



**PATIENT**

Scout Frey-  
Frankenfield

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

11.5 years

**WEIGHT**

5 lbs

**INTERPRETED BY**

Andrea Nicastro,  
DVM, Diplomate ACVIM  
(Small Animal Internal  
Medicine)

**IMAGING  
PERFORMED BY**

Christina Sitton

**HOSPITAL NAME**

Sherwood Family PC

**REFERRING VET**

Christina Sitton

**INVOICE**

10644

**DATE**

3/31/22

**PRESENTING CLINICAL SIGNS**

History: weight loss, loose stool (chronic issue but normally self resolves)  
Abnormal PE/Chem/CBC/UA Results: chem Albumin 2.5 (2.6-3.9); was 3.3 UA USG 1.049 pH 6 trace  
blood 2+ protein CBC WBC 19.7 (3.9-19) Neutrophils 16292 ((2620-15170) Monocyte 985 (40-530)  
otherwise chem/cbc/t4/fpl/proBNP wnl

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is not definitively visualized, likely due to contraction and/or pelvic location.

The left kidney is normal size (3.51 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.37 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.33 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

**Spleen**

The spleen is normal in size (0.62 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of gravity dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts are visible/tortuous but not overtly dilated (up to 0.21 cm in diameter) and can be followed to the level of the duodenal papilla. There is no obvious evidence of an intraluminal obstruction.

**Gastrointestinal**

The gastric lumen is mildly fluid-distended. The gastric wall is mildly thickened (up to 0.54 cm), with apparent retention normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with fluid and chyme (mild). The small intestinal wall is normal to mildly thickened (up to 0.26 cm). In one segment, there is a questionable loss of the normal layering pattern. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.



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**Pancreas**

The pancreas is diffusely prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is borderline dilated (0.25 cm in diameter).

**Free Abdomen**

There is no evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.08 cm in length.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- The gastric and small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The pancreatic changes are consistent with chronic pancreatitis.

**Secondary Findings**

- Mild, nonspecific age-related renal changes

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Fecal evaluation for ova and Giardia
- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
- Malabsorption panel, including serum cobalamin and folate, TLI and PLI
- Consider three-view thoracic radiographs to assess for occult neoplasia in the chest.
- Depending on the results of the above diagnostics, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis. Surgical biopsy would be ideal in that all portions of bowel, as well as abdominal lymph nodes, can be sampled.
- If biopsies are not pursued, consider empirical treatment for inflammatory bowel disease (i.e., corticosteroids +/- hypoallergenic diet) as long as the client understands the risks of treatment without a definitive diagnosis.



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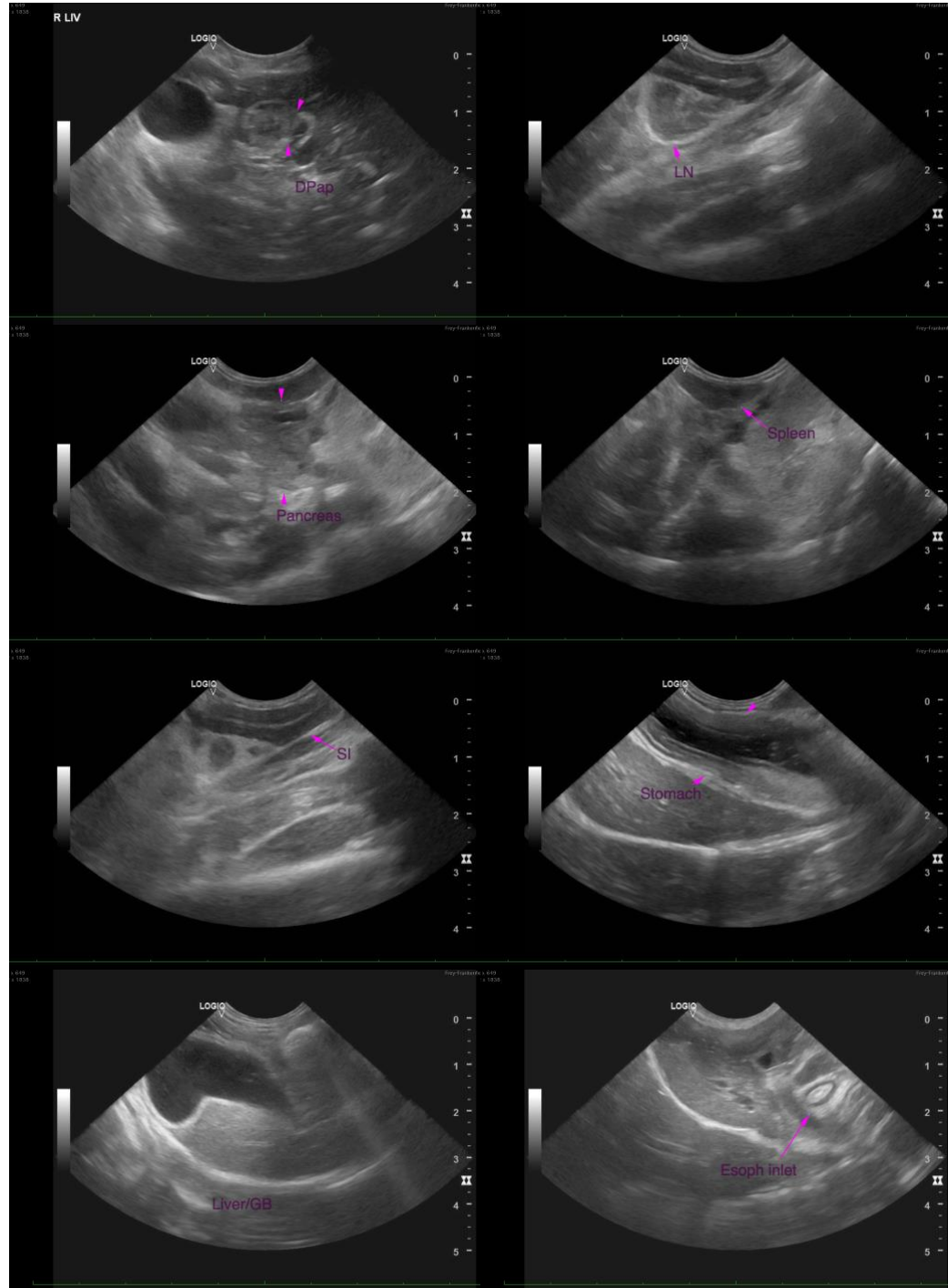
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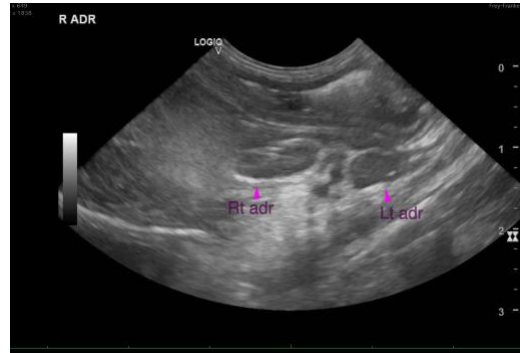
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)  
info@SonoPath.com