**PATIENT**

Macy Coleman

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years

WEIGHT

9.8 Pounds

INTERPRETED BYKathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)**IMAGING
PERFORMED BY**

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Mitten Animal Hospital

INVOICE

35841

DATE

2/23/22

PRESENTING CLINICAL SIGNS

Waxing and waning vomiting and diarrhea along with weight loss. More recent decrease in appetite. Abnormal PE/Chem/CBC/UA Results: See attached.

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 (4.52 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 (4.23 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.39 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 0.39 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 large in size, and normal in 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.

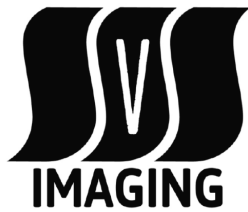
The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

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. No masses or focal lesions were observed.

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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. There are some areas that appear moderately thickened and have less distinct layering. Jejunum wall measured 0.30 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 heterogeneous with a prominent pancreatic duct.

Free Abdomen

There is a scant amount of free fluid. There are prominent mesenteric lymph nodes visualized measuring 0.97 cm, 0.42 cm, and 0.60 cm. The omentum is of increased echogenicity around the prominent mesenteric lymph nodes.

ULTRASONOGRAPHIC FINDINGS

- Moderate mesenteric lymphadenopathy – The moderate mesenteric lymphadenopathy could be concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease (tick born disease-such as bartonella, fungal infections, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.
- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Subjectively thickened small intestine with decreased layering detail in some areas – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.
- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

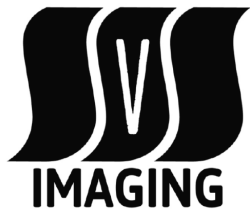
Subjectively, the bowel appears somewhat thickened with reduced detail of layering in some areas. These findings could be consistent with age related change, inflammation, or a neoplastic change. Additionally, there are prominent mesenteric lymph nodes and a prominent pancreas.

- Consider a fine needle aspirate of mesenteric lymph nodes.
- Consider a GI panel to Texas A&M with a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- If liver enzymes are elevated, consider a fine needle aspirate of the liver.

If a definitive diagnosis is desired, you could consider obtaining GI biopsies and lymph node biopsies. Alternately, you can consider conservative therapy such as a hydrolyzed protein/novel protein diet, probiotic therapy, treatment for pancreatitis if the PLI is elevated, and if a definitive diagnosis is not desired, you could consider an anti-inflammatory dose of Prednisolone.

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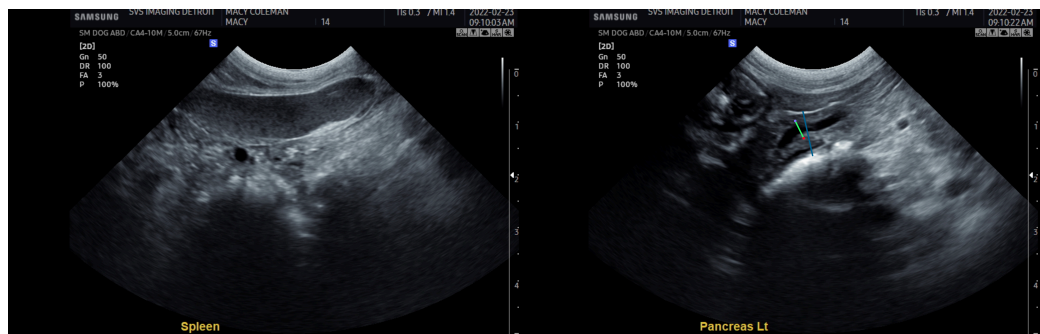
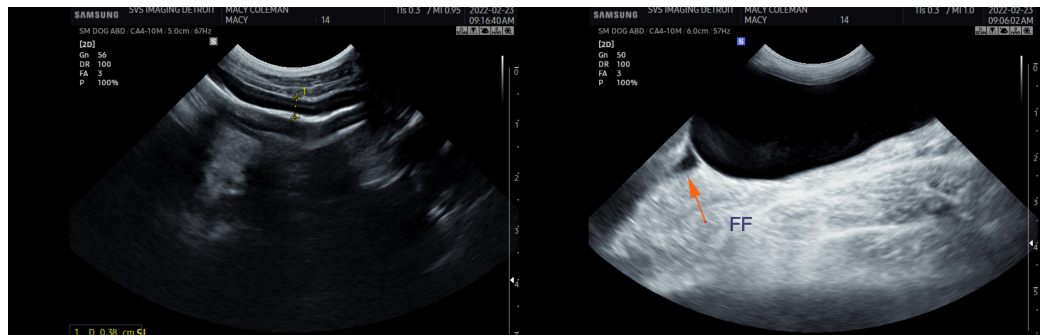
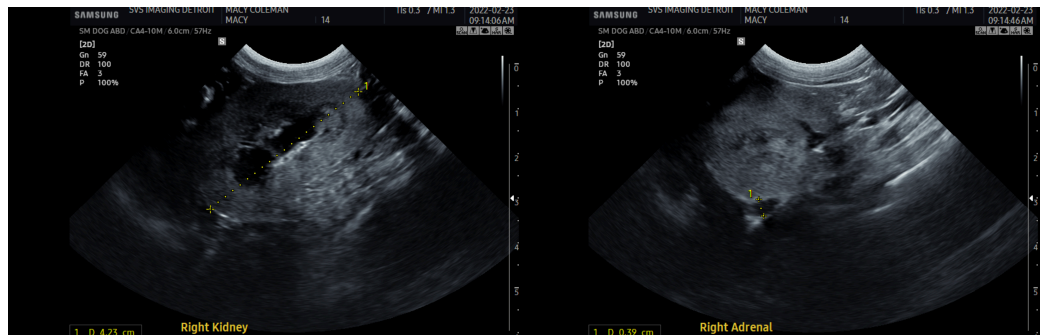
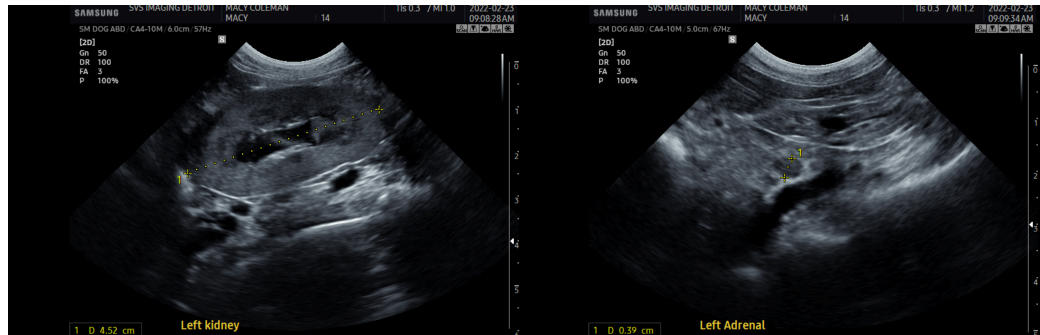
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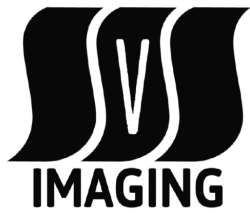
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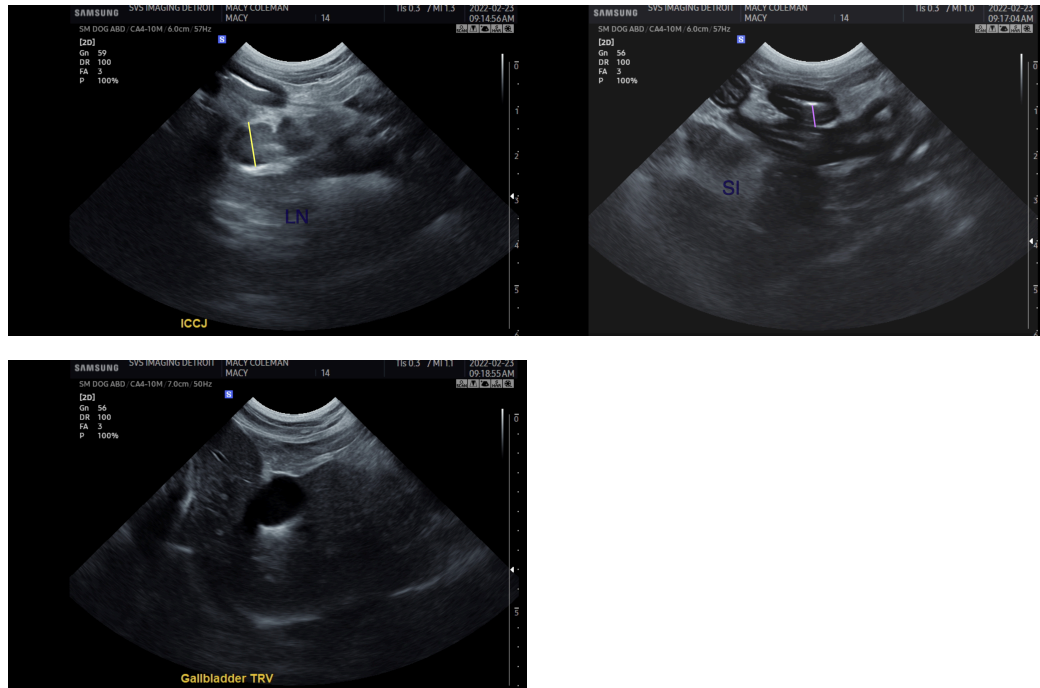
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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