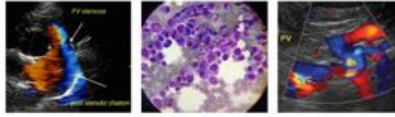
IMAGING PERFORMED BY
svsimagingqc.net 309-737-3070



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Nonna Karnes 275310

SPECIES
Feline

BREED
DLH

SEX
Spayed Female

AGE
9 years

WEIGHT
4.3 kg

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

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
WVRC- Dr. Lewis

INVOICE
11260

DATE
7.22.22

PRESENTING CLINICAL SIGNS

History
Nonna presented to the WVRC-Emergency Service on 7/22/2022 for evaluation of vomiting.

3 days ago Nonna was not defecating and not eating. Her appetite came back but then the next day she produced a large amount of vomit. Nonna last ate at 7am today.

Per owners, the abdominal x-rays revealed +/- intestinal blockage but Nonna has not improved.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System
The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (3.67 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.84 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter

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.

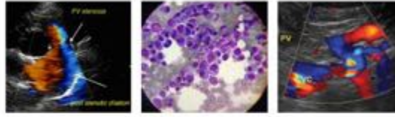
The right adrenal gland is normal size (0.42 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
The spleen is contracted (0.46 cm in width at the level of the hilus) with normal curvilinear peripheral contours. 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 gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are visible/tortuous but not overtly dilated.

Gastrointestinal
The gastric lumen is mildly distended with fluid and ingesta and appears hypomotile. The gastric wall is borderline thickened (up to 0.35 cm) with retention of the normal layering pattern. The pyloric outflow tract is patent. The duodenum is normal in thickness with a normal layering pattern and does not appear dilated. The jejunal wall is normal to mildly thickened (up to 0.32 cm) with retention of the normal layering pattern. Within the jejunum, soft shadowing material is present within the lumen. One jejunal segment appears mildly plicated. The other segments are empty to mildly distended with chyme and hypomotile. No discreet masses are identified. The ileocecocolic junction and colonic wall are normal.



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Pancreas

The pancreas is diffusely prominent to enlarged, particularly the left limb. The peripheral margins are slightly irregular. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.17 cm in diameter). Surrounding mesentery is hyperechoic.

Free Abdomen

The mesentery throughout the abdomen is hyperechoic. There is no evidence of free fluid. A 0.61 cm gastric lymph node is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are consistent with moderate acute pancreatitis with adjacent peritonitis.
- Suspected jejunal foreign material, which may be transient or may be causing a partial obstruction
- Diffuse peritonitis, likely secondary to pancreatitis and/or bowel pathology

Secondary Findings

- The prominent gastric lymph node is likely reactive.
- The splenic contraction is most likely secondary to dehydration.
- Bilateral, chronic, age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma. Nutritional support (i.e., via trickle feeding or a temporary feeding tube) should be considered to help maintain enterocyte health and prevent hepatic lipidosis.
- Thoracic radiographs (three-view) are recommended to assess secondary cardiopulmonary effects of pancreatitis.
- Given the suspected jejunal foreign body, an abdominal exploratory can be considered. However, it is unclear whether the material is obstructive at this time. Therefore, a more conservative approach would be a repeat abdominal ultrasound in 12-18 hours. If the bowel changes are similar or more dilated, and exploratory surgery may be warranted.
- Baseline lab work, including a CBC, chemistry panel, urinalysis and T4 is recommended, if not already performed. The patient's metabolic functions should be closely monitored while treating the pancreatitis.

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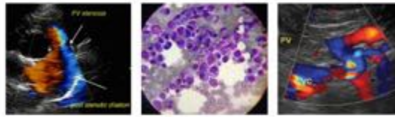

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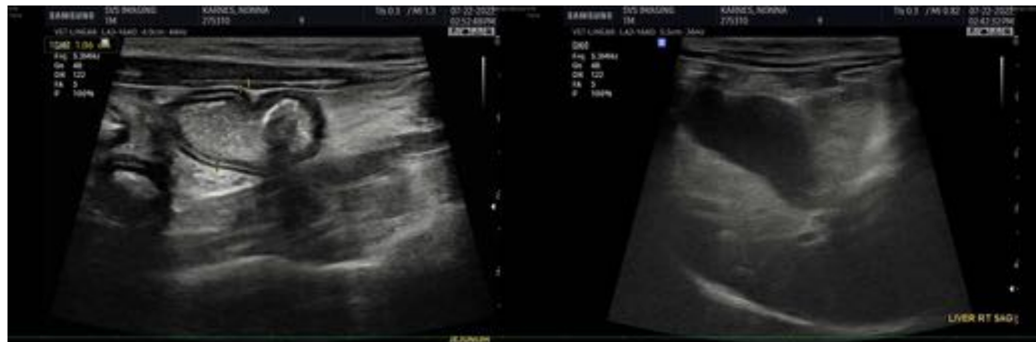

