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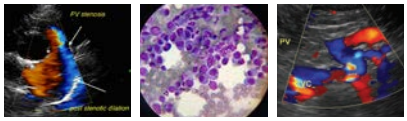

SonoPath

Clinical Sonography & Telecytology

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**DATE**

8/9/22

**PATIENT**

Oyster Lawson

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

6/14/12

**WEIGHT**

6.6 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Stephanie Warga RDCS, RVT

**HOSPITAL NAME**

Essex Middle River VC

**REFERRING VET**

Dr. Beizavi

**INVOICE**

40258

## PRESENTING CLINICAL SIGNS

Presented for chronic weight loss and vomiting on 6/24/22 - weight 6.6 lbs. Weight was 8 lbs on 1/20/22

Current Medications: None at this time.
Lab Results: No abnormalities on CBC/Chem/T4 - performed 6/24/22 -didn't attach because all WNL.
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 mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (2.86 cm). Overall echogenicity is slightly hyperechoic with poor 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 (3.19 cm). Overall echogenicity is slightly hyperechoic with poor 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 0.30 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 0.31 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 (0.87 cm in width at the level of the hilus). The spleen echotexture is heterogenous and mildly mottled, 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 mild amount of non-organized echogenic debris. The common bile duct appears mildly dilated and prominent.

### *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 0.30 cm. Duodenum wall measured 0.27 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.

### *Free Abdomen*

There is a scant amount of free abdominal fluid. There is a diffuse mild mesenteric lymphadenopathy with mesenteric lymph nodes measuring 0.41, 0.44 cm. The omentum is diffusely mildly hyperechoic.

## PRIMARY FINDINGS

- Mildly mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Prominent, hypoechoic pancreas with prominent pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

- Prominent “ropey” small intestine with prominent muscularis and mild fluid dilation – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

- 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

- Mildly echogenic debris visualized in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

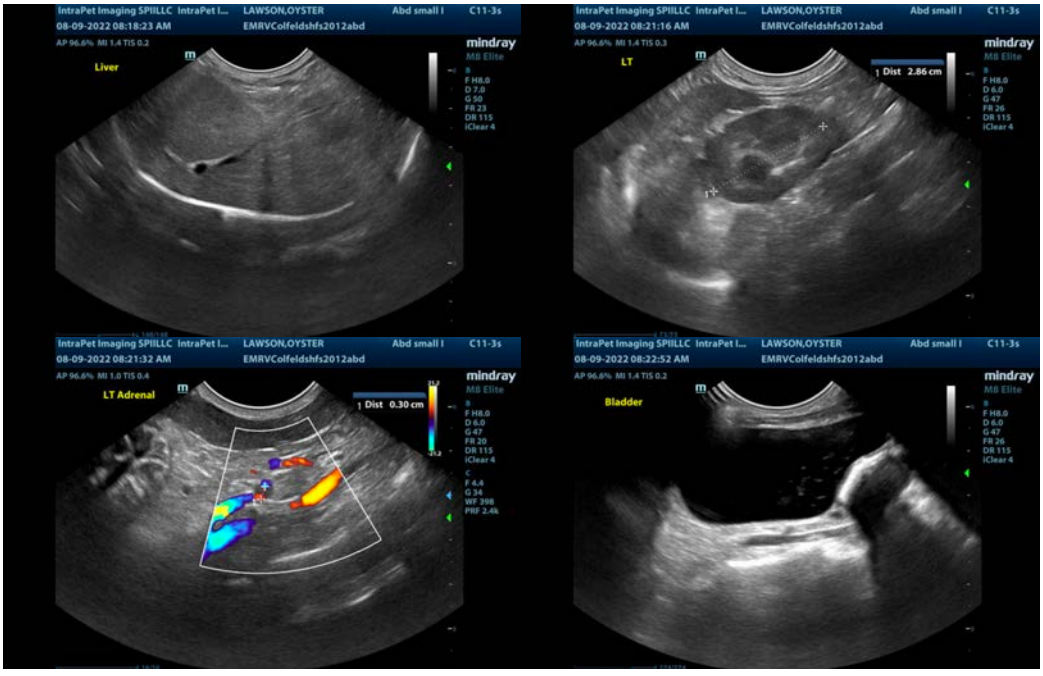
- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

