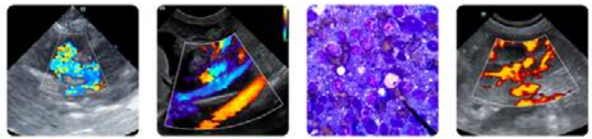


SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Marco Yackshaw

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

10 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Brittany Wolfe

HOSPITAL NAME

HomeVets

REFERRING VET

Dr. Brittany Wolfe

INVOICE

72537

DATE

1/28/26

PRESENTING CLINICAL SIGNS

Acute on chronic vomiting. P has recently been having severe vomiting episode. Sometimes multiple times a day and sometimes not able to keep much food down in a given day. Recent weight loss.

Abnormal PE/Chem/CBC/UA Results: CBC: borderline anemia 30.7% Chem: new mild sdma elevation 17, other renal values stable T4 borderline low USG 1.014

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 has a normal shape and size (3.95 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 (3.79 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The right adrenal gland is normal in size measuring 0.36 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.

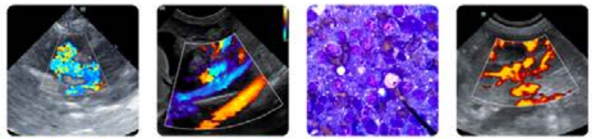
Spleen

The spleen is subjectively normal in size (0.80 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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains a mild amount of fluid. A significant portion of the stomach wall appears relatively normal, measuring at 0.29 cm with intact wall layering. There is an extensive focal section of gastric wall that has more severe thickening, measuring at 0.80 cm, with a significantly thickened submucosal layer.

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. Duodenum wall measures 0.25 cm. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. 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 pancreas is prominent and hypoechoic as compared to the surrounding isoechoic 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. A pancreaticoduodenal lymph node measures 0.47 cm x 0.69 cm. Mesenteric lymph nodes are visible measuring 0.18 cm and 0.19 cm. A prominent cranial abdominal lymph node near the stomach measures 0.60 cm x0 .79 cm. The omentum is hyperechoic in the cranial abdomen.

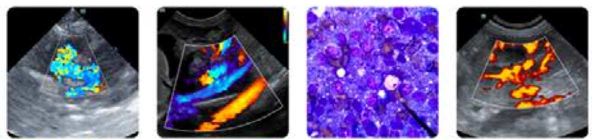
ULTRASONOGRAPHIC FINDINGS

- Prominent, hypoechoic right limb of the pancreas – Findings are most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Focal thickening of the gastric wall with prominent submucosal layer and mildly reduced detail of wall layering – Findings could be consistent with infiltrative disease such as neoplasia (carcinoma, round cell neoplasia, etc.), eosinophilic infiltrates, fibrosis, severe gastritis, edema, etc.
- Cranial abdominal lymphadenopathy – Findings are most consistent with highly reactive or neoplastic lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A gastric wall appears focally thickened with somewhat reduced detail of wall layering, but the thickening involves primarily the submucosal layer. This could be consistent with an early neoplastic process (round cell neoplasia, carcinoma, other) or other infiltrative disease (eosinophilic infiltrates, granulomatous disease, etc.) or even severe gastritis. If the thickening is persistent despite treatment, surgical biopsies of the gastric wall may be necessary (provided you cannot get a diagnosis based on a cytologic sample).

There are changes in the pancreas most consistent with chronic pancreatic remodeling and possible chronic pancreatitis. Correlate with PLI level and consider concurrent treatment for pancreatitis.



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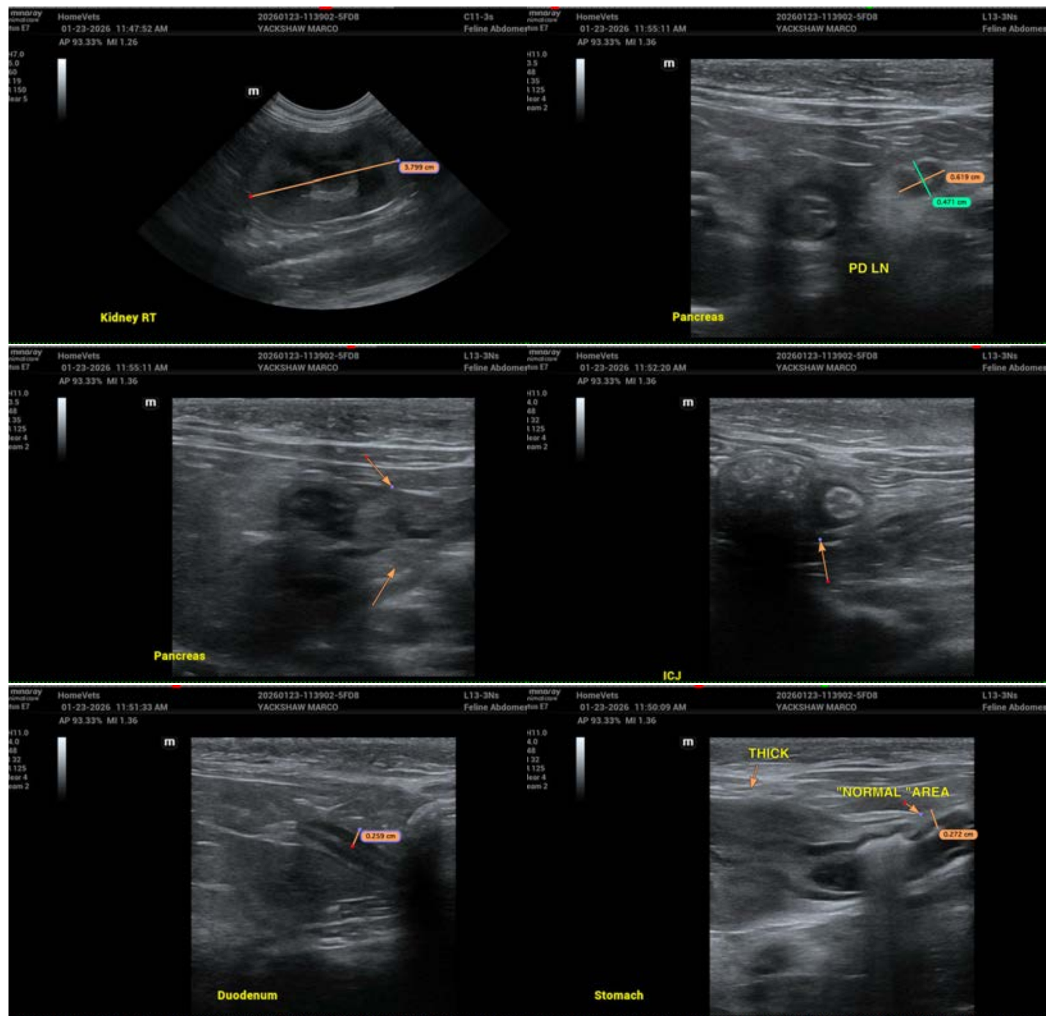
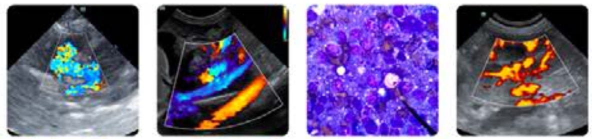
There are cranial abdominal lymph nodes that are somewhat prominent. I suspect these would be challenging to sample, but if a safe window is available, you could consider a fine needle aspirate.

If cytologic evaluation is non-diagnostic, this could be seen with a neoplasm that does not exfoliate well (carcinoma, etc.) or with an inflammatory process. Initial treatment could be consistent with gastritis, with a hydrolyzed protein prescription diet, symptomatic therapy, possibly treatment for helicobacter, etc. If symptoms are persistent and/or the thickening is persistent, consider surgical biopsies of the stomach, small intestine, and prominent lymph nodes.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).





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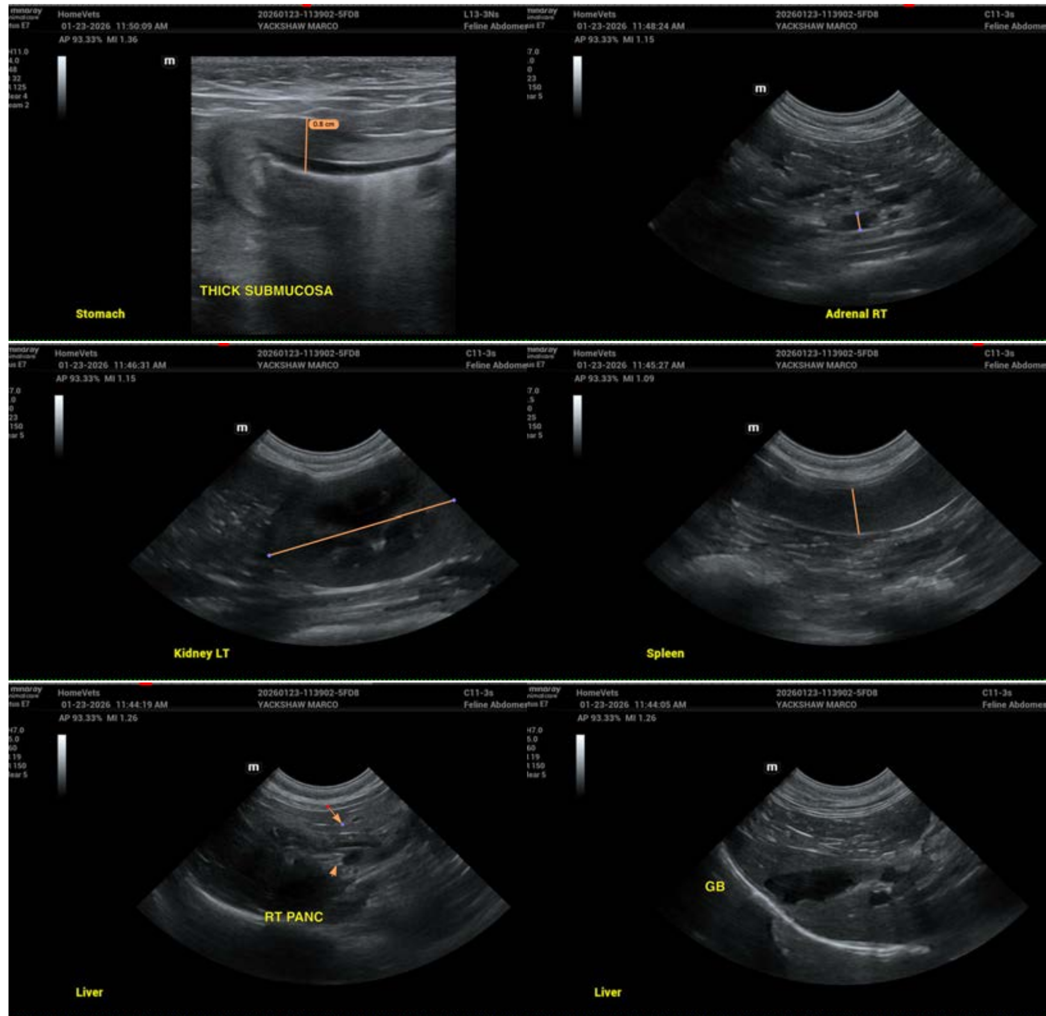

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com