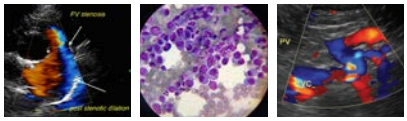
IMAGING PERFORMED BY

IntraPet.com



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DATE

9/2/21

PATIENT

Cosmo O'Neill

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2010

WEIGHT

11.59 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Everhart VH

REFERRING VET

Dr. LEH

INVOICE

25156

PRESENTING CLINICAL SIGNS

History: Loud digestive noises for months, intermittent vomiting/nausea.
Current Medications: N/A
Lab Results: Pending
Radiographs: N/A
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not needed.
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 is small (2.83 cm) and irregular (consistent with previous infarcts) with decreased corticomedullary distinction. Occasional small non-obstructive nephroliths noted and pyelectasia at 0.12 cm.

The right kidney has a normal shape and size (4.10 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 0.38 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 0.41 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, 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 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 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 measures 0.35 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. There is a mild mesenteric lymphadenopathy. A cluster of mesenteric lymph nodes near the root of the mesentery measure 0.45 and 0.55 cm. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of increased echogencity around the clusters of enlraged lymph nodes.

PRIMARY FINDINGS

- Decreased corticomedullary distinction in both kidneys. The left kidney is small and irregular, consistent with previous infarcts and has mild pyelectasia – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Subjectively thickened small intestine with prominent muscularis layer – 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 prominent hypoechoic pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

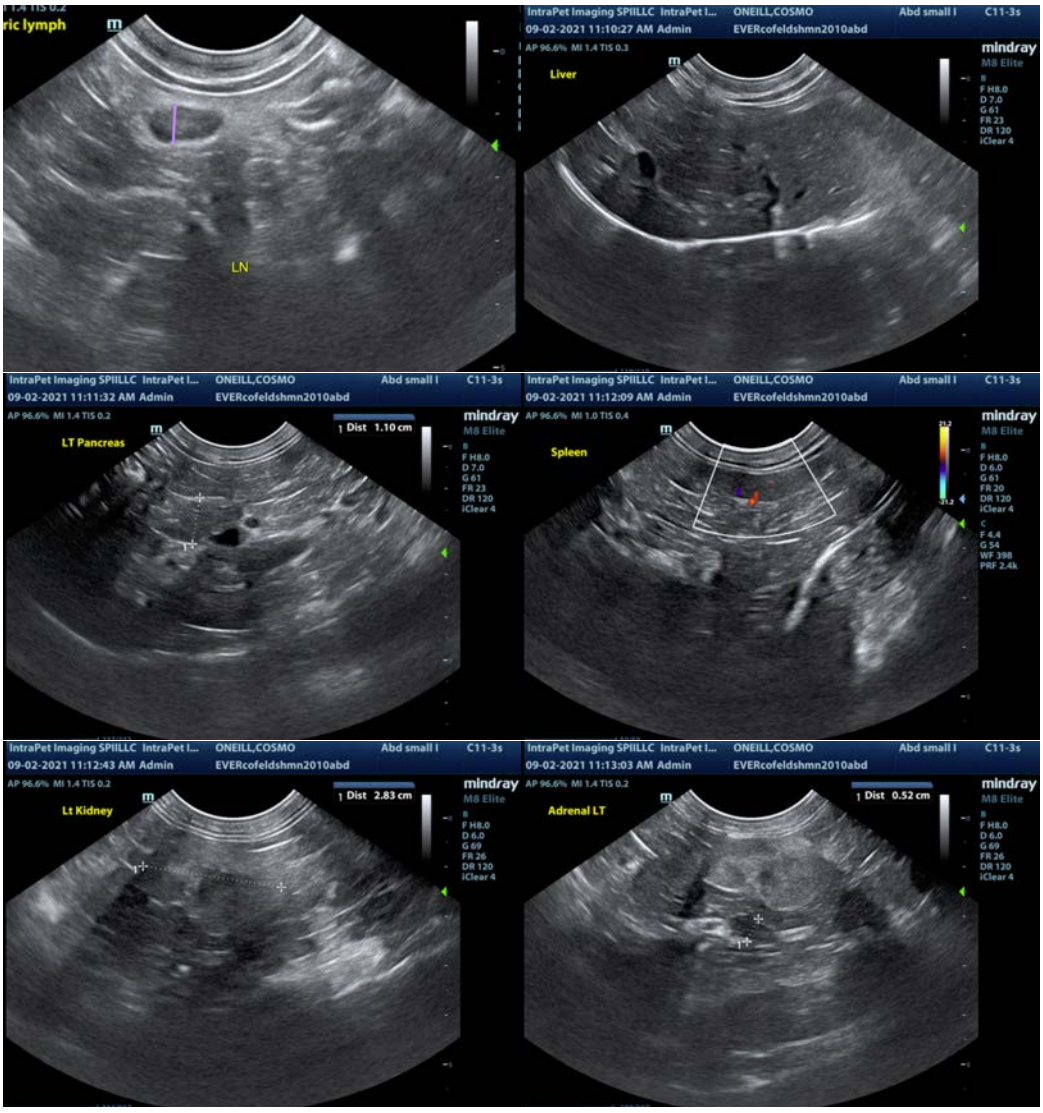
There is evidence or chronic kidney disease. Recommend urinalysis and culture with blood pressure evaluation and urine protein/creatinine ratio.