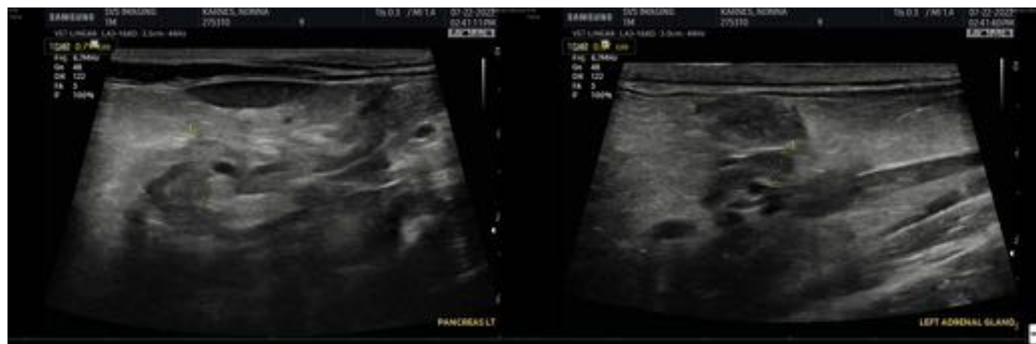

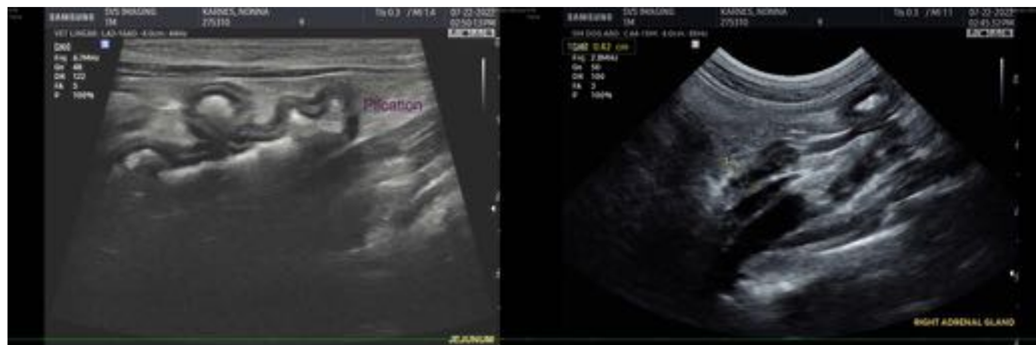

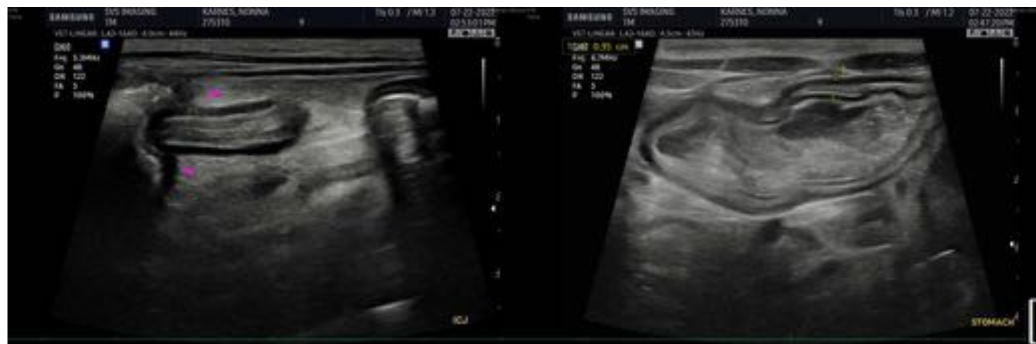

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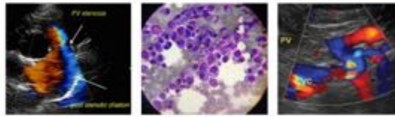

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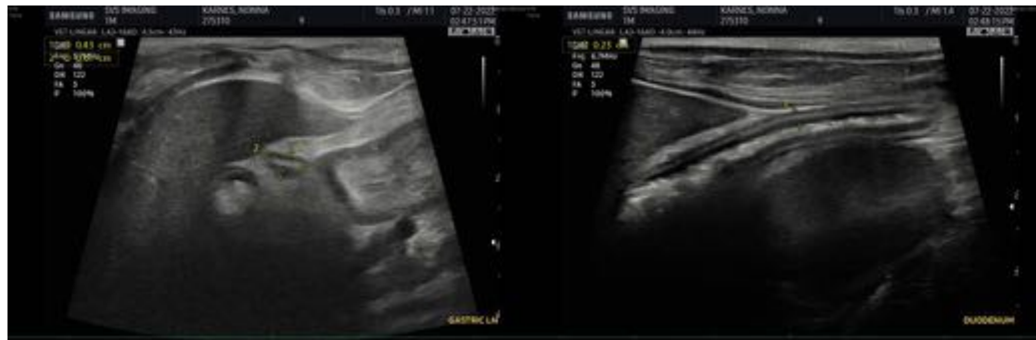

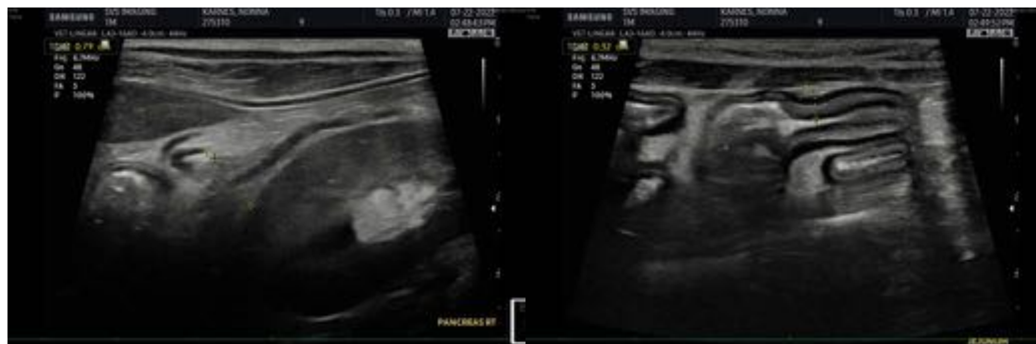

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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