



PATIENT

Kali Barker

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years 11 Months

WEIGHT

4.2 kg

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Alastair Westcott

HOSPITAL NAME

Dr. Alastair Westcott

REFERRING VET

Dr. Alastair Westcott

INVOICE

26072

DATE

10/5/21

PRESENTING CLINICAL SIGNS

There has been a one month history of frequent vomiting and some coincident weight loss. Abnormal PE/Chem/CBC/UA Results: Bloodwork taken 2 weeks ago suggested moderate thrombocytopenia but was otherwise unremarkable. A urinalysis was not performed at that time. Radiographs taken were essentially unremarkable with perhaps some retroperitoneal, mottled, wispy opaque tendrils sometimes associated with mild effusion or inflamed fat.

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 (3.42 cm). Overall echogenicity is slightly hyperechoic with poor 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.

The right kidney has a normal shape and size (3.79 cm). Overall echogenicity is slightly hyperechoic with poor 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 0.34 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 0.27 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/borderline enlarged in size (1.02 cm – normal is <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 mildly 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 lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts 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. The pyloric antrum wall appears prominent, measuring 0.3 cm with a prominent muscularis layer. There is no irregularity noted, and no mass effect.

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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. Jejunum wall measures 0.18 cm. Duodenum wall measures 0.2 cm. Visualized peristalsis appears appropriate. While no significant thickening is visualized, there are several areas of corrugated bowel consistent with multifocal enteritis.

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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.

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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.

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Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. Mild mesenteric lymphadenopathy is present. There are prominent lymph nodes surrounding the colon at the root of the mesentery, measuring 0.29, 0.34 cm. The omentum is generally of increased echogenicity around the caudal abdomen, colon, and the cystic structure described.

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Other

There is a somewhat irregular, hypoechoic, possibly fluid-filled structure measuring 0.56 cm x 0.73 cm in the caudal abdomen, surrounded by hyperechoic mesentery. A direct association with other structures is not visualized.

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PRIMARY FINDINGS

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- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

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- Subjectively thickened pylorus and multifocal areas of corrugated bowel – most consistent with enteritis/inflammation. These findings are non-specific but consistent with a gastroenteropathy.

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- Amorphous, hypoechoic structure in caudal abdomen surrounded by hyperechoic mesentery – This could be a cystic structure, part of the pancreas, or its own discreet lesion. Necrotic fat could have this appearance. FNA pending per history.



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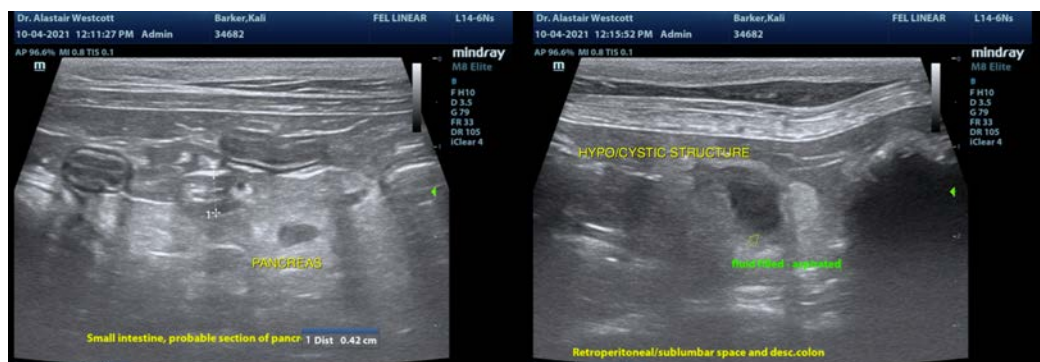
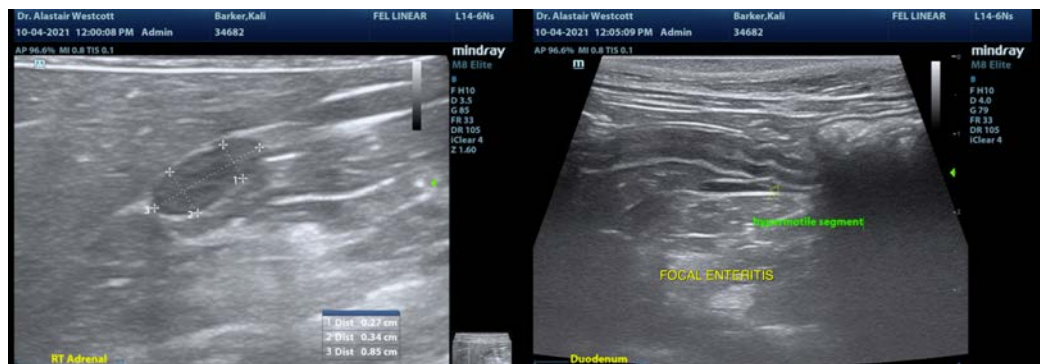
SECONDARY FINDINGS

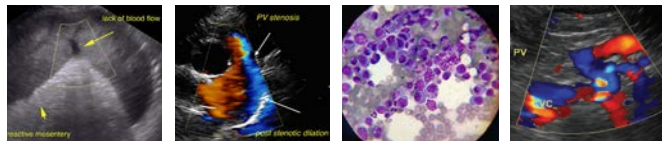
- Echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Prominent wall of the pylorus – This could be normal for this individual, or could be consistent with inflammation, infiltration, edema, etc.
- Mild mesenteric lymphadenopathy – 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

There appears to be a source of inflammation in the abdomen considering both the pancreas and small intestine. Associated lymph nodes are prominent, and the mesentery is hyperechoic. The relevance of the amorphous cystic structure is unknown. It is excellent that there is a fine needle aspirate pending. Primary differentials would be necrotic fat or pancreatic abscess or cyst (?).

Recommend GI panel with a quantitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and GI tract. The focal areas of enteritis are somewhat unusual for IBD. I do not see evidence of foreign material, but this cannot be ruled, and it can sometimes be associated with pancreatitis. Consider symptomatic therapy for pancreatitis and a diet change to a hydrolyzed protein or novel protein diet if the patient will eat it. If symptoms are not resolving, you may need to consider exploratory to obtain GI stomach/pyloric biopsies, pancreatic and liver biopsies. Recommend urinalysis and culture due to the echogenic debris in the urinary bladder.





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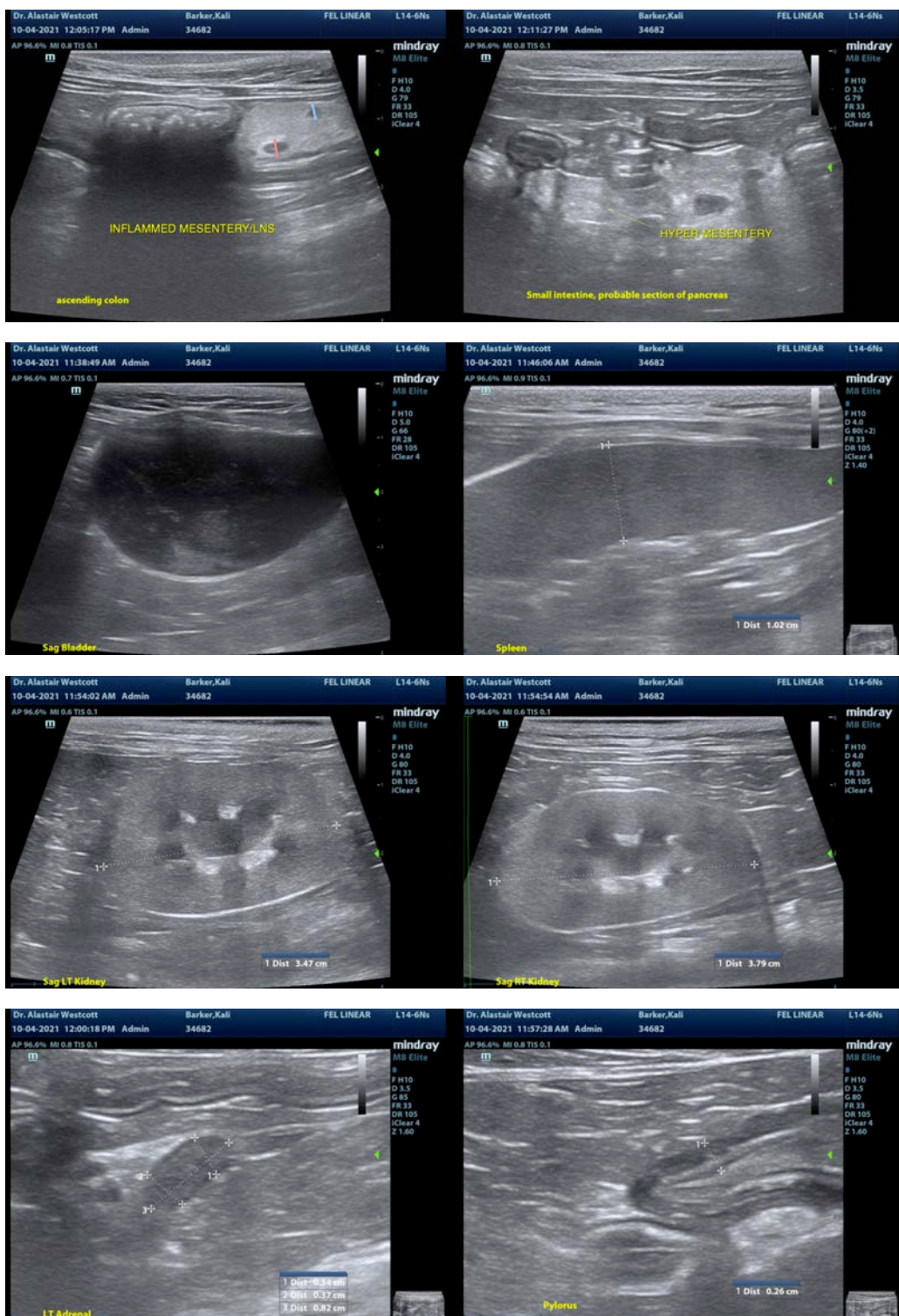
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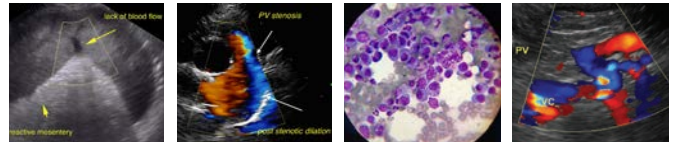
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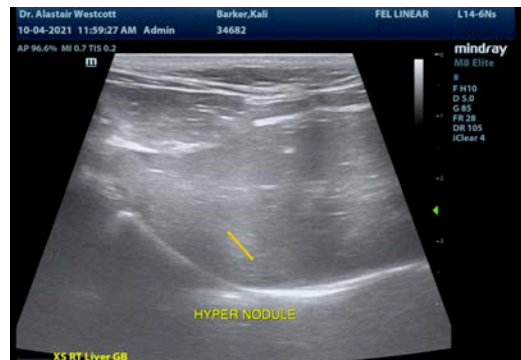
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com