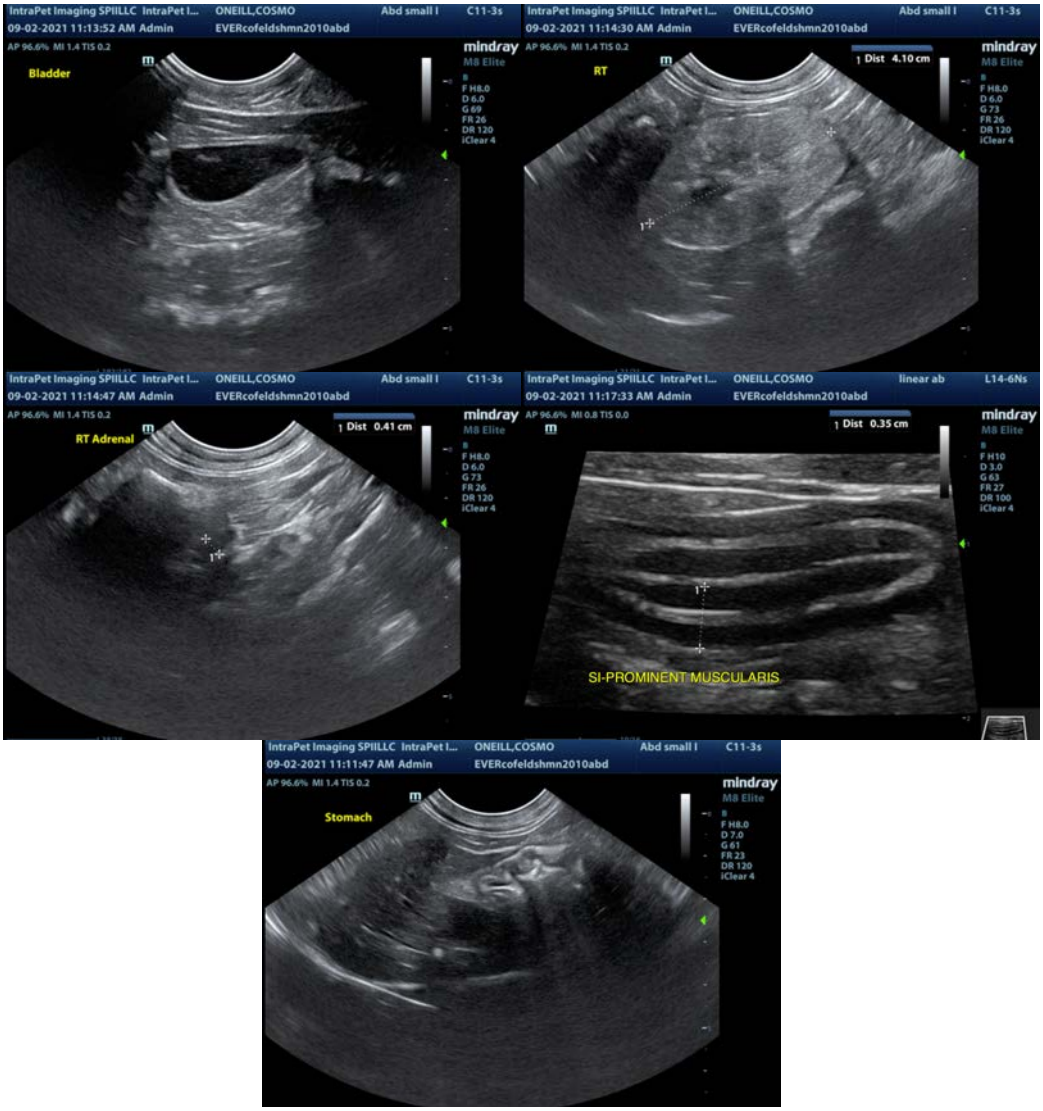
The symptoms described are likely associated with underlying GI disease. The bowel appears thickened, and there are prominent mesenteric lymph nodes, most consistent with an inflammatory (cannot rule out neoplastic) process involving the GI tract. Consider primary causes such as GI parasitism, mild pancreatitis,

bacterial dysbiosis, food allery, IBD, and less likely intestinal neoplasia.

In older patients with more chronic symptoms, I would most strongly consider food allergy, IBD, and intestinal neoplasia.

-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)
-Consider fine needle aspirate of a mesenteric lymph node
-If symptoms are progressing consider obtaining GI biopsies





The information and recommendations provided are based on the images presented by the referring veterinarian. 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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