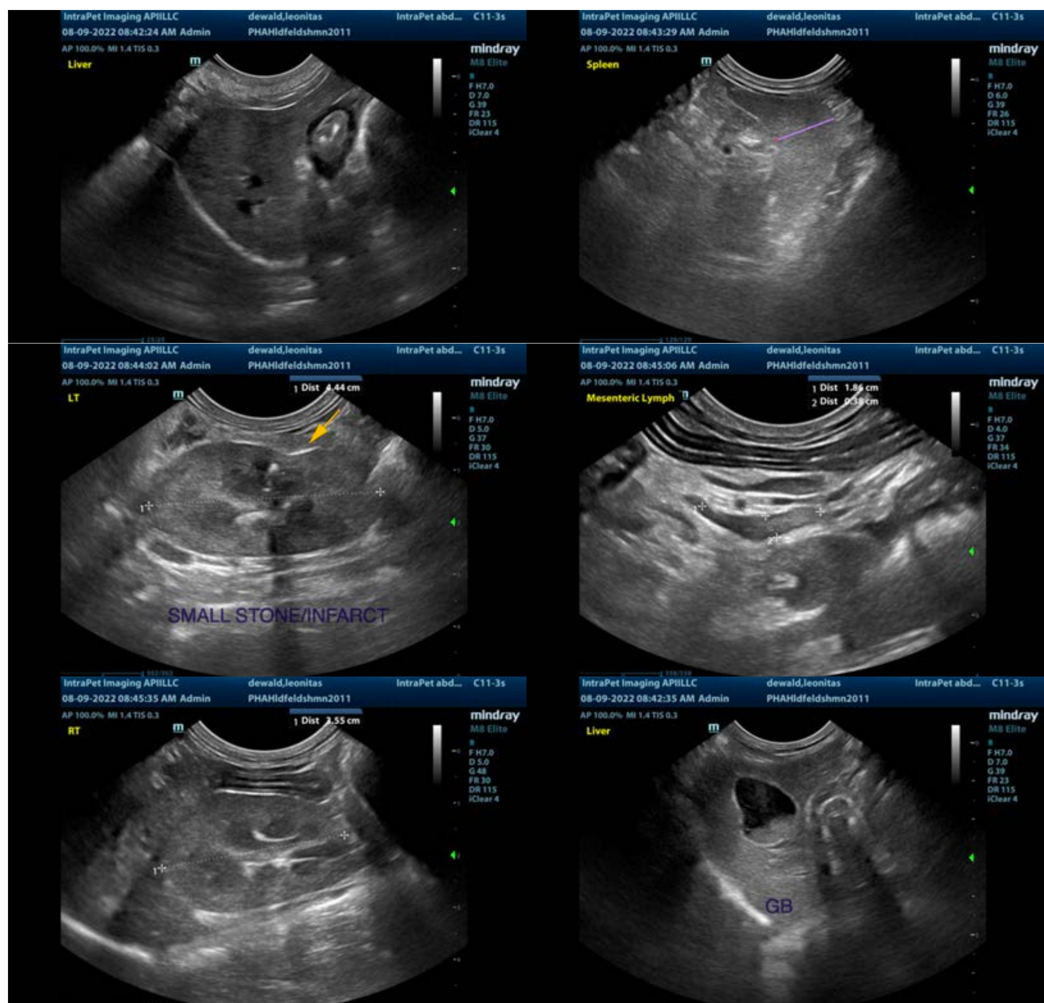
- Small non-obstructive nephrolith visualized in the left kidney with a likely previous infarct – The solitary renal lesion identified is ill defined and hyperechoic, this could be consistent with a previous renal infarct and can be an indicator of current or previous renal disease.

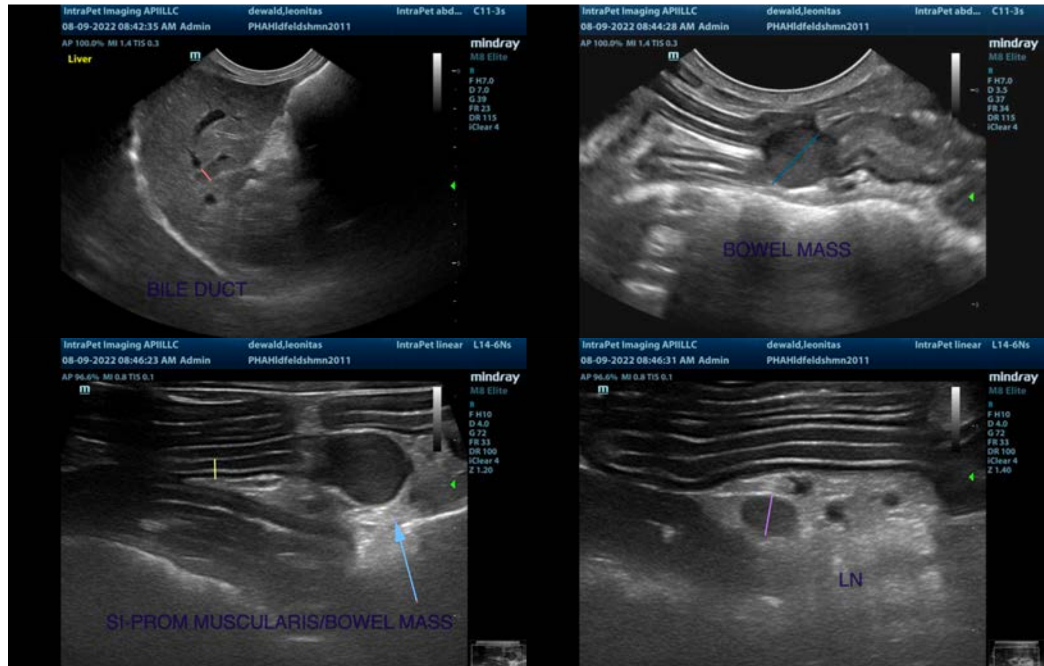
- Mildly mottled pancreas with prominent pancreatic duct – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is generalized subjective small bowel thickening with a prominent muscularis layer as well as a focal bowel mass. Options moving forward include a fine needle aspirate of the bowel mass or surgical explore with resection and biopsy of more normal appearing bowel. If surgery is pursued, consider also biopsy a mesenteric lymph node. There is concern for round cell neoplasia here based on the lymphadenopathy and history of possible malabsorption, but this could also be a benign mass with secondary diffuse intestinal disease.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Recommend a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Recommend chronic probiotic therapy.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.





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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