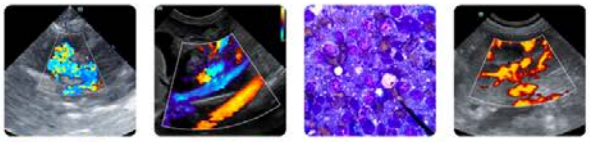


PATIENT

Herbie Chubb

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years

WEIGHT

9.4 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Shally Gastelu

INVOICE

72484

DATE

1/26/26

PRESENTING CLINICAL SIGNS

Acute 1-d history of vomiting (food, then bile), hyporexia. Diabetes mellitus, historic; managed with (Novolin-N) at 7u (0.74mg/kg) q12h. EENT/oral: pink moist mm, crt <2s, bilateral cataracts, missing all teeth besides back molars. Abd: Guarded and tense with palpation, difficult to assess due to body condition. Musc: MCS 2/3, front declawed, no lameness

Abnormal PE/Chem/CBC/UA Results: CBC: Unremarkable - Chem: Glu 348 (H), GGT 7 (H) - Pancreatic lipase: 40.6 (H) - EPOC: Na 145 (H), Glu 377 (H) -

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Left kidney measures 4.6 cm. Right kidney measures 4.8 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left measures 0.45 cm in thickness. Right measures 0.52 cm in thickness.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

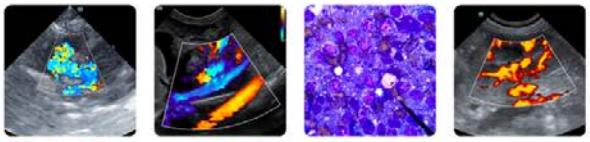
The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is diffusely mildly increased and wall layering is distinct with a slightly prominent muscularis layer. There were no focal lesions consistent with obstruction or a mass effect observed.



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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 left and right pancreatic limbs are enlarged and hypoechoic with surrounding hyperechoic mesentery. No fluid accumulations visualized. No mass effect consistent with pancreatic neoplasia visualized.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis with focal peritonitis.
- Mildly thickened small intestines with prominent muscularis layer.
- Aging renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pancreatic changes are consistent with acute pancreatitis. Treatment for pancreatitis is supportive and involves fluid support, GI support (anti-nausea, appetite stimulant), analgesia and enteral nutrition. Antibiotics are generally not warranted for acute pancreatitis as it is generally sterile. Serial imaging is indicated if clinical signs are not resolving to assess for possible progression to pancreatic abscessation or post hepatic bile duct obstruction. Recurrent pancreatitis is a common comorbidity seen with diabetes mellitus.

Small intestinal changes are most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or GI lymphoma being the top differentials. Changes are relatively mild and may reflect acute enteritis or be a variation of normal in this cat. Correlate clinical significance with chronicity/recurrence of GI signs. No overt neoplastic criteria present in the bowel given that curvilnear layering is still intact. Ultrasound cannot differentiate between small cell lymphoma and inflammatory bowel disease, and GI biopsies are recommended for definitive diagnosis, especially if there is a poor response to empirical efforts or recurrence of clinical signs after initial control. Endoscopic biopsy is less invasive but may miss lesions due to inability to obtain samples from all sections of the GI tract, especially the jejunum which is the most common site of development of disease. Surgical biopsies are more likely to be diagnostic but are more invasive. A GI panel (PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation.

Empiric treatment for IBD includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, GI support as needed (anti-nausea, appetite stimulant). Treatment with steroids (budesonide vs prednisolone) is often required – biopsies should be acquired prior to treatment with steroids. Steroids may ultimately be tapered to the lowest effective dose or discontinued in some cases. Use of steroids with diabetes mellitus can make control of DM more challenging.

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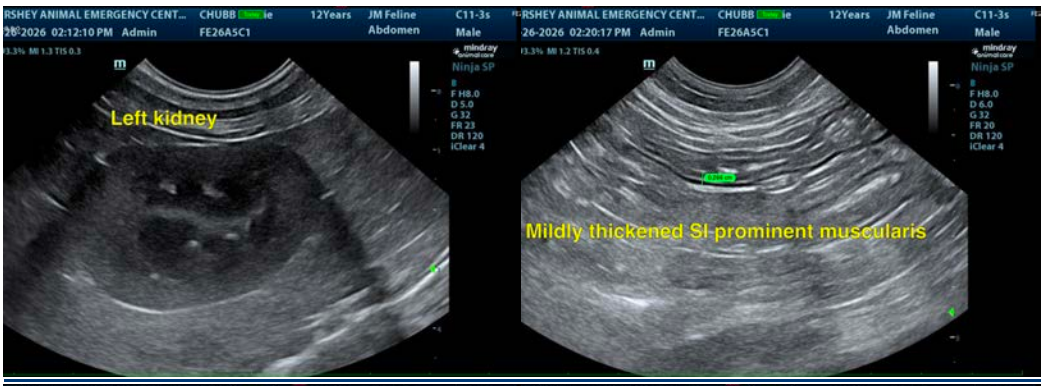

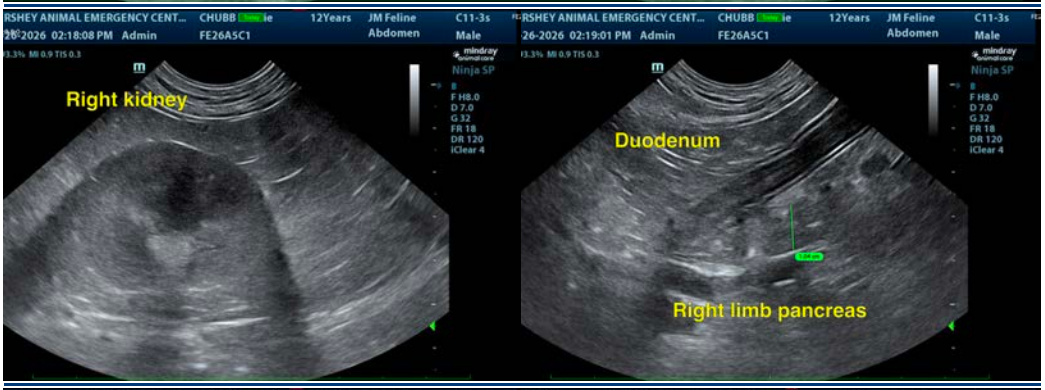

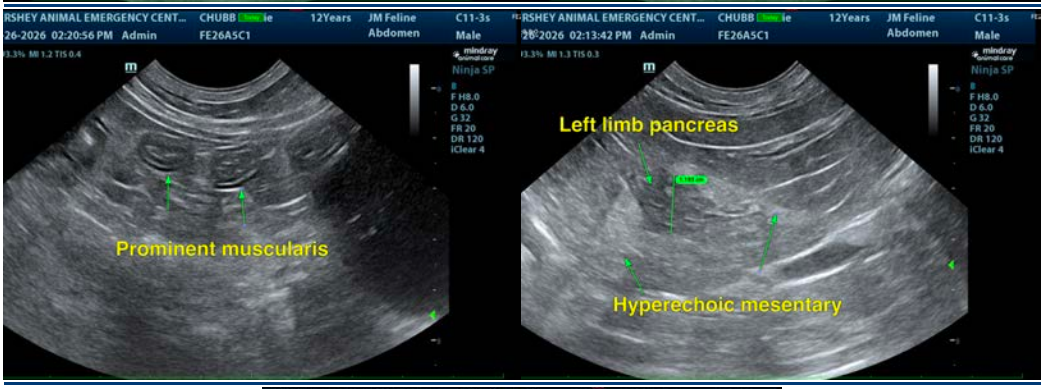

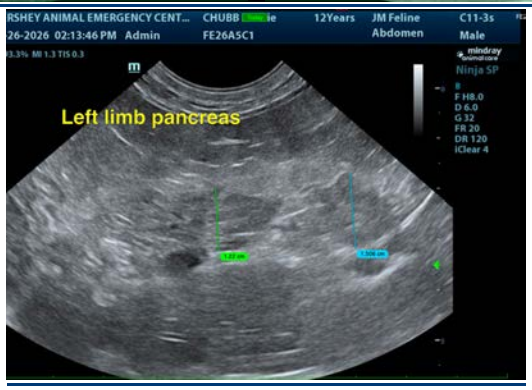

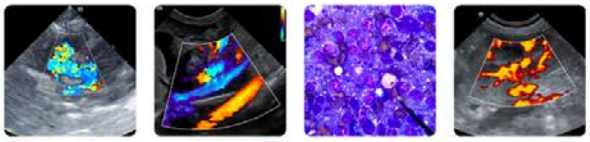

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com