



PATIENT PRESENTING CLINICAL SIGNS

Ginger Simmons

2/12 - presented to ER service for vomiting and lethargy for about 1 week. Brborygmi on exam at ER clinic, otherwise normal exam. Bloodwork showed mild neutrophilia (11k/uL) and mild eosinopenia (0.1k/uL). Hyperglycemia at 231mg/dL (no noted PUPD). All of other values wnl. P treated with SQF and cerenia 1mg/kg SQ. 2/14 - presented with us for follow-up. No further vomiting, but largely anorexia and no bowel movement since ER visit. SQF, Cerenia repeated. Also added OTM buprenorphine to go home. Rads taken - report concluded: CONCLUSIONS: 1. Mild small intestinal dilation is most consistent with functional ileus and may be secondary to enteritis or a diffuse enteropathy such as inflammatory bowel disease or intestinal lymphoma. Partial intestinal obstruction cannot be entirely ruled out. 2. Decreased cranial abdominal serosal detail suggestive of regional peritonitis (e.g. pancreatitis) or scant peritoneal fluid. 3. Prominent spleen may be a normal variant, however enlargement associated with regenerative changes (extramedullary hematopoiesis, lymphoid hyperplasia) or round cell neoplasia cannot be ruled out. RECOMMENDATIONS: Recommend abdominal ultrasound to further evaluate the gastrointestinal tract, pancreas, and spleen. Incidental 2 x Bates bodies noted in/near gastric shadow. 2/16 - presented for AUS - P has been eating and doing better at large, but weight is down 3% in the last 48 hours [although P was fasted 9hrs for the scan and there may be scale discrepancies]. P received SQF again here today, going home with more buprenorphine OTM and Cerenia tabs, HydraCare.

Abnormal PE/Chem/CBC/UA Results: Very tense cranial abdominal palpation. Slightly high FAS, but Torb 0.3mg/kg IV helped the exam.

SPECIES

Feline

BREED

Domestic Longhair

SEX

Spayed Female

AGE

13 years

WEIGHT

9.6 lbs

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 (3.5 cm). Overall echogenicity is normal with adequate 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 (3.9 cm). Overall echogenicity is normal with adequate 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.

INTERPRETED BY

Kathleen Sennello
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ACVIM (Small Animal
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IMAGING PERFORMED BY

Dr. Sorbo

HOSPITAL NAME

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REFERRING VET

Dr. Sorbo

Adrenal Glands

The left adrenal gland is normal in size measuring 0.45 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.

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The right adrenal gland is normal in size measuring 0.4 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.

DATE

2/16/22



PATIENT

Spleen

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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. The spleen measured 0.85 cm at the level of the hilus.

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Liver

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The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature appear normal. No focal nodules or cystic lesions are observed. The gallbladder lumen is moderately distended. The wall of the gallbladder is hyperechoic and mildly thickened. It appears to have a smooth mucosal surface. Luminal contents are primarily anechoic aside from a focal, hypoechoic shadowing stone visualized measuring 0.57 cm. The cystic and common bile ducts are suspected to be dilated at 0.47 cm with a thickened hyperechoic wall at 0.14 cm. Color flow on these structures would be necessary to confirm.

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Gastrointestinal

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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. No masses or focal lesions were observed.

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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. The duodenum measured as normal and the jejunum measured as normal (0.24 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.

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Pancreas

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The pancreas is normal and isoechoic to surrounding 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, 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.

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ULTRASONOGRAPHIC FINDINGS



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PRIMARY FINDINGS:

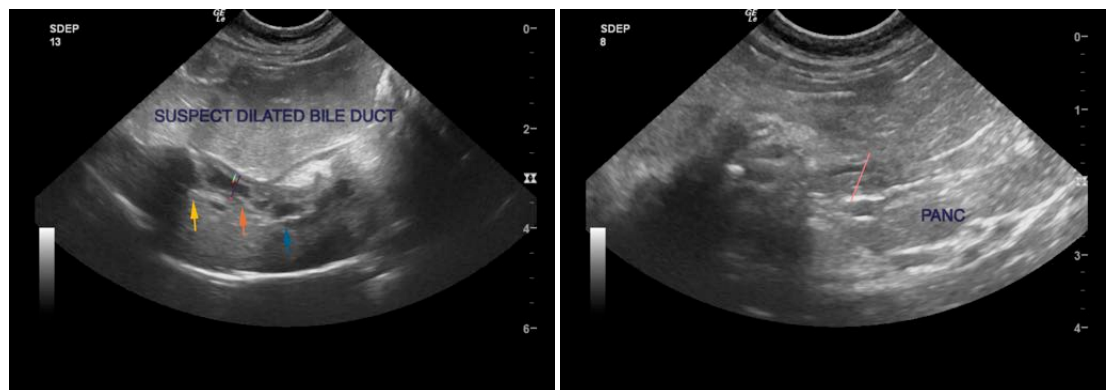
- Echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.
- Stone visualized in the gallbladder and suspected bile duct dilation. The significance of this is unclear with a lack of liver enzyme elevation and no surrounding inflammation or gallbladder distension.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No lesions are visualized associated with the pancreas or gastrointestinal tract. Unfortunately there are many causes for vomiting which cannot be diagnosed with ultrasound alone. Consider differentials such as acute gastroenteritis, dietary intolerance, GI parasites, foreign body ingestion, pancreatitis, IBD and less likely intestinal neoplasia.

- Consider a GI panel with quantitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Consider a novel protein/hydrolyzed protein diet.
- Consider probiotic therapy
- Recommend symptomatic treatment for gastroenteritis/pancreatitis. If the patient is worsening, symptoms are not improving or lab work is not improving then consider reimaging and reevaluation. GI biopsies may be necessary if vomiting continues.

There is a stone visualized within the gallbladder lumen. I suspect there is some bile duct dilation and possible thickening. No distal obstruction is visualized, but cannot be ruled out. If liver values are normal I would recommend to continue monitoring. If there is a spike in liver enzymes or the patient starts to feel sick then consider reevaluation.





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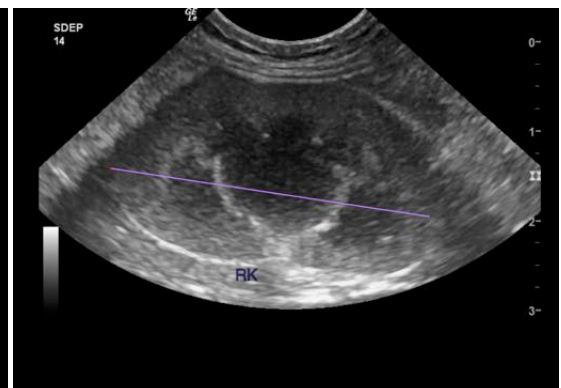
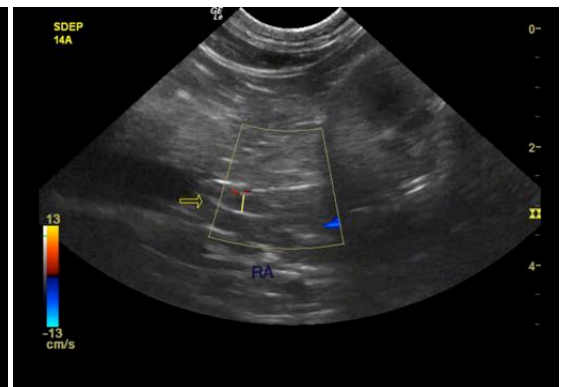
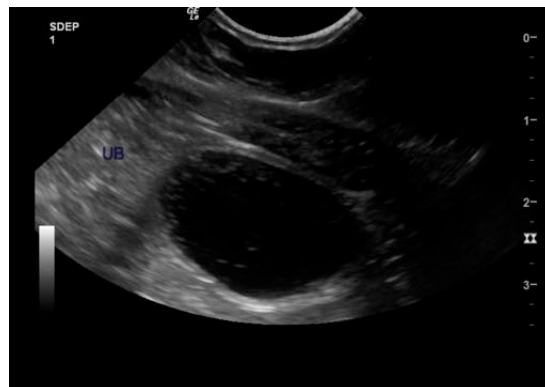
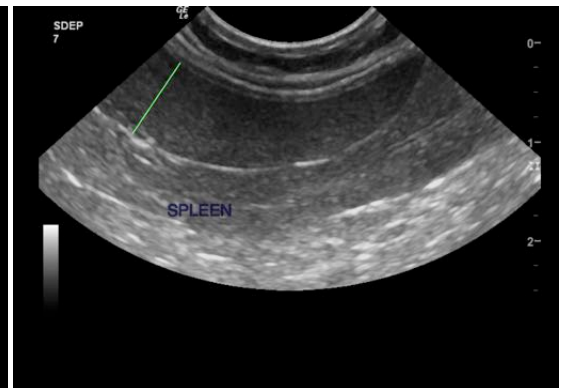
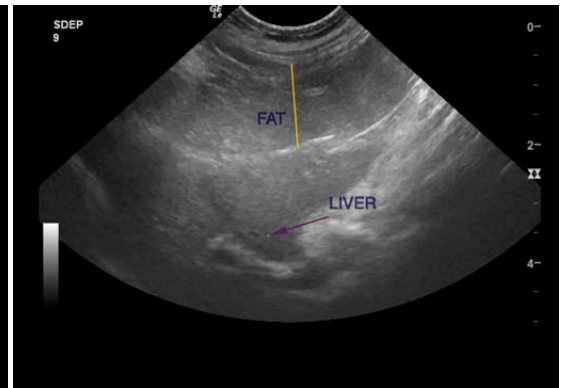
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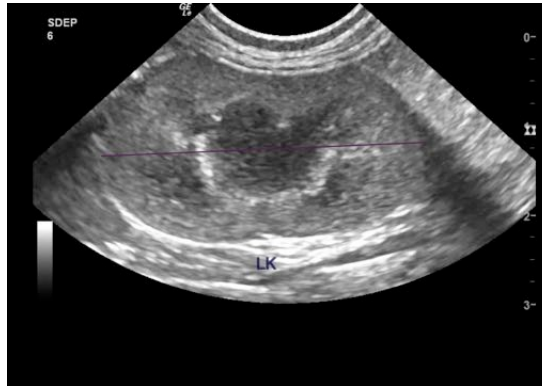
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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