

PATIENT

Milano Dibellis

SPECIES

Feline

BREED

Ragdoll X

SEX

Spayed Female

AGE

8.8 Years

WEIGHT

11.8 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Tam Mengine

INVOICE

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DATE

1/20/22

PRESENTING CLINICAL SIGNS

Presumptive dx in 3/21, based on diarrhea, started on prednisolone & z/d diet. Seen 6/21 for acute respiratory distress - diagnosed with asthma, increased prednisolone dose for 2 weeks & ongoing terbutaline - signs resolved. Seen repeatedly since 9/21 for inappetence, vomiting and diarrhea - resumed pred, but client felt it then made cough recur, so it was stopped. Currently managing signs with cerenia & tylosin. Most recent CBC / Chem (12/21) - Alb 2.0, else unremarkable, fPL normal, multiple negative fecals.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. 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 cystic calculi.

The left kidney was normal in size (3.62 cm), but irregular in shape. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. In the transverse view there is irregular hypoechoic tissue measuring approximately 0.47 cm x 1.9 cm. This tissue is either adjacent to or associated with the left kidney. Renal vasculature is normal.

The right kidney has a normal shape and size (3.9 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.33 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 0.37 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.

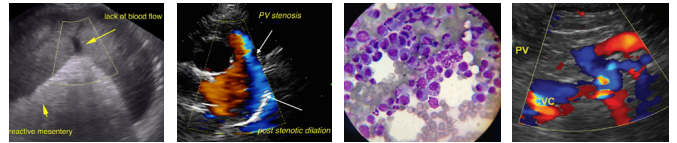
Spleen

The spleen is subjectively normal in size, 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 hypoechoic with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder is somewhat abnormal in appearance, in that it appears bilobed. There is no evidence of primary gallbladder disease. The wall of the gallbladder is not thickened, and it has a smooth mucosal surface. Luminal contents are primary anechoic, and the cystic and common bile duct are normal/not visible.



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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 uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measured 0.4 cm. Jejunum wall measured 0.32, 0.31, 0.29 cm. Visualized peristalsis appears appropriate. There is at least one area of focal bowel where the layering gets indistinct and bowel wall thickness increases. One such area measures at 0.46 cm in thickness. Additionally, the duodenum appears focally corrugated.

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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Wall measures 0.11 cm. 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.

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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.

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Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of increased echogenicity around the abnormal bowel.

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PRIMARY FINDINGS

- Abnormal hypoechoic tissue adjacent to or associated with the left kidney – Possible differentials include renal neoplasia or focal pancreatic tissue, etc.
- Diffusely prominent muscularis layer with focal areas of bowel thickening and reduced detail of layering – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. A reduction in the detail of wall layering favors either severe intestinal disease or neoplastic infiltration. Biopsy is recommended.
- Heterogeneous, slightly hypoechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.

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SECONDARY FINDINGS

- Bilobed gallbladder – This is likely an incidental finding.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

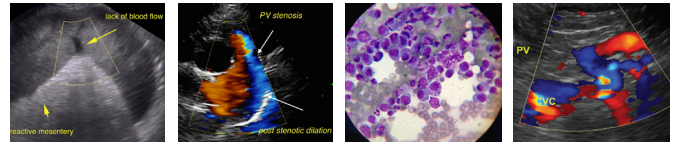
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There is diffuse bowel thickening and prominence of the muscularis layer. Additionally, there are some areas of small intestine that appear focally thickened with reduced detail of layering. These findings in combination with the low albumin and history of GI disease increase my concern for either severe IBD or underlying neoplasia. Additionally, there is some abnormal tissue adjacent to the left kidney. This tissue could be arising from the kidney or could be in very close proximity. A fine needle aspirate of this area could be considered, as well as a fine needle aspirate of the liver.

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If cytology of the liver and abnormal area adjacent to the kidney is not diagnostic, then it is likely that GI biopsies will be necessary to try to obtain more information. It is possible that the steroid therapy has muted the appearance of the lesions, making it somewhat more difficult to diagnosis. A definitive focal mass lesion is not observed.

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While I strongly suspect there is a protein losing enteropathy present, you could consider a urine protein/creatinine ratio and a liver function test to rule out concurrent renal or liver disease.

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Recommend 3-view thoracic radiographs.

