

**PATIENT**

Fannie Dunning

**SPECIES**

Feline

**BREED**

Maine Coon

**SEX**

Spayed Female

**AGE**

1 Year 9 Months

**WEIGHT**

11.44 Pounds

**INTERPRETED BY**Beth Johnson, DVM  
DACVIM**IMAGING PERFORMED BY**

Amy Mayhew, LVT

**HOSPITAL NAME**

SVS Imaging MI

**REFERRING VET**

Airport Vet Hospital

**INVOICE**

43811

**DATE**

7/13/23

**PRESENTING CLINICAL SIGNS**

Vomiting and not eating since yesterday. Very lethargic.

Abnormal PE/Chem/CBC/UA Results: Abnormal feline pancreatitis SNAP in house. Very painful when touched on rear end/around spine.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (4.23 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (3.93 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

**Adrenal Glands**

The right adrenal gland is normal in size (0.40 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.45 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**Spleen**

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

**Liver**

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is mildly subjectively overdistended. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no pathologic cystic or common bile duct dilation noted, but the cystic and common bile duct are mildly tortuous all the way to the level of the duodenal papilla.

**Gastrointestinal**

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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The visible small intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen is mildly diffusely fluid distended without evidence of foreign material, obstruction, or plication.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

***Pancreas***

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted. This change is most appreciated in the left limb of the pancreas.

***Free Abdomen***

There is a trace amount of anechoic free fluid in the cranial abdomen.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

**ULTRASONOGRAPHIC FINDINGS**

- Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- Mild gallbladder distention with a tortuous cystic and common bile duct
- Acute pancreatitis, primarily left limb
- Inflammatory bowel disease (IBD) pattern with diffuse mild fluid distention – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling. The diffuse mild fluid distention is concerning for ileus.
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Trace amount of free fluid in the cranial abdomen.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The findings described above are suggestive of feline “Triaditis” involving the pancreas, the hepatobiliary system, and the gastrointestinal tract. Further diagnostic recommendations could include:

- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- Fine needle aspirate of the liver if patient’s coagulation status is appropriate.
- In the meantime, Treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad

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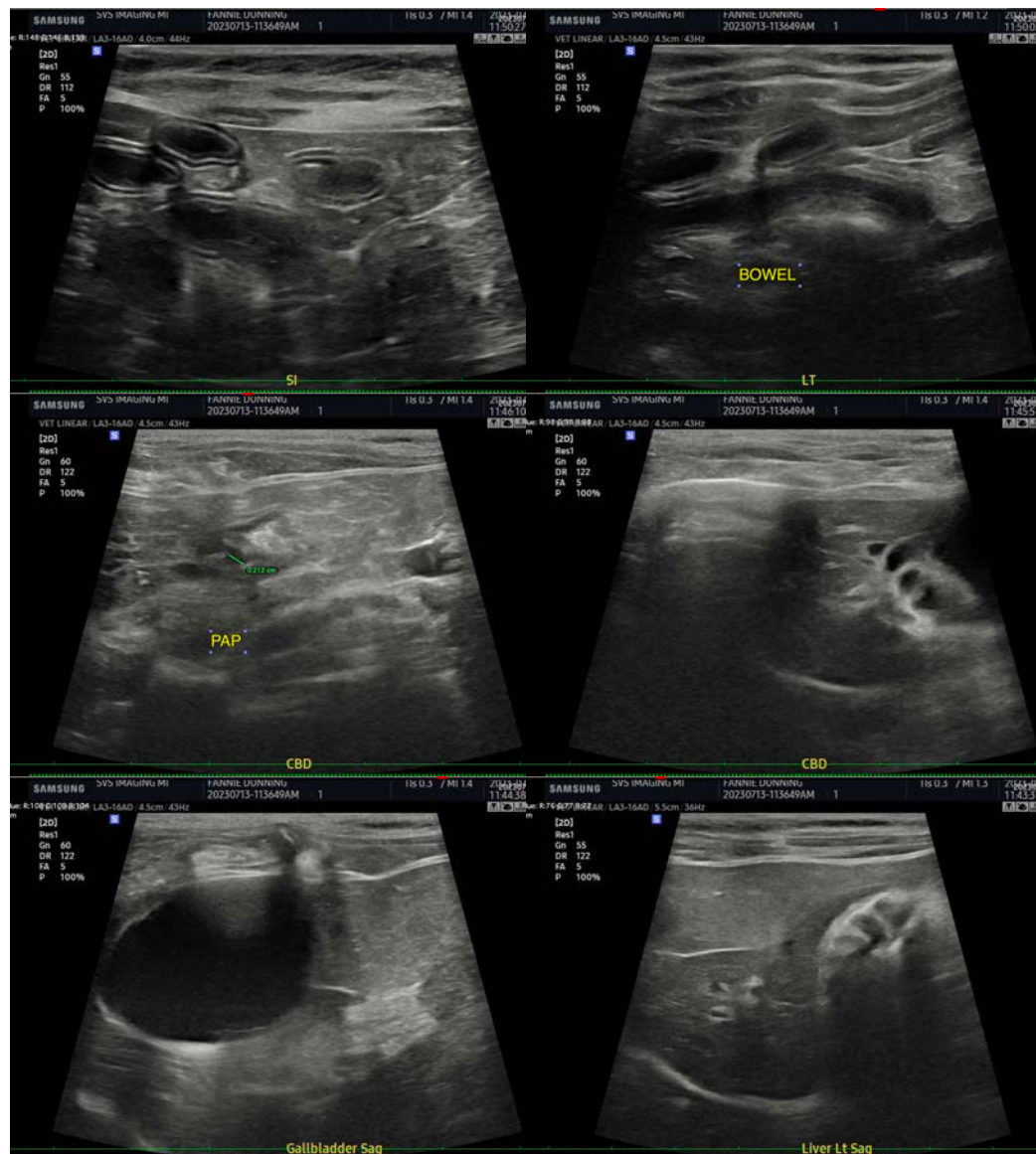
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spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.

- Ultimately, pending patient response to this treatment as well as whether clinical signs recur, etc., further evaluation of suspected infiltrative bowel disease, which could be predisposing to secondary hepatobiliary infections via biopsies of the GI tract, may be warranted.
- In the meantime, once patient is stable, transition in diet could be considered prior to pursuing biopsies, beginning with a hydrolyzed protein diet.



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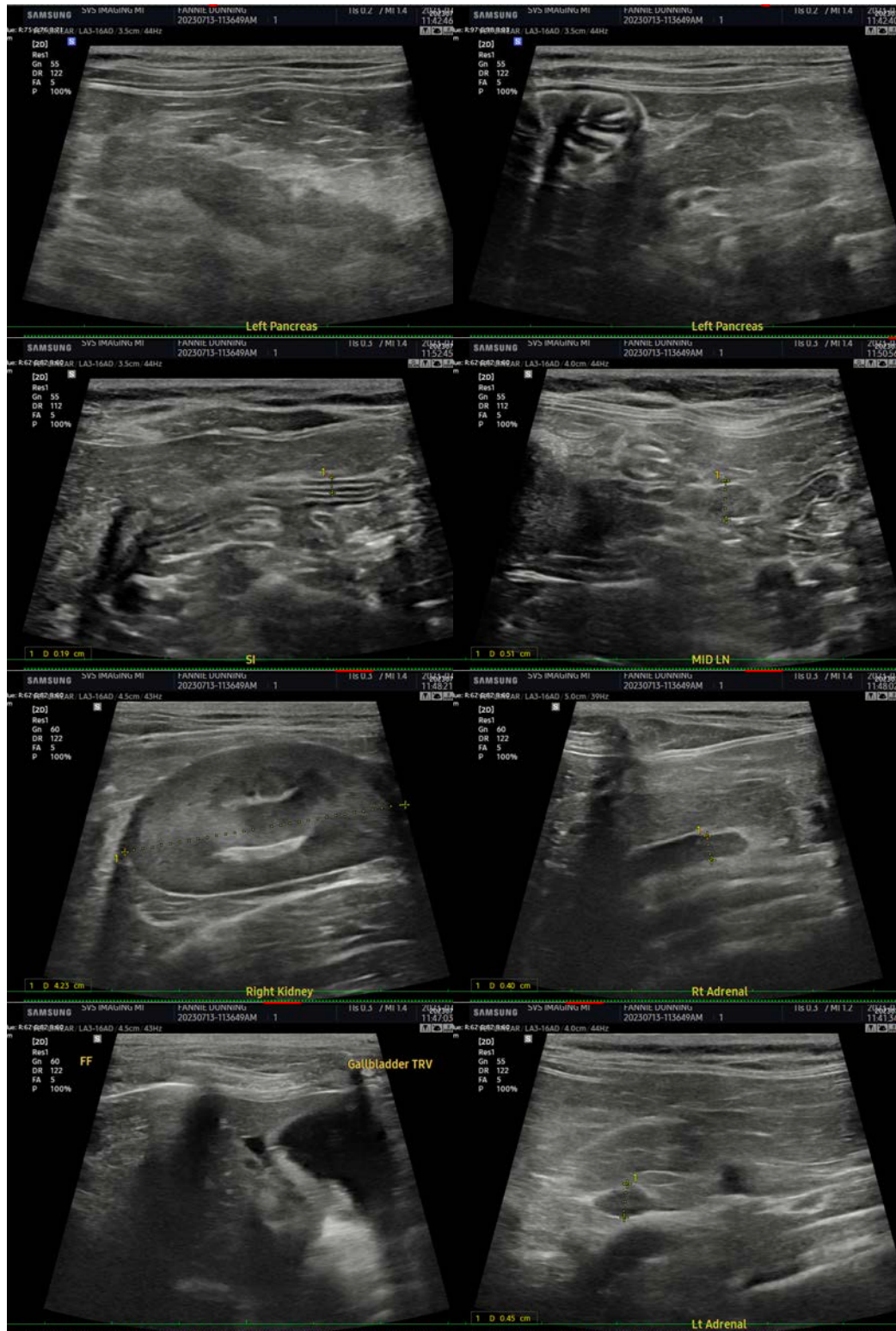
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Beth Johnson, DVM, DACVIM**  
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