


DATE PRESENTING CLINICAL SIGNS

3/15/22

PATIENT

Penelope Hagy

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6/22/15

WEIGHT

10.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

 Animal Emergency
 Hospital

REFERRING VET

Dr. Nacke-Horney

INVOICE

36191

Recently moved home in December - was noted to have a decreased appetite but suspected it was due to stress 1 month ago stopped eating her dry food - 3 weeks ago stopped eating treats. Has not really eaten anything for the past 2 weeks - have been trying to syringe some broth the past few days (last was 1 ml in the AM), ate a couple of bites of tuna yesterday. Was at rdvm on Tuesday - gave some fluids and meds - expressed concerns for pancreatitis, inflammation was noted in the abdomen on FAST scan - ALT/ASR/TBIL were elevated - prescribed cerenia (16mg q24 - finished) and mirtazapine (1.5" strip q24 - last given tonight) - appetite did not improve. Became jaundice in the past 48 hours - owners noted that she has been hiding a lot. Owner gave one dose of CBD last night - 0.4 ml. Known IBD - on prescription dry.

Current Medications: Vitamin B, Cerenia, Protonix.
 Lab Results: See attached.
 Date of Previous IntraPet Ultrasound: No previous.
 Sedation: Not required to complete full diagnostic ultrasound.
 Stat Report: Not requested.

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 (4.12 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 (4.25 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 0.40 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 0.36 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 and irregular. 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. Bile duct is visualized measuring 0.14 cm.

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.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measured 0.26 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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

Free Abdomen

There is a small amount of free abdominal fluid visualized. No lymphadenopathy. The omentum is of slightly increased echogenicity around the pancreas and the bowel.

ULTRASONOGRAPHIC FINDINGS

- Mottled, prominent pancreas surrounded by hyperechoic mesentery – The pancreatic changes are most consistent with mild 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, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Very prominent muscularis layer of the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Small volume free abdominal fluid.