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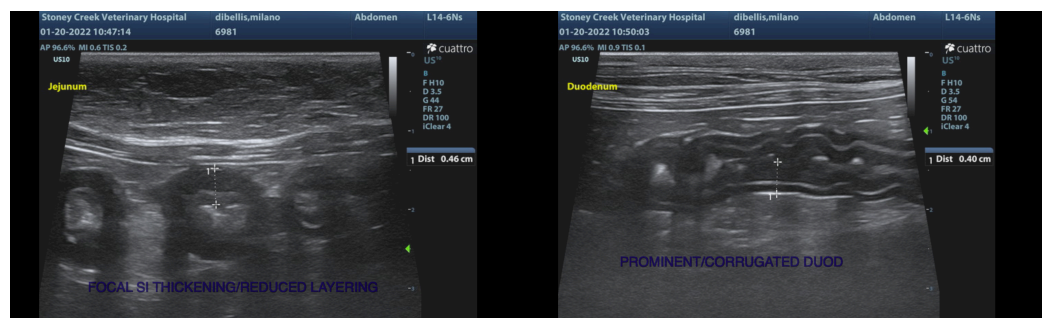
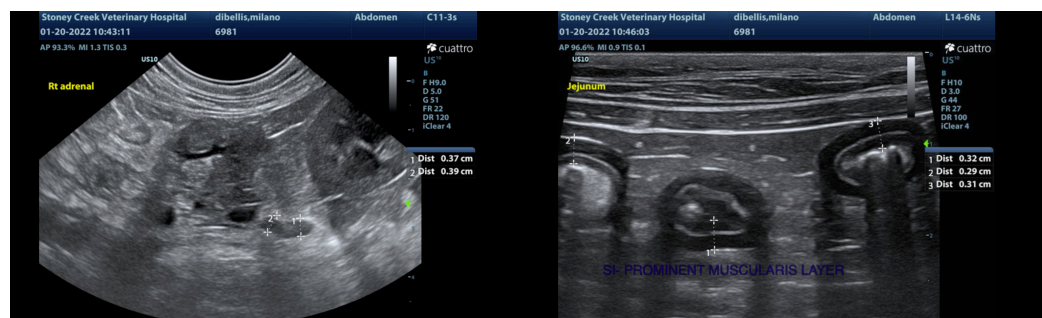
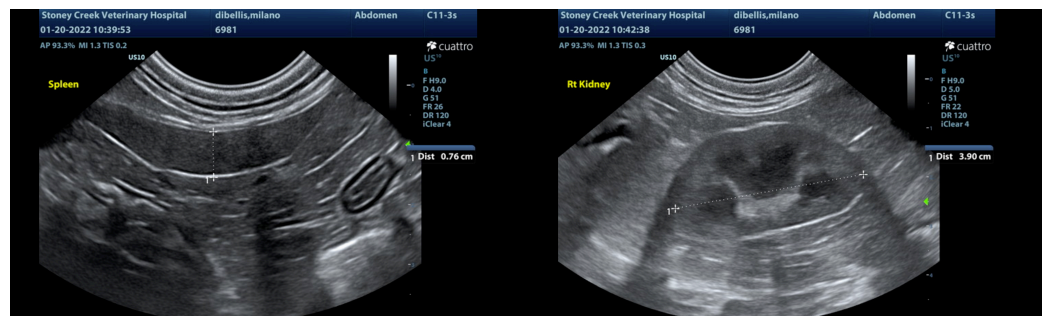
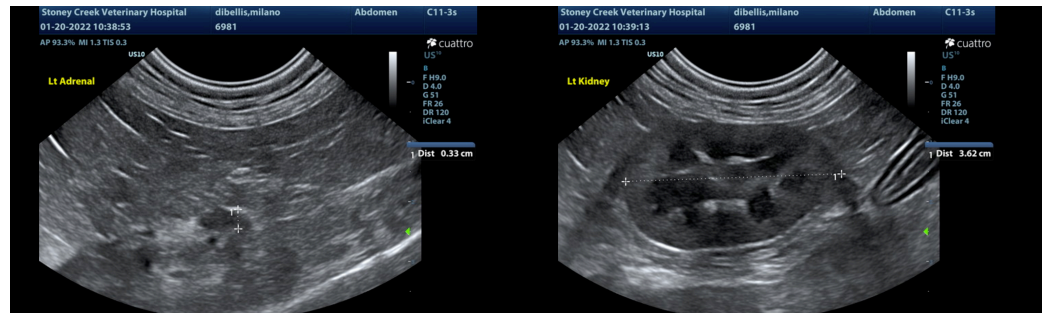
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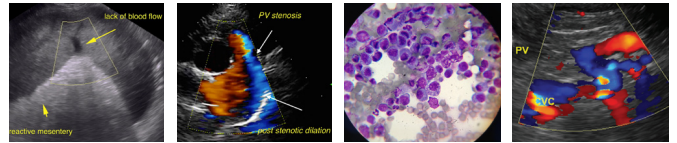
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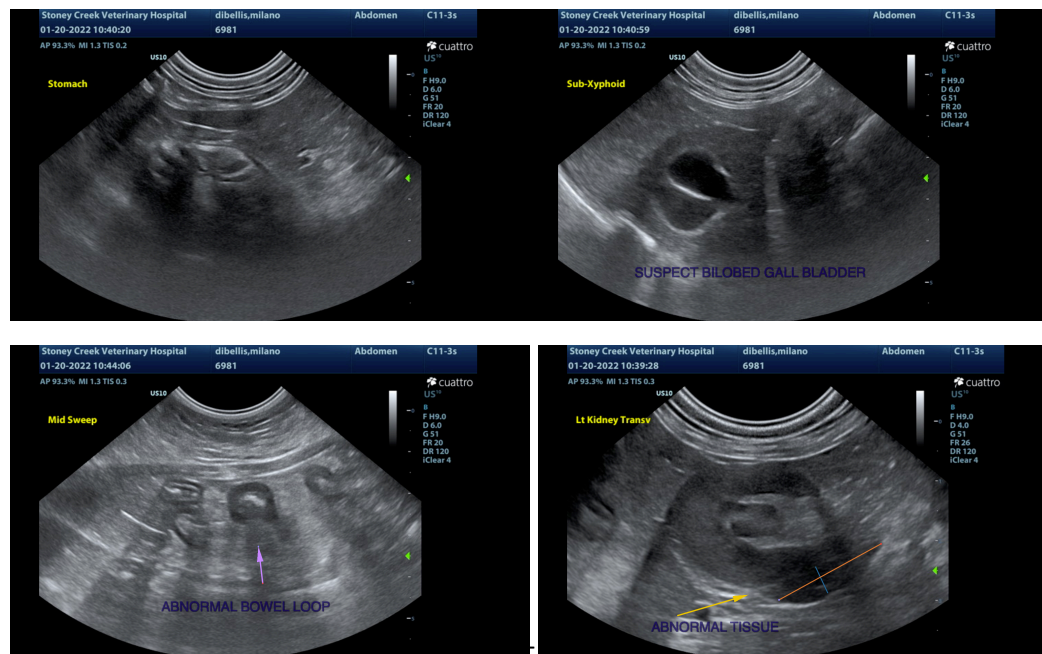
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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