



PATIENT

Penny Treis

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7 Years

WEIGHT

7.75 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

M. Kermendy CVT

HOSPITAL NAME

Wauwatosa VC

REFERRING VET

Dr. Elaine Binor

INVOICE

35549

DATE

2/9/22

PRESENTING CLINICAL SIGNS

History of thin body condition and vomiting. Was seen for lethargy, shaking, vomiting. Vomiting is infrequent. There is concern for hypercalcemia on blood panel. Plan to check for structural GI disease such as LSA, IBD, or other neoplasia.

Abnormal PE/Chem/CBC/UA Results: Calcium=12.5 (8.2-11.2) Ionized Calcium=1.41 (1.13-1.38)
The remainder of the CBC/Chemistry/FPL panel was WNL

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 (3.46 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 (3.73 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. 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 (0.75 cm 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 normal/borderline large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is mildly 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 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 measured 0.22, 0.23, 0.25 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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

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

- Borderline large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. If liver enzymes are not elevated, this could be normal for this individual.

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7.75 Pounds

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Kathleen Sennello DVM,
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Medicine)

No focal lesions were visualized on today's scan. The liver subjectively appears somewhat large, but if there is no evidence of liver enzyme elevations, this could be normal in this individual. Unfortunately, it is not uncommon to not be able to diagnosis all causes of vomiting based on ultrasound alone.

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M. Kermendy CVT

- Consider metabolic causes (if not already done). Based on baseline bloodwork, thyroid evaluation and a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate recommended to further evaluate the pancreas and small intestine.
- If metabolic disease seems unlikely, then consider primary GI causes such as food allergy/dietary sensitivity, dietary indiscretion, GI parasites, IBD, and less likely intestinal neoplasia.

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In more chronic cases, I most strongly consider food allergy, IBD, or intestinal neoplasia.

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- Consider a hydrolyzed protein/novel protein prescription diet.
- Consider chronic probiotic therapy.
- Consider symptomatic therapy for pancreatitis, particularly if PLI levels are elevated.
- If symptoms persist, and no other abnormalities can be identified, consider obtaining GI biopsies.
- Recommend 3-view thoracic radiographs to rule out concurrent intrathoracic disease.
- In the radiographs provided, the patient appears somewhat constipated. Consider Miralax therapy in case this is contributing.

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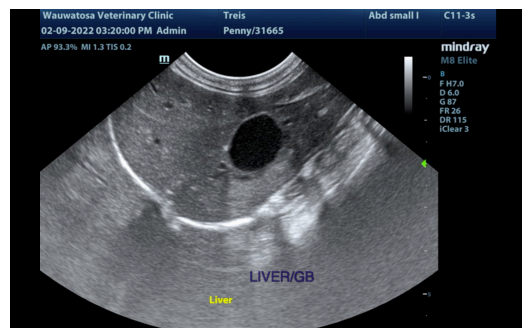
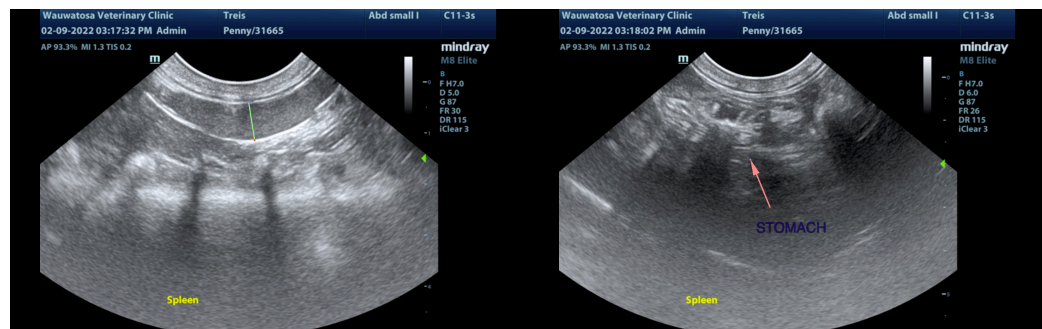
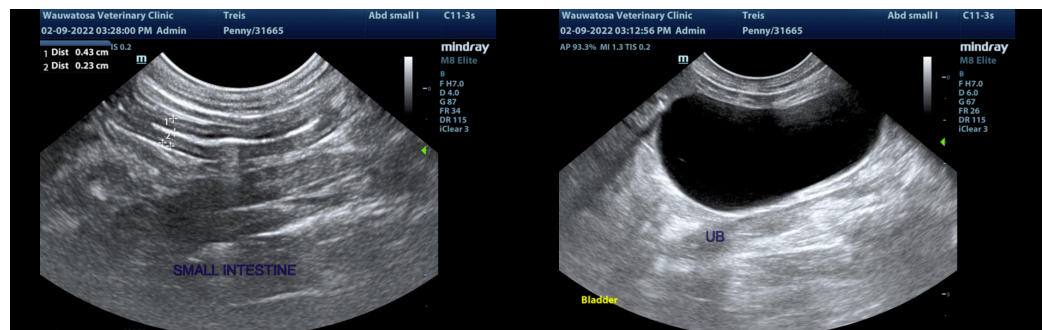
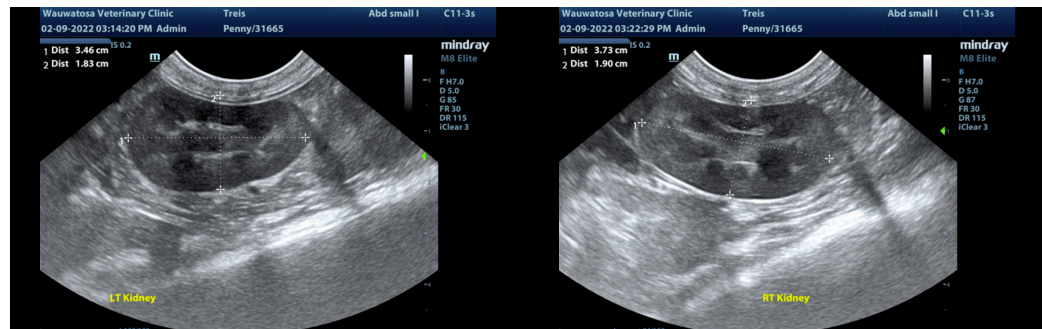
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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