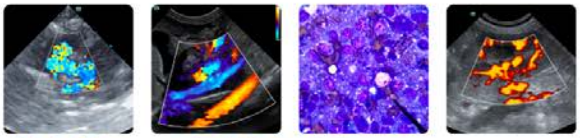




SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

**PATIENT**

Freya Pomper

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

16 Years

**WEIGHT**

6.8 kg

**INTERPRETED BY**

Dr Brittany Sinclair, BVSc(hons), DACVECC

**IMAGING PERFORMED BY**

Amanda Stewart

**HOSPITAL NAME**

New Hamburg VC

**REFERRING VET**

Dr. Von Hausen

**INVOICE**

72019

**DATE**

1/7/26

## PRESENTING CLINICAL SIGNS

Findings: - Known diabetic, currently on 1 unit glargine q 12hr - Recurrent pancreatitis in the past 6 months (2 flare ups) - Chronic intermittent diarrhea and hyporexia in the past 2 months despite switching to RC renal + HP and Z/D canned food - PE WNL except overweight, mild dental disease Current Medications - 1 unit glargine insulin SQ q 12 hr, Proviable DC capsule PO q 24hr, Mirataz ointment TD q 24hr, B12 0.25ml SQ q 7 days for 6 weeks

Abnormal PE/Chem/CBC/UA Results: Values - CBC/Chem/Lytes WNL except mild hypokalemia (3.4) - cPLI mild increase (10.5 ref range 4.4) - UPCR 1.34 (proteinuria) Radiographic Findings N/A Rads - AFAST abdomen 02/05/2025, hypoechoic structure within small intestine, right kidney large with hyperechoic cortex (possibly thickened), left kidney small with reduced corticomedullary definition, hypoechoic pancreases and abdominal fat Primary Question to Be Answered in This Exam Cause of chronic hyporexia/vomiting/diarrhea? Addition tx options? IBD vs lymphoma VS other cause?

## 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 left kidney is small with significant decrease in corticomedullary distinction, consistent with left renal atrophy. Left kidney measures 2.3 cm.

The right kidney is enlarged with a moderate decrease in corticomedullary distinction and mild to moderate pyelectasia with renal pelvis measuring 0.48 cm in diameter. Right kidney measures 4.93 cm.

### *Adrenal Glands*

The left adrenal gland is mildly enlarged, rounded, and hypoechoic. Left measures 0.50 cm in thickness.

The right adrenal gland is visualized on still images only but measures enlarged. Right measures 0.57 cm in thickness.

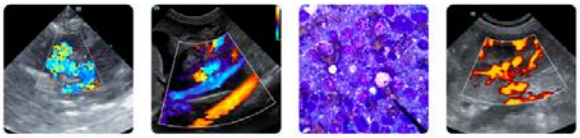
### *Spleen*

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 enlarged in size with slight rounding of lobes and homogenous hyperechoic parenchyma with no specific nodules or masses. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

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





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### *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 increased with normal wall layering and maintenance of normal mucosa/muscularis ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

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 limbs of the pancreas are enlarged and hypoechoic with surrounding hyperechoic mesentery. The capsule is somewhat irregular, and parenchyma has diffuse small hypoechoic structures consistent with diffuse pancreatic cysts.

### *Lymph Nodes*

No clinically significant lymphadenopathy or abnormalities noted.

### *Free Abdomen*

No masses or free fluid were noted.

## ULTRASONOGRAPHIC FINDINGS

- Cystic pancreatitis.
- Thickened small intestines.
- Bilateral degenerative renal changes, left worse than right, with left renal atrophy and compensatory right renomegaly.
- Mild bilateral adrenomegaly.
- Hyperechoic hepatomegaly – consistent with diabetes mellitus.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pancreatic changes are consistent with acute pancreatitis. The irregular capsule and presence of diffuse pancreatic cysts together with history are strongly suggestive of chronic active pancreatitis. Unfortunately, this is a common condition seen in conjunction with diabetes mellitus and can be difficult to control. Treatment 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.

The presence of small intestinal thickening may be a variation of normal or may indicate concurrent IBD. Switching to a select protein diet may be helpful in controlling both pancreatitis and IBD, if present, as patients do not always response to hydrolyzed diet. Ultimately, GI biposy would be needed to differentiate from lymphoma or other causes of pancreatic and small intestinal changes.

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The degenerative renal changes are likely age related degeneration. Left renal atrophy is the likely cause of right renomegaly, with compensatory hypertrophy. The inciting cause for left renal atrophy is not apparent on ultrasound.

Hepatic parenchymal changes are a common finding in the face of diabetes mellitus, though other endocrinopathy (hypothyroidism), infectious or inflammatory hepatitis (bacterial, viral, auto-immune other), and neoplasia among other things remain possibilities. Especially if elevated liver enzymes are present, fine needle aspirate is recommended to further define.

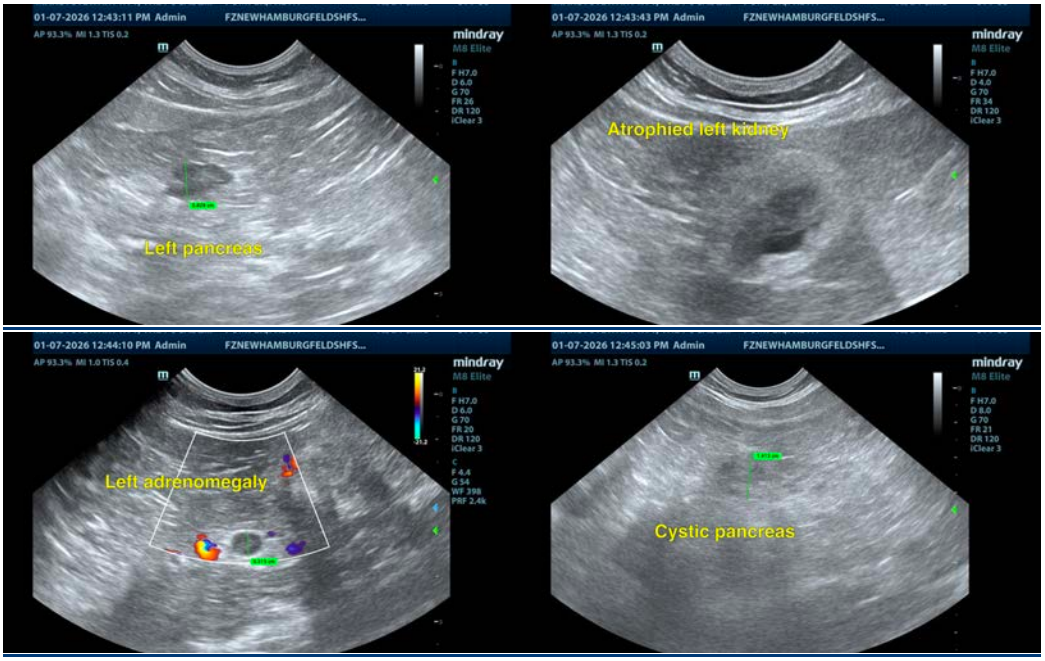
Bilateral adrenomegaly is of uncertain clinical significance. It may be a variation of normal, may represent response to stressful illness or may indicate underlying hormonal disease.

Hyperadrenocorticism, hyperaldosteronism and acromegaly are endocrine diseases which can cause adrenomegaly in the cat. Adrenal gland function testing could be considered if indicated (plasma aldosterone level - requires concurrent assessment of potassium, IGF-1, LDDST).

Hyperaldosteronism is a common cause of systemic hypertension. There is often, but not always, a high/high normal sodium and low/low normal potassium with this disease.

Hyperadrenocorticism and acromegaly are often, but not always, seen in cats with uncontrolled diabetes mellitus.

Rarely adrenomegaly can be seen with infiltrative disease such as lymphoma or fungal disease, but this is generally not the only sign of these diseases.



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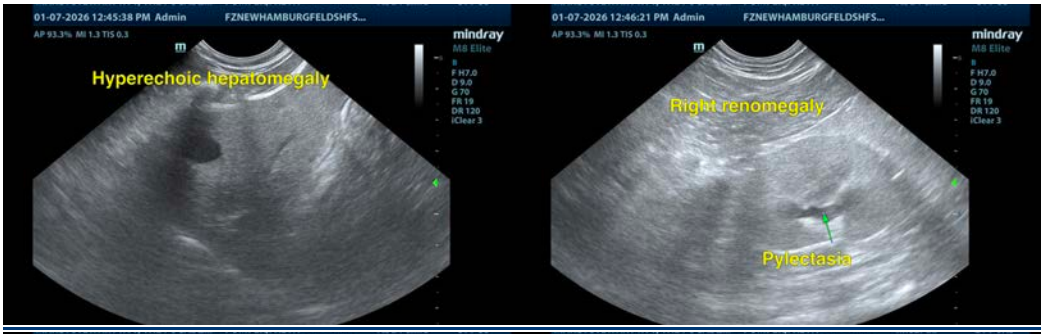


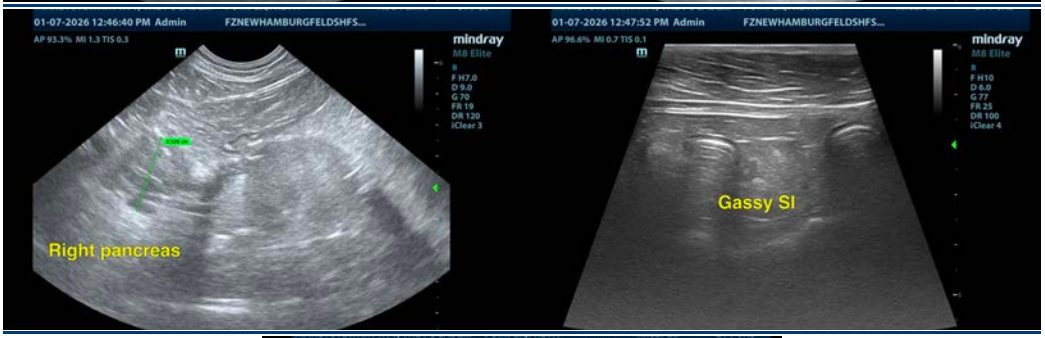


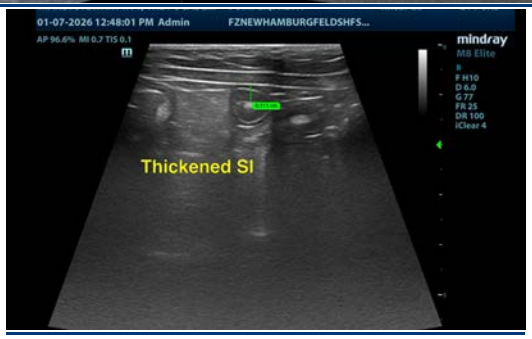


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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