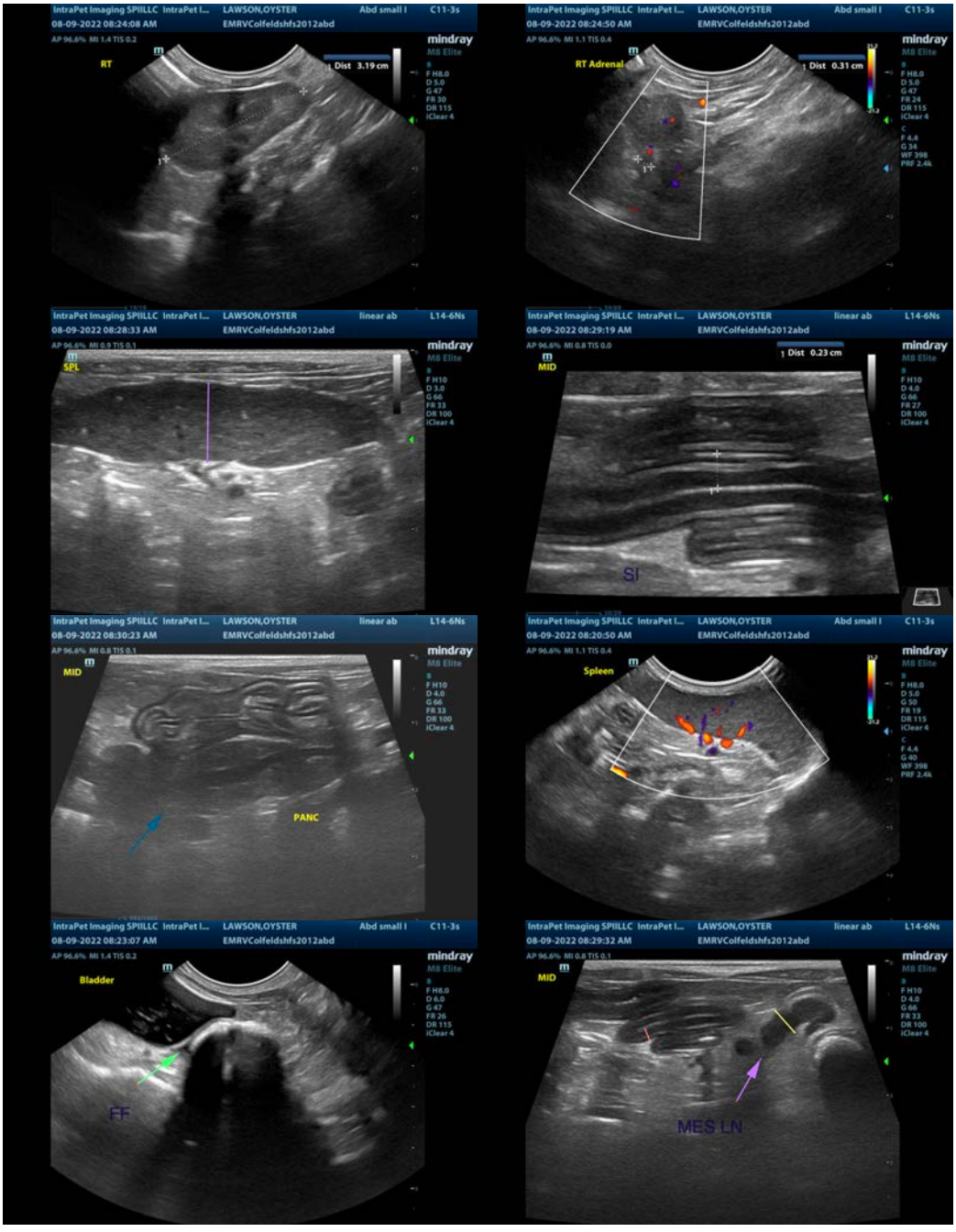
- Mild gallbladder debris with prominent bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease,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

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are many subjective/mild lesions described on today's scan. Some of these may be age related and insignificant. Given the history of vomiting and weight loss, I am most concerned about the changes observed in the GI tract, pancreas, and the prominent mesenteric lymph nodes. No focal lesions are observed, but there is the general impression of inflammation. Normal bloodwork makes metabolic disease much less likely. Consider the following for further workup of underlying GI disease:

- Recommend a novel protein/hydrolyzed protein prescription diet.
- Recommend chronic probiotic therapy.
- Recommend a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- If signs are consistent with pancreatitis, and fPLI levels are elevated, consider treatment for mild pancreatitis.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- Consider a fine needle aspirate of a mesenteric lymph node.
- If symptoms persist, consider obtaining GI biopsies.

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mindray
RT
Dist 3.19 cm
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RT Adrenal
Dist 0.31 cm
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SPL
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MID
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MID
PANC
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Spleen
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mindray
Bladder
FF
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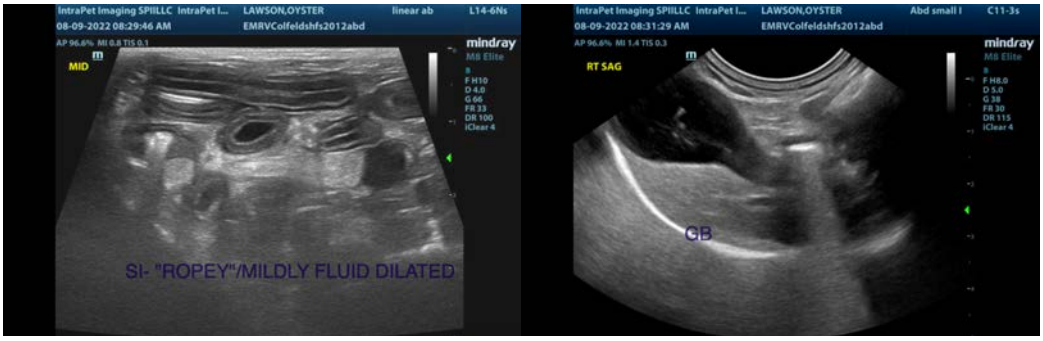
mindray
MID
MES LN




**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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