



PATIENT PRESENTING CLINICAL SIGNS

Sally Pineau
SPECIES
 Feline
 Presented several times over the last few days with hematemesis, lethargy and anorexia. Admitted to hospital April 4th for more aggressive care, start IVF, place NG feeding tube for trickle feed, injectable meds. PE unremarkable, mildly tense on abdominal palpation, ocular discharge, some dental disease. Start Maropitant, ondansetron, metronidazole, ampicillin, pantoprazole

BREED
 DSH
 Abnormal PE/Chem/CBC/UA Results: ALT 155(12-130) Tbili 29(0-15) U/A - UBG 12mg/dL BIL 6mg/dL Protein 30mg/dL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

SEX
Urinary System

Spayed Female
 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.

AGE
 13 Years
WEIGHT
 6.15 kg
 Both kidneys are normal in size, shape, and position. Corticomedullary definition is moderately decreased. Kidneys are hypoechoic overall, which is likely enhanced by hyperechogenicity caused by peritonitis. Right renal pelvis is very mildly dilated, consistent with fluid therapy. The left kidney measured 4.24 cm in length. The right kidney measured 4.59 cm in length.

INTERPRETED BY
Adrenal Glands

Dr Brittany Sinclair, BVSc(hons), DACVECC
 Adrenal glands are visualized and measured on still images only. Resolution is inadequate to assess glandular detail or confirm measurement. The left adrenal gland measured 0.48 cm in thickness. The right adrenal gland measured 0.42 cm in thickness.

IMAGING PERFORMED BY
Spleen

Crystal Hill
 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.

HOSPITAL NAME
Liver

Beatties PH Stoney Creek
 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. A small anechoic cyst is visible.

REFERRING VET
 Dr. Song
INVOICE
 14873
 The gallbladder is nearly completely empty with a hyperechoic wall. There is fluid visible within the gallbladder fossa.

DATE
 04/06/26
Gastrointestinal
 The stomach is significantly distended with echogenic nonshadowing material most consistent with fluid. 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.



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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. 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 limb and body of the pancreas are enlarged and hypoechoic with surrounding hyperechoic mesentery. No fluid accumulations visualized. No mass effect consistent with pancreatic neoplasia visualized.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

There is scant anechoic effusion visible.

Subcutaneous edema is apparent, likely from subcutaneous fluid administration.

Mesentery is diffusely hyperechoic consistent with peritonitis.

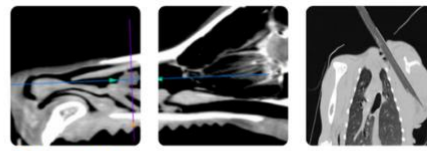
ULTRASONOGRAPHIC FINDINGS

- Pancreatitis.
- Peritonitis.
- Significant gastric distention with echogenic nonshadowing contents.
- Liver cyst.
- Scant abdominal effusion.
- Empty gallbladder with surrounding free fluid.
- Aging renal changes.
- Subcutaneous edema- consistent with previous subcutaneous fluid administration.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pancreatic changes are consistent with severe pancreatitis. The prognosis of acute pancreatitis is largely dependent on the severity of clinical signs and response to treatment. Mortality is reported as high as 25% and secondary organ dysfunction and systemic inflammatory response syndrome can occur as inflammation progresses. Ultrasonographically, pancreatic inflammation is severe in this patient. Ultimately the need for hospitalization for treatment is based on the patient's cardiovascular stability, pain and appetite. Hydration and enteral nutrition are key factors in positive outcomes and if these cannot be achieved on an outpatient basis, hospitalization for 24-hour care is strongly recommended.

Treatment for pancreatitis is entirely supportive and involves fluid support, GI support - anti-nausea (ondansetron, Cerenia 2mg/kg PO SID), appetite stimulation (mirtazapine, elura), analgesia (buprenorphine, gabapentin) and enteral nutrition as needed. Antibiotics are generally not warranted



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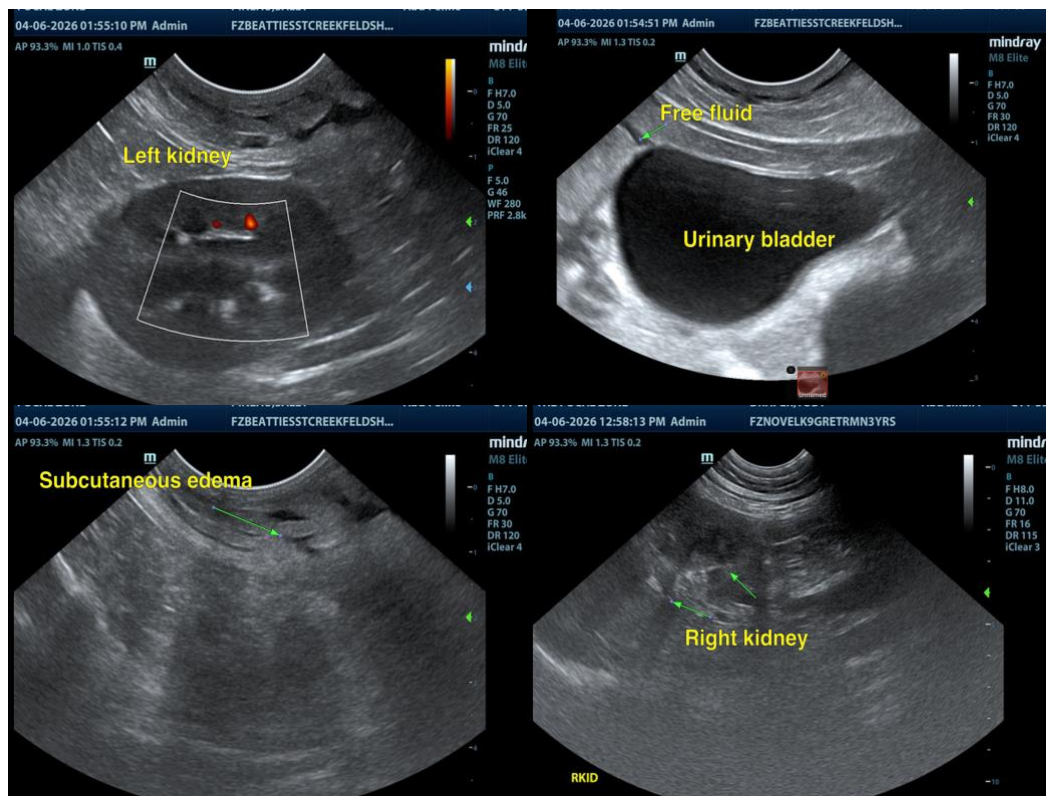
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for acute pancreatitis as it is usually sterile, however given the severity of inflammation I would use antibiotics (ex Unasyn +/- fluoroquinolone) in this case. Intravenous antibiotics are preferred to ensure absorption and decrease GI side effects of oral antibiotics which can lower appetite compromising treatment and recovery. Anti-inflammatory steroids may be tried in an attempt to reduce inflammation if traditional supportive care is inadequate. Serial imaging is indicated to monitor response to treatment.

Abdominocentesis with plan for fluid analysis and cytology, as well as contemporaneous assessment of patient's serum total bilirubin and the abdominal fluid bilirubin level is strongly recommended. Hyperbilirubinemia may be secondary to hepatitis due to inflammation or other primary liver disease. However, given the empty gallbladder, there is a concern for potential gallbladder rupture (not directly visualized on ultrasound) and abdominal fluid assessment is recommended to further investigate. Liver FNA should be considered to further define liver value elevations. Small hepatic cyst is likely incidental.





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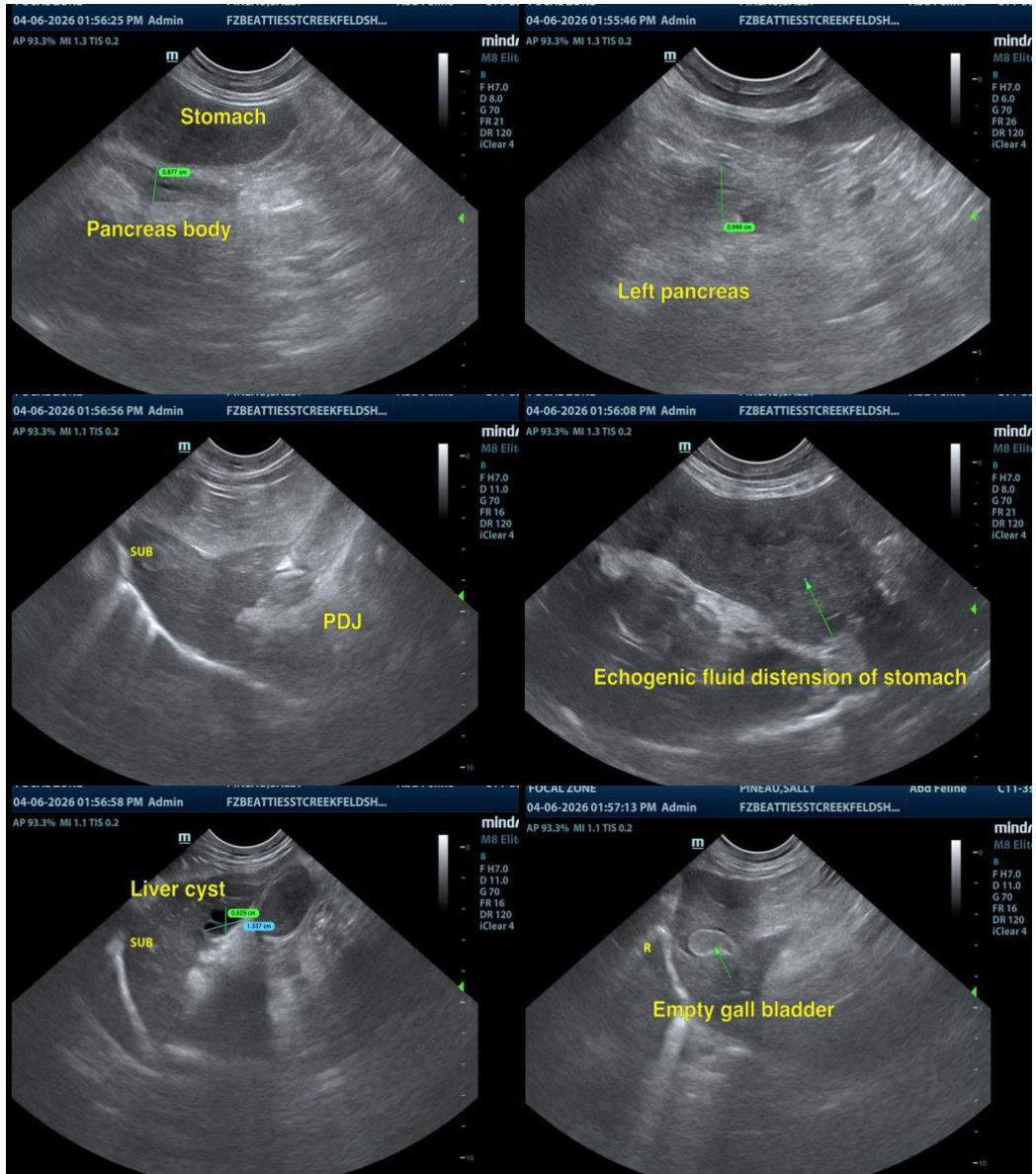
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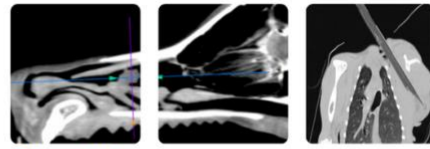
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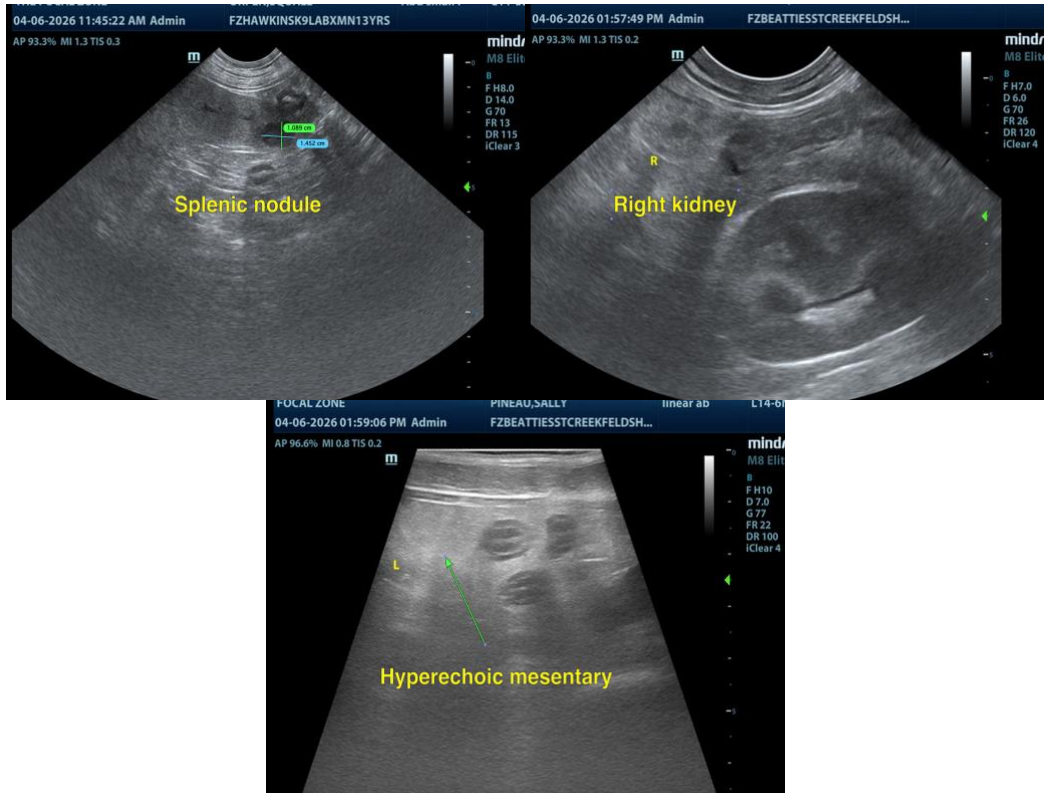
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com