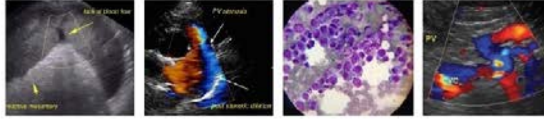


PATIENT

Leo Wallace

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years

WEIGHT

3.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Snelgrove VS

REFERRING VET

Dr. Gunsinger

INVOICE

43671

DATE

12/22/22

PRESENTING CLINICAL SIGNS

Has been on renal food for years. Owner is not sure of age. Recently has been very picky with his eating, only licking the gravy and sometimes not eating at all. Owner mentions that he is now vomiting/regurgitating bile. No diarrhea, not pooping. Indoor only. Current Medications Famotidine 1/4 of a 10 mg tab SID

Abnormal PE/Chem/CBC/UA Results: ABNORMAL Labwork Values Lipase - 4803 (100-1400) Na 166 (150-165) TT4 66 (10-60)

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 (3.43 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 (3.7 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 0.32 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 0.32 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.

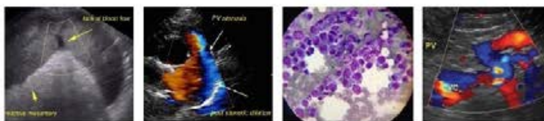
Spleen

The spleen is subjectively normal in size, 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.



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Gastrointestinal

The stomach contains moderate to large fluid distention. 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.

Some of 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 0.24 cm. Visualized peristalsis appears appropriate. In the distal abdomen, there are numerous loops of small intestine that appear somewhat fluid distended, possibly with decreased peristalsis.

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. Dilated pancreatic duct noted. Consistent with mild to moderate 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

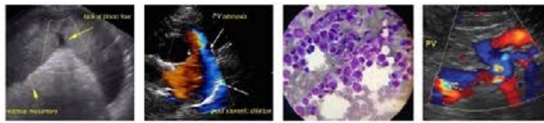
- Large, hypoechoic, irregular pancreas with dilated pancreatic duct and surrounding inflammation – The pancreatic changes are most consistent with mild to moderate pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

- Large fluid distended stomach – Correlate with the feeding history. This could be consistent with ingesta, delayed gastric emptying, or pyloric outflow tract obstruction (none observed but visualization is limited by shadowing ingesta).

- Mild fluid distention of the small intestine – No focal obstruction is visualized. Differentials would include ileus, a recent meal, or a complete or partial obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most prominent observation on today's scan is that of a large, hypoechoic, irregular pancreas. Findings are most consistent with mild to moderate pancreatitis. Correlate these values with a quantitative fPLI level. The stomach and some areas of small intestine appear significantly fluid dilated. This could be consistent with ileus secondary to pancreatitis, but I cannot definitively rule out the possibility of ingested foreign material. Correlate these findings with abdominal radiographs. Consider treatment for pancreatitis with serial radiographs, looking for resolution of the obstructive pattern. If the patient worsens or the obstructive pattern becomes more dramatic, then consider the options of repeat ultrasound or surgical evaluation.



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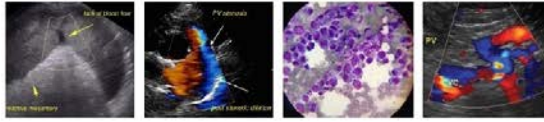
Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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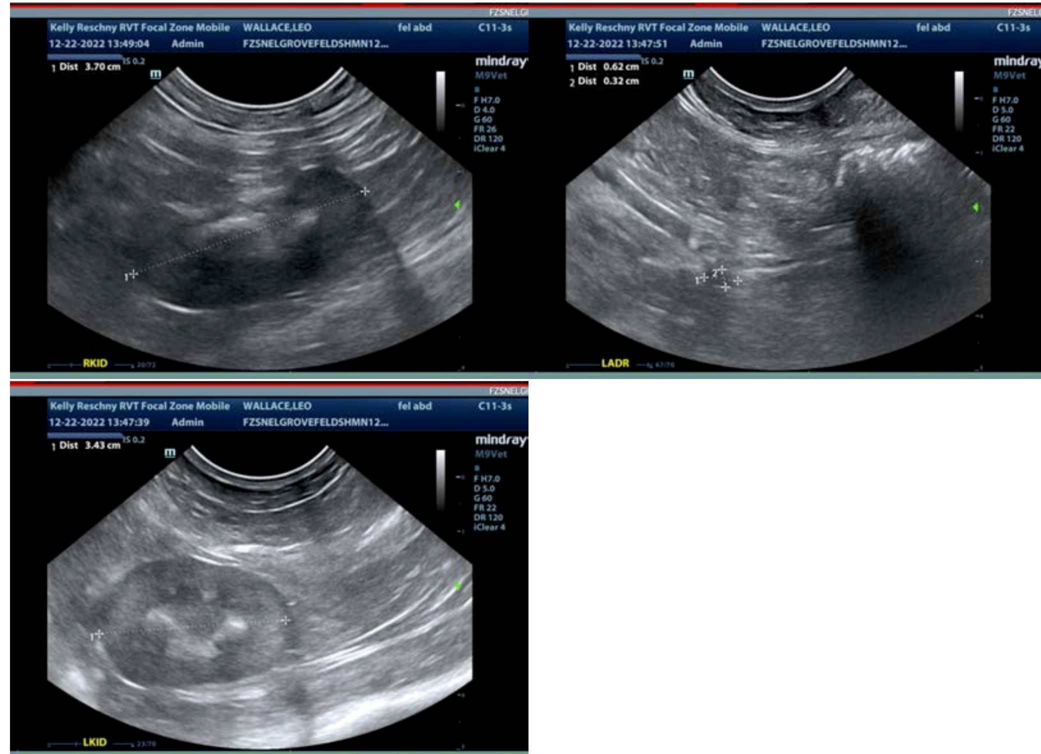

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com