

**DATE PRESENTING CLINICAL SIGNS**

9/3/21

History: Mary has not eaten since Wednesday night. Yesterday morning she vomited her food, and she has been vomiting every 2-3 hours since and now the vomit has a pink tinge. She is drinking water but vomits after that. She had been tried with a Cerenia tablet yesterday, but she vomited it up an hour later. She is not typically a FB cat. Concerned about a possible pancreatitis/mass.

PATIENT

Mary Roe

Current Medications: No current medications.

SPECIES

Feline

Lab Results: Attached separately.

Radiographs: Attached separately.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: IM sedation utilized for AUS

Stat Report: not requested

BREED

DLH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**SEX**

Spayed Female

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.

AGE

2/23/16

The left kidney has a normal shape and size (4.15 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. Non-obstructive stones present measured 0.28 and 0.37 cm. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

WEIGHT

14 Pounds

The right kidney has a normal shape and size (4.56 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. A non-obstructive stone was present measuring 0.33 cm. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

INTERPRETED BY

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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.

HOSPITAL NAME

Animal Emergency
Hospital

The right adrenal gland is normal in size measuring 0.50 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.

REFERRING VET

Dr. Goessling

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.

INVOICE

25190

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 0.26 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 lymphadenomegaly present, measuring 0.3, 0.28, and 0.5 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 echogenicity around the thickened bowel loops and the pancreas.

PRIMARY FINDINGS

- Subjectively thickened small intestine with prominent muscularis layer – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.
- Prominent, hypoechoic pancreas with surrounding hyperechoic mesentery – The pancreatic changes are most consistent with mild/moderate pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- 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

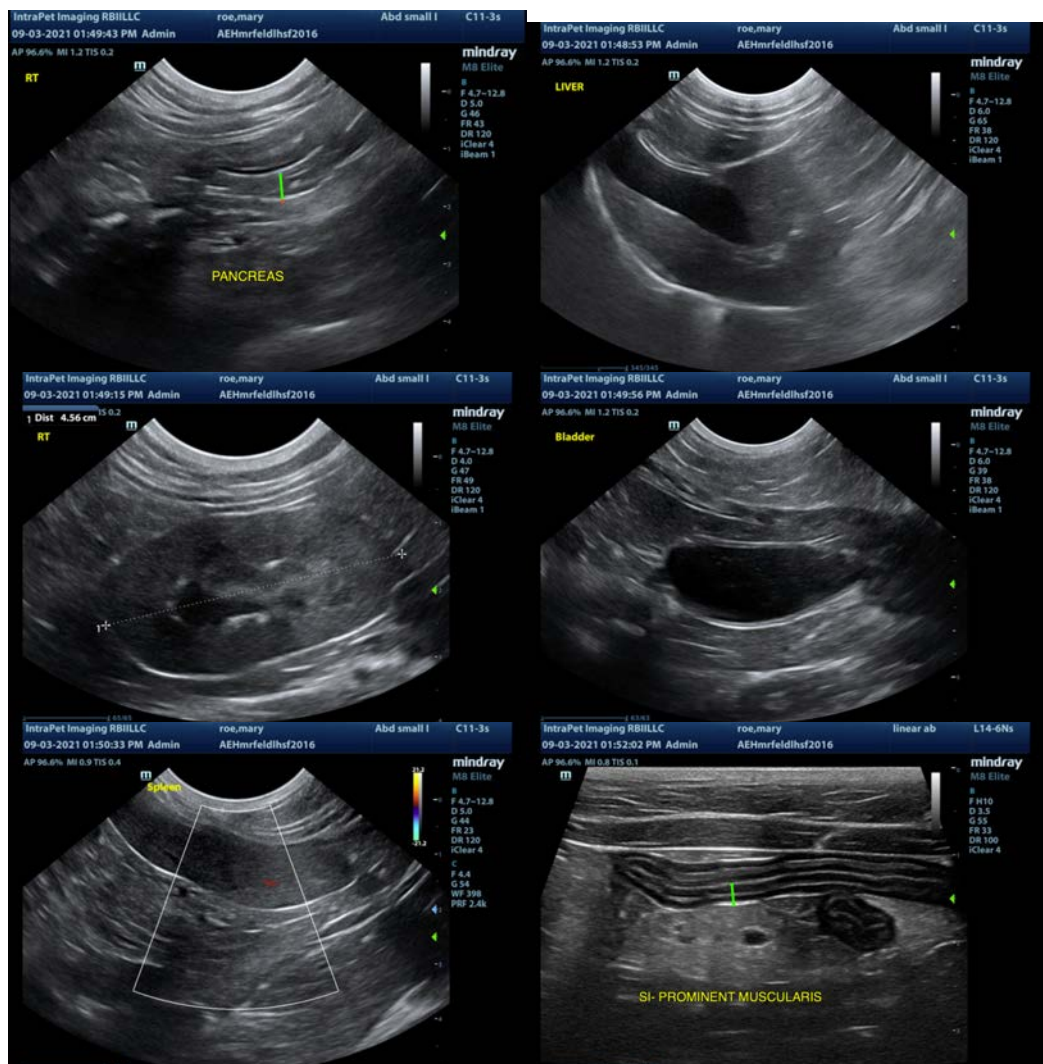
- Non-obstructive nephroliths visualized in both kidneys – The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.

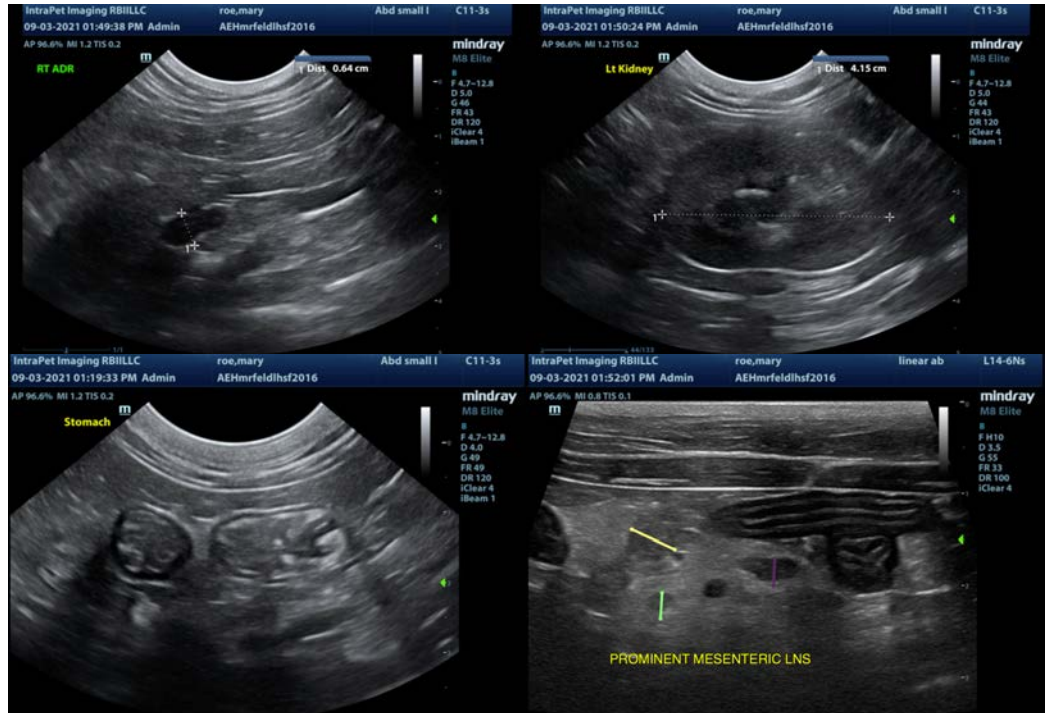
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The findings are somewhat non-specific and consistent with enteritis. Unfortunately, the severity of the ultrasonographic findings does not always correlate with the severity of the GI symptoms exhibited. Possible primary GI causes would include GI parasitism, dietary indiscretion, mild pancreatitis, bacterial dysbiosis, food allergy, IBD, and less likely intestinal neoplasia.

- Recommend GI panel for evaluation of quantitative fPLI, B12 and folate levels to further evaluate the pancreas and GI tract.

- Recommend symptomatic treatment for gastroenteritis/pancreatitis.
- Recommend serial radiographs to look for evidence of foreign material. Ultrasound is sometimes insensitive in identifying this.
- Recommend 3-view thoracic radiographs to evaluate the esophagus and the lung parenchyma.
- Recommend close evaluation under the tongue if possible for a linear foreign object (opening mouth and holding the head abnormally in history).
- If GI symptoms persist, and a metabolic/esophageal problem seems very unlikely, then consider abdominal explor to obtain GI biopsies and gastric biopsies +/- pancreas and evaluation for foreign material.





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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