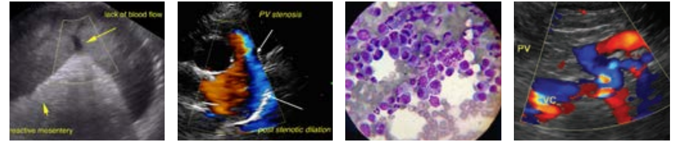
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT
Chica Small

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
15 Years

WEIGHT
9.46 Pounds

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

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
Westwood Regional

REFERRING VET
Dr. Hartwick

INVOICE
42722

DATE
11/10/22

PRESENTING CLINICAL SIGNS

Patient presents for vocalizing, multiple episodes of vomiting from 2am-4am this morning, passing normal stools, weight loss (was 11 lbs, now 9.46 lbs), tense abdomen. Vomit= white foam with some food - did not eat this morning. Radiographs show prominent liver, possible thickened loops of bowel. On IVFs in-hosp, started Buprenex, Cerenia, Famotadine, and Unasyn.

Abnormal PE/Chem/CBC/UA Results: CBC= WBC 8.53, elevated neutrophils, low lymp., Chem= glob 3.7, alb. 3.9, lipase 137, Alk. Phos. 81, AST 445, ALT 391, T4 and U/A pending.

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 (3.75 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 (3.41 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 0.36 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

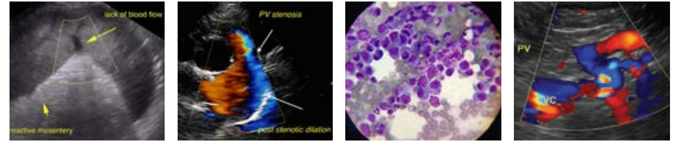
Spleen

The spleen is subjectively normal in size (0.73 cm in width at the level of the hilus), 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 duct appear somewhat tortuous and dilated, measuring up to 0.52 cm proximally with some hyperechoic inflammation surrounding. There is no evidence of significant debris or stones visualized.



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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm 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 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 0.23 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.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

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 normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic, prominent pancreas (particularly in the body/right limb) – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

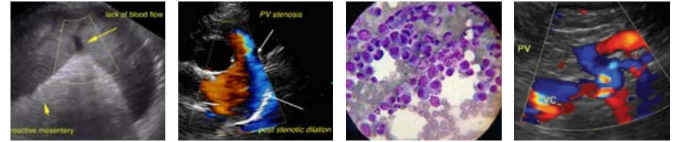
- Dilated, tortuous common bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).

- Prominent muscularis layer to the small intestine – The small intestinal wall changes could be consistent with an underlying inflammatory process. These types of changes can sometimes be seen in normal older cats. Correlate with clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The lesions observed on today's scan are relatively mild. The pancreas is somewhat prominent with some mildly hyperechoic surrounding mesentery. Additionally, there was some discomfort when scanning in this area. Concurrently, there is a dilated bile with some inflammation, which could be causing some discomfort as well. This could be associated with the ALT elevation report. The muscularis layer to the small intestine is prominent, the significance of this is unclear, but could be related to primary gastrointestinal disease.

Recommend treatment for pancreatitis and evaluation of a quantitative fPLI level. Additionally, consider the possibility of a primary hepatopathy and biliary disease. Cholangiohepatitis would be a possibility. You could try a round of Ursodiol +/- antibiotics. Additionally, these issues could be tied



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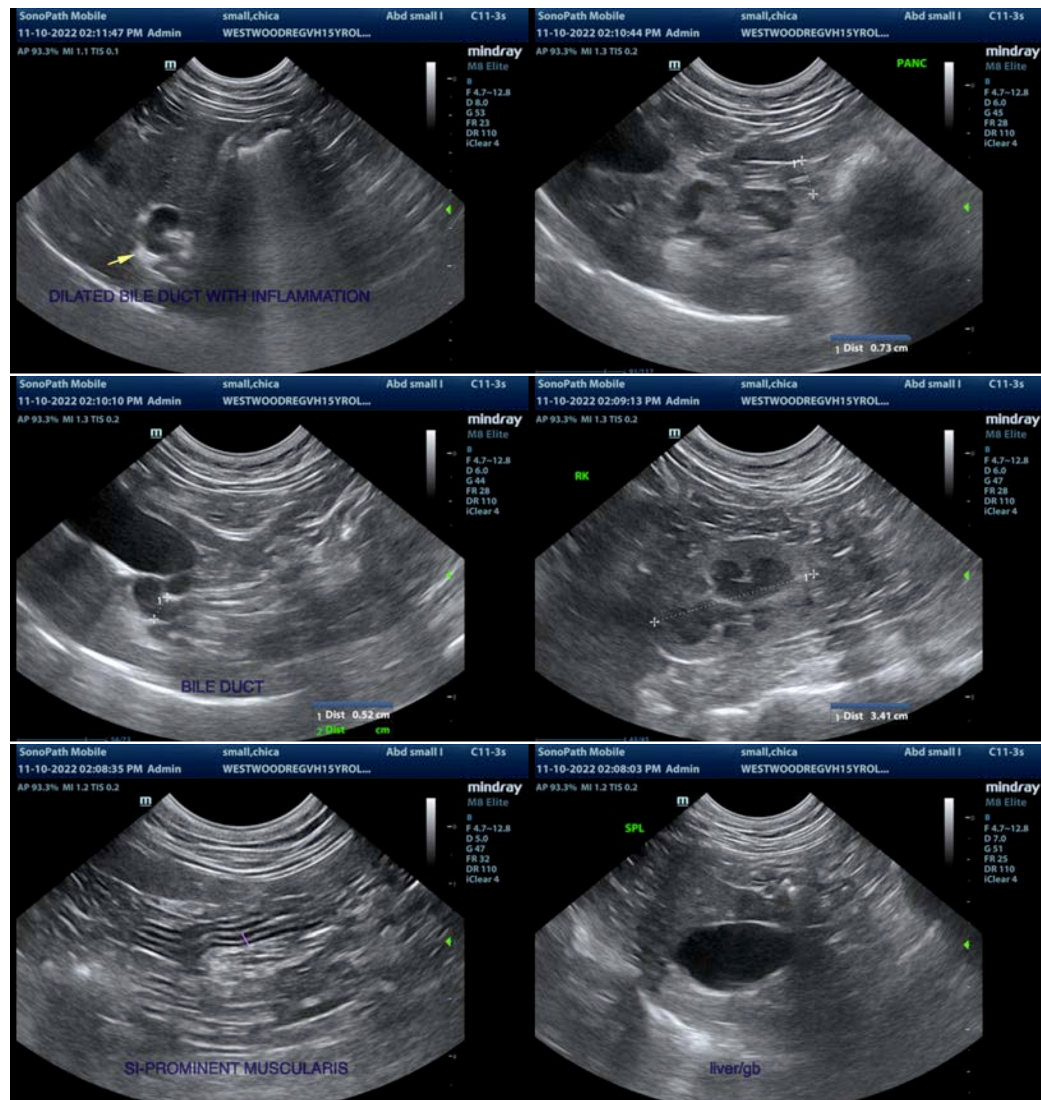
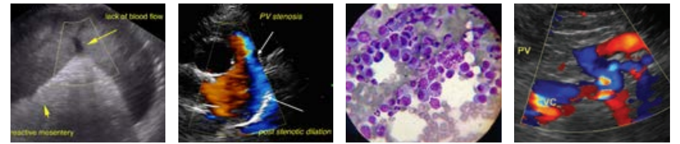
together with possible Triaditis. Recommend continued monitoring of the bile duct and liver values to look for possible progression of this lesion. If values are increasing or there is progressive dilation of the bile duct, more aggressive intervention may be necessary. Additionally, if coagulation parameters are normal, a fine needle aspirate of the liver could be helpful to try and rule out underlying neoplastic change, look for inflammation, 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.
- Recommend treatment for acute pancreatitis and cholangiohepatitis as well as obtaining a fine needle aspirate of the liver, is possible.

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





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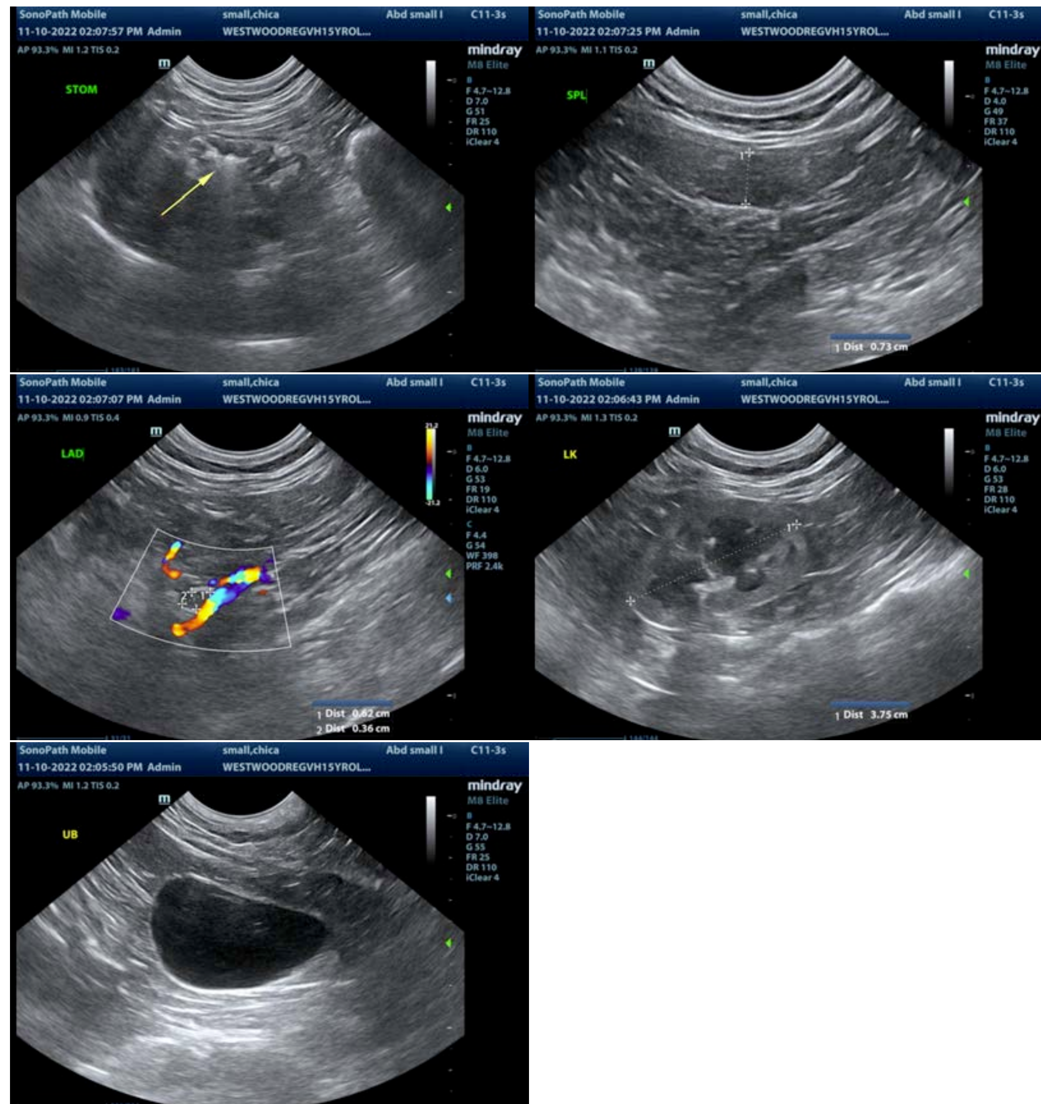

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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