

**PATIENT**

Izzy Cat Care

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

16 Years

**WEIGHT**

8.7 Pounds

**INTERPRETED BY**Kathleen Sennello DVM,  
MS, Diplomate ACVIM  
(Small Animal Internal  
Medicine)**IMAGING  
PERFORMED BY**

Amy Mayhew, LVT

**HOSPITAL NAME**

SVS Imaging MI

**REFERRING VET**Cat Care of Rochester  
Hills - Dr. Sloan**INVOICE**

43994

**DATE**

1/5/23

**PRESENTING CLINICAL SIGNS**

Chronic GI problems; AUS performed 13 months ago Presumed GI lymphoma Repeating AUS due to overall decline, development of UTI (possible pyelonephritis- BW and culture pending), and passage of dark, slightly tarry stools today. Also, increased vomiting (digested food and bile) last few weeks.

Abnormal PE/Chem/CBC/UA Results: Very gassy and bloated/ somewhat cushingoid Tender on palpation of abd- unsure if kidneys or U GIT (she's cranky at the best of times, so hard to localize area of discomfort)

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The urinary bladder is moderately distended with mild primarily suspended echogenic debris and some dependent shadowing/sandy 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, sandy debris or small calculi. Correlate findings with abdominal radiographs, urinalysis and culture.

The left kidney has a normal shape and size (3.23 cm) with pyelectasia at 0.28 cm. Overall echogenicity is slightly hyperechoic with poor 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.47 cm) with pyelectasia at 0.17 cm. Overall echogenicity is slightly hyperechoic with poor 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.51 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. There is a small hyperechoic focus, possibly consistent with mineralization noted.

The right adrenal gland is normal in size measuring 0.34 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 (1.0 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.

**IMAGING PERFORMED BY**SVS Mobile Imaging MI 734-637-7711  
svsimagingmi@gmail.comEDUCATIONAL TELECONSULTATION SERVICES™  
1-800-838-4268 info@sonopath.com SonoPath.com**PATIENT**

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***Gastrointestinal***

The stomach contains moderate fluid/ingesta. 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.

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 0.27 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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. Colon wall measures 0.17 cm.

***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. Prominent pancreatic duct noted at 0.29 cm.

***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 hyperechoic in the cranial abdomen around the pancreas and kidneys.

**ULTRASONOGRAPHIC FINDINGS**

- Decreased corticomedullary distinction in both kidneys with bilateral pyelectasia – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the kidney(s) could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Dependent sandy debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Hypoechoic, prominent pancreas with prominent pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Moderate fluid and gas within the gastric lumen – Correlate with feeding history. If the patient was adequately fasted, then consider the possibility of delayed gastric emptying or a partial outflow tract obstruction (none observed).

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Based on the appearance of the kidneys and the positive urine culture, there would be concern for possible pyelonephritis. Enterococcus infections are notoriously difficult to treat and often relapse. Recommend strict culturing, lifelong probiotic therapy, and if an underlying cause for the urinary tract infections can be identified, this would be very helpful (recommend exam of external genitalia, neuro exam, etc.).

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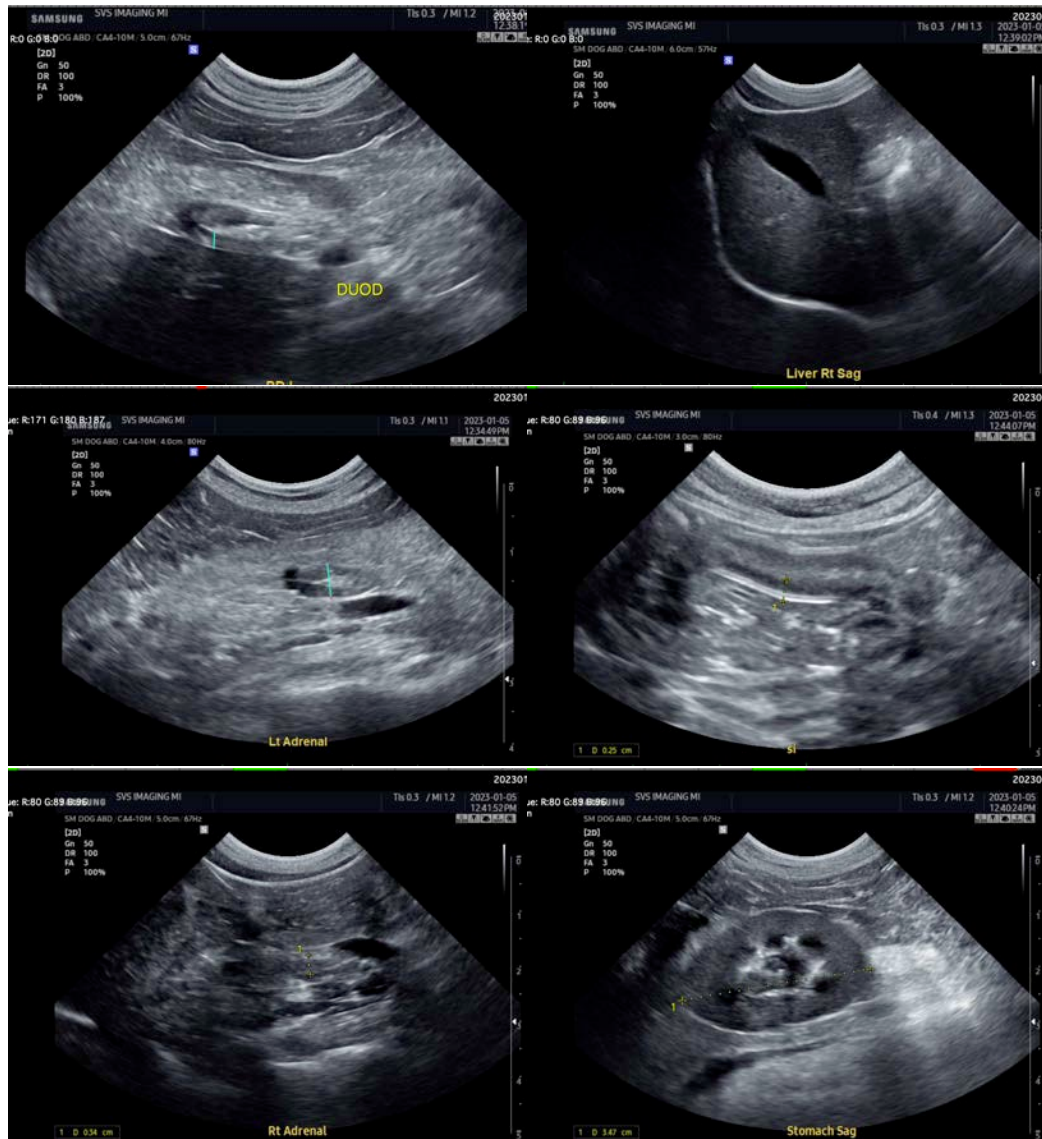
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The pancreas is prominent and hypoechoic, and there is surrounding hyperechoic mesentery. This hyperechoic mesentery could be associated with inflammation around the kidneys or the pancreas. The appearance of the pancreas itself would be most consistent with mild current pancreatitis or a previous episode of pancreatitis. Correlate with a qualitative fPLI level and consider empirical treatment for pancreatitis.

No significant GI abnormalities were noted on today's exam. That certainly does not rule out the possibility of underlying gastrointestinal disease. General recommendations could include:

- 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.
- Recommend chronic probiotic therapy.
- If symptoms persist, consider obtaining GI biopsies.



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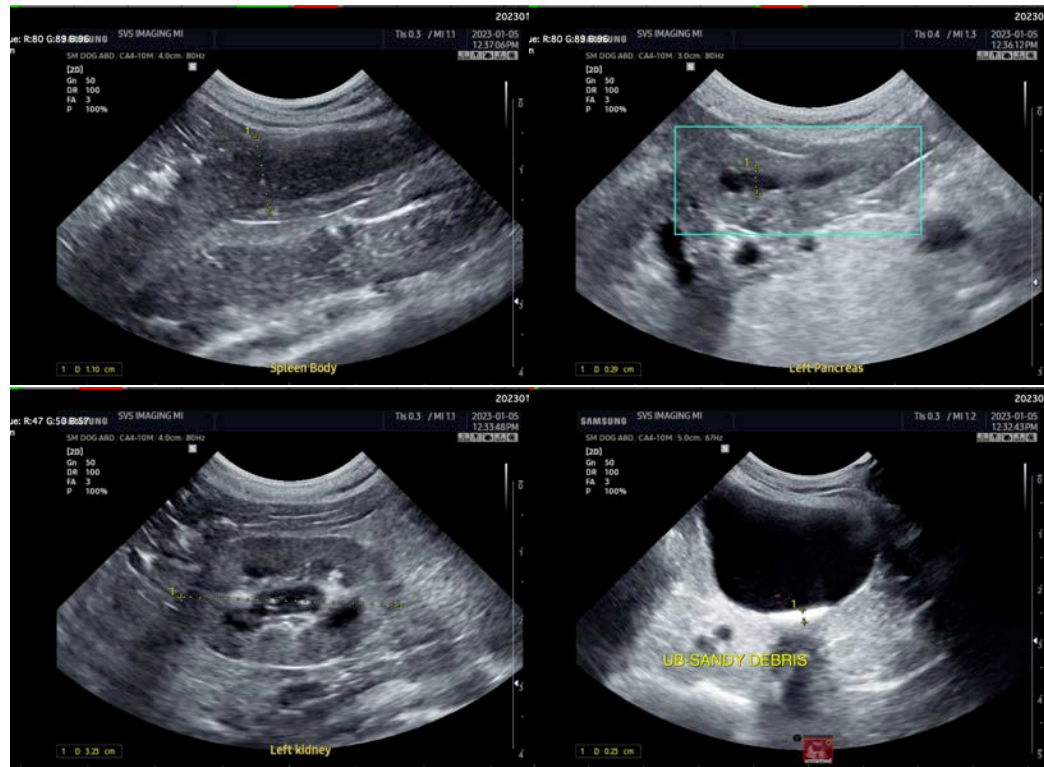
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com