



**PATIENT**

Ash Speight

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

4 Years

**WEIGHT**

Not Provided

**INTERPRETED BY**

Kathleen Sennello DVM,  
MS, Diplomate ACVIM  
(Small Animal Internal  
Medicine)

**IMAGING  
PERFORMED BY**

Jessica Miller

**HOSPITAL NAME**

Andover AH

**REFERRING VET**

Dr. Bihlear

**INVOICE**

44262

**DATE**

1/17/23

**PRESENTING CLINICAL SIGNS**

At annual owner reported patient frequently vomits- tried smaller portions but did not resolve; r/o IBD vs other. No current meds.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.87 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.73 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.25 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.46 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

**Spleen**

The spleen is subjectively normal in size (0.83 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

**Liver**

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

**Gastrointestinal**

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. 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. Jejunum wall measures 0.20 cm. Visualized peristalsis appears appropriate. There are occasional areas of small bowel that appear slightly fluid dilated and have a somewhat focally corrugated appearance. No evidence of shadowing foreign material is observed. Findings are most consistent with focal mild enteritis, although passing foreign material cannot be ruled out.

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 pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

**Free Abdomen**

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes and a prominent lymph node near the ileocecal junction. These measure at 0.31 and 0.34 cm. The omentum is slightly hyperechoic in the region of the abnormal small intestine and the ileocecal junction.

**ULTRASONOGRAPHIC FINDINGS**

- Echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Mildly fluid dilated/corrugated area of small intestine – The significant of this is unclear. This could be consistent with focal mild enteritis or less likely passing foreign material.
- Occasional prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The changes observed on today's scan are relatively mild. There are no overt mass effects or severe lymphadenopathy noted, and there is no evidence of an obstructive pattern. There is a focal section of small intestine that appears mildly fluid dilated and somewhat corrugated in appearance. Correlate this with abdominal radiographs. Findings are most consistent with focal enteritis, although a small area of passing foreign material, etc. cannot be ruled out. Continued monitoring is warranted.

Unfortunately, there are many causes for chronic vomiting that cannot be diagnosed by ultrasound alone. Consider such differentials as food allergy/dietary intolerance, GI parasitism, chronic pancreatitis, IBD and less likely neoplasia, etc..

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Consider chronic probiotic therapy.
- If symptoms persist, consider reimaging and/or obtaining GI biopsies, provided there is no evidence of metabolic disease on lab work and thyroid testing.



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There is a small amount of dependent echogenic debris visualized in the urinary bladder. Recommend a urinalysis and culture.

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Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

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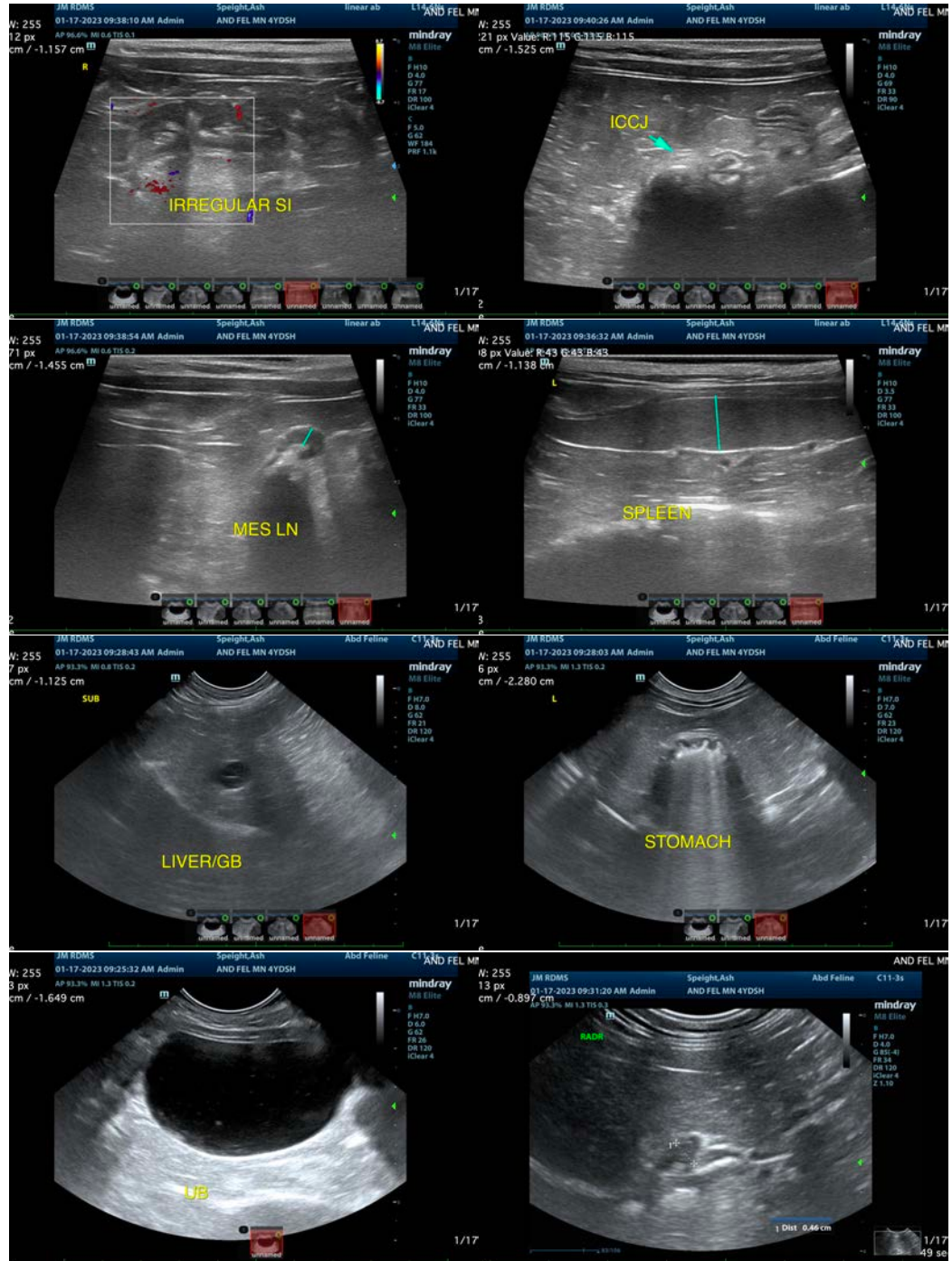
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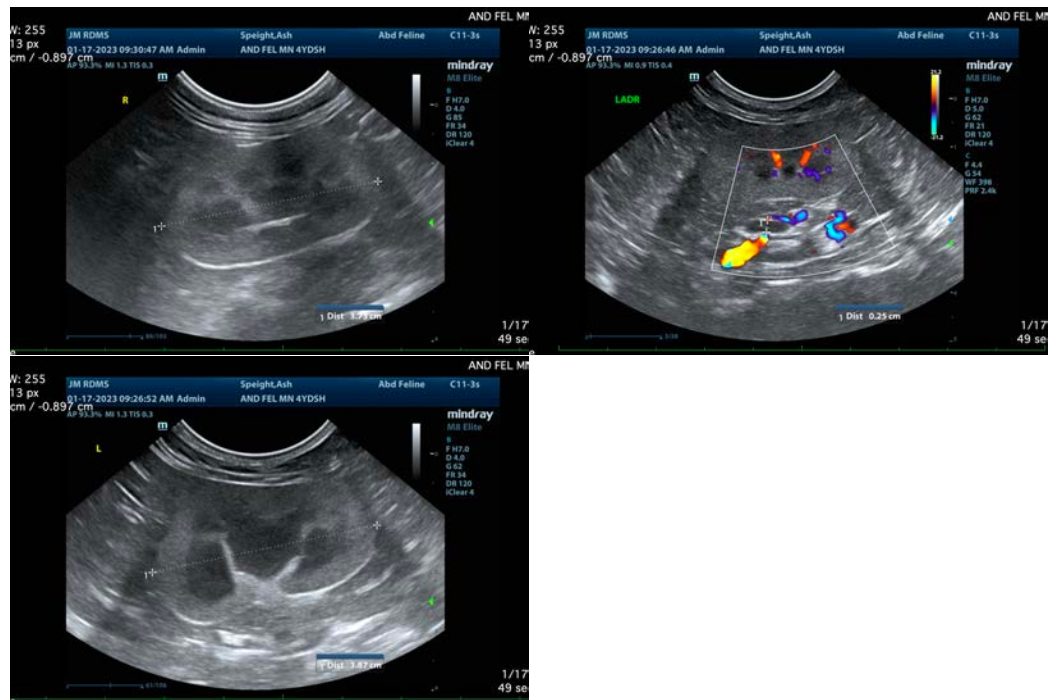
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**IMAGING PERFORMED BY**

Jessica Miller

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com

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