



PATIENT

Jack McFadden

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years

WEIGHT

8.8 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Jack Reese

HOSPITAL NAME

Willow Run VC

REFERRING VET

Dr. Jack Reese

INVOICE

43466

DATE

12/14/22

PRESENTING CLINICAL SIGNS

Decreased appetite and significant weight loss over last 2-3 months (3lbs). Owner has also noted increased urinary accidents in house. Will eat small amounts of kibble, but ingests canned food quickly and will vomit soon after. Owner noted dark yellow/gold color to urinary accidents at home.
Abnormal PE/Chem/CBC/UA Results: Total Protein 9.4 (6.3 - 8.8 g/dL) Globulin 6.4 (3.0 - 5.9 g/dL) ALT 202 (27 - 158 U/L) AST 70 (16 - 67 U/L) ALP 164 (12 - 59 U/L) Bilirubin - Total 0.7 (0.0 - 0.3 mg/dL) 1+ Struvite crystals noted in urine sample

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 (4.76 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 (4.22 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 0.31 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 0.52 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 (0.88 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 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 appears slightly prominent and thickened, measuring at 0.16 cm. Luminal contents are mild and primarily anechoic. The cystic duct and common bile duct appear prominent and tortuous, measuring at 0.29 cm.



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Gastrointestinal

The stomach was distended with a moderate to large amount of fluid and 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. 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 prominent and hypoechoic as compared to the surrounding isoechoic mesentery, particularly in the left limb. 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, 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 left limb of the 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.
- Prominent gallbladder wall with prominent, slightly tortuous bile duct – Findings could be consistent with mild cholecystitis.
- Moderate to large gastric distention with fluid/ingesta – 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 clearly observed).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is heterogeneous with no focal lesions and the gallbladder appears slightly prominent with a prominent wall and a very slightly prominent bile duct. Primary differentials would include cholangiohepatitis, round cell neoplasia, etc., but other differentials such as toxicities, infectious hepatitis, lipidosis, FIP, etc. are possible. Consider the following:



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- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc..

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- Recommend thyroid evaluation (if not already done)

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- If not already done, consider pre and post prandial bile acids to evaluate liver function (can skip if bilirubin is elevated)

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- Consider fine needle aspirate if round cell neoplasia is on your differential list (25 g needle, normal coags)
- If cytology is not helpful and there is no response to therapy, consider liver biopsy with samples obtained for histopathology and culture.

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- Recheck gall bladder and bile duct in 48-72 hours to look for progressive distension.

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- If triaditis is suspected consider therapy for cholangiohepatitis ((fluids, ursodiol, probiotics, +/- steroids/antibiotics), testing for pancreatitis and evaluation for IBD (GI panel to Texas A&M GI lab)

Based on the changes observed in the gallbladder, pancreas, and liver, I would most strongly consider obtaining a fine needle aspirate and starting Ursodiol therapy with antibiotics and close continued monitoring. If there is no response to that, recheck evaluation may be necessary +/- a liver biopsy.

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

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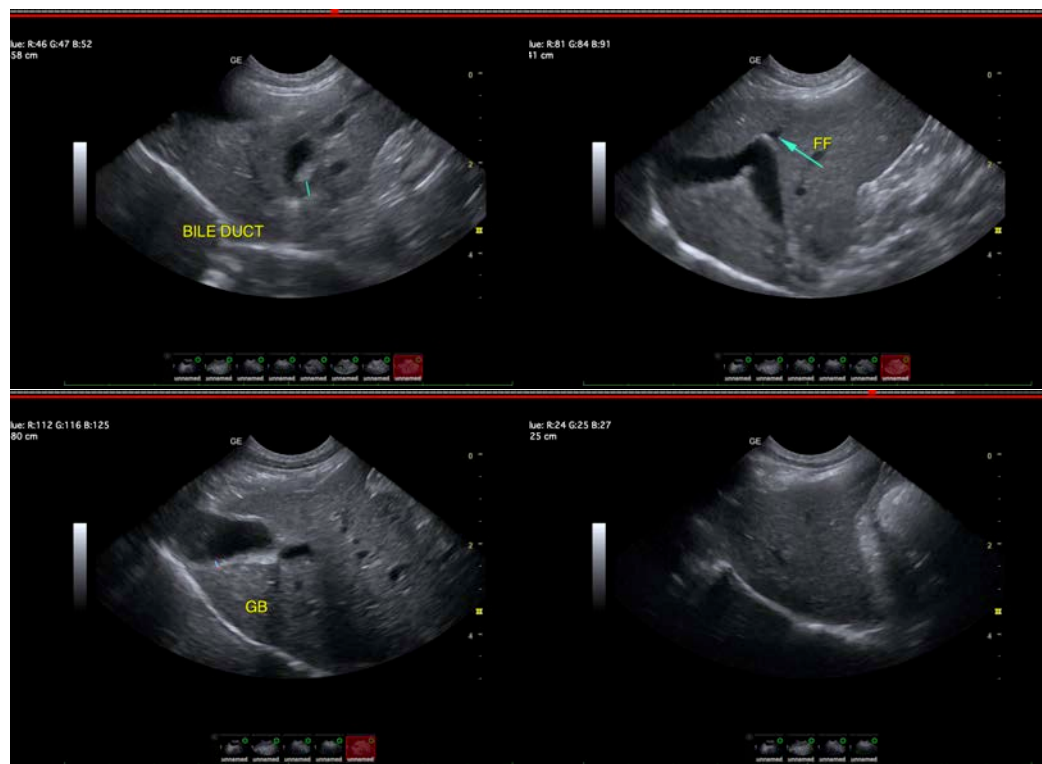
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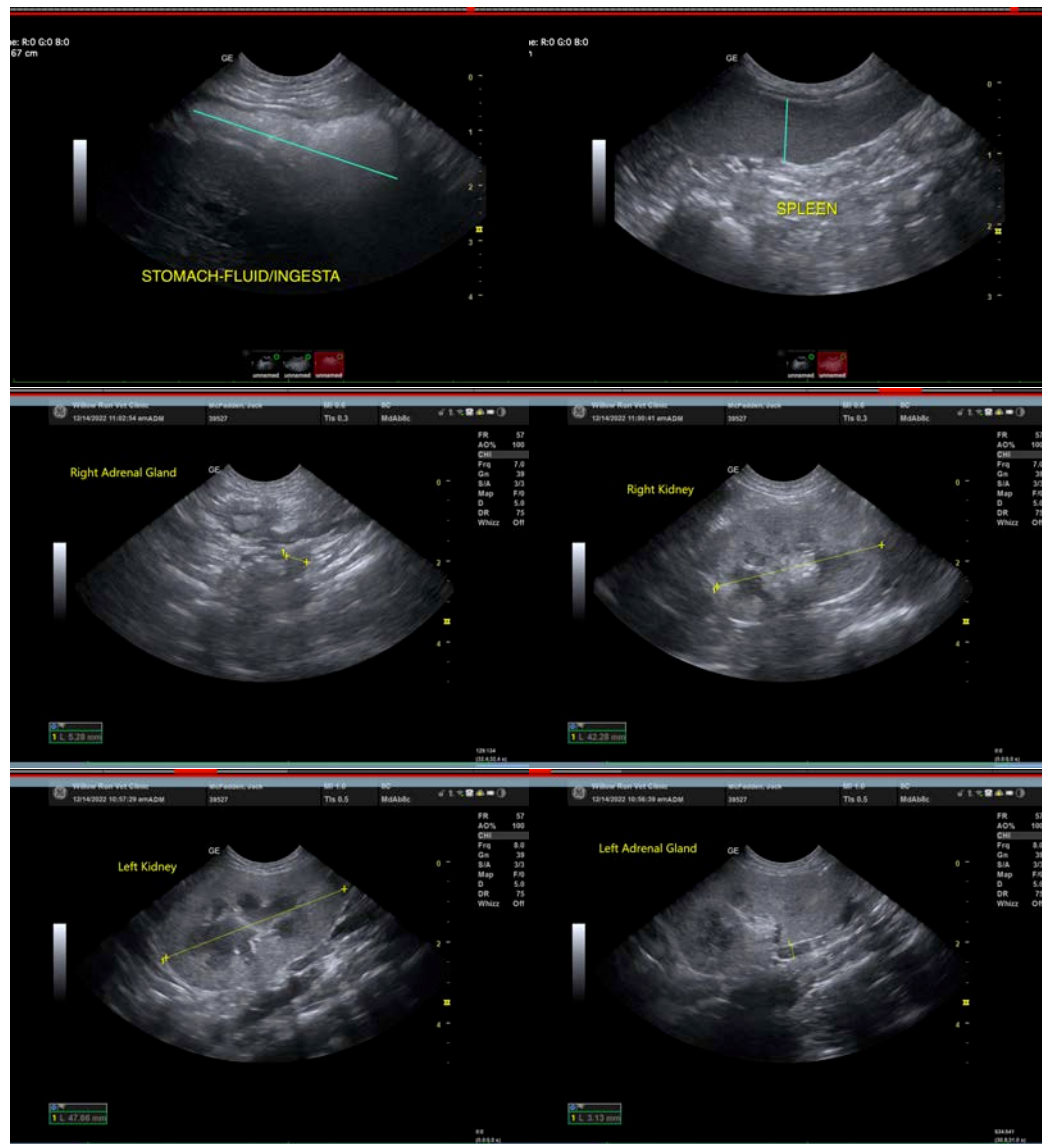
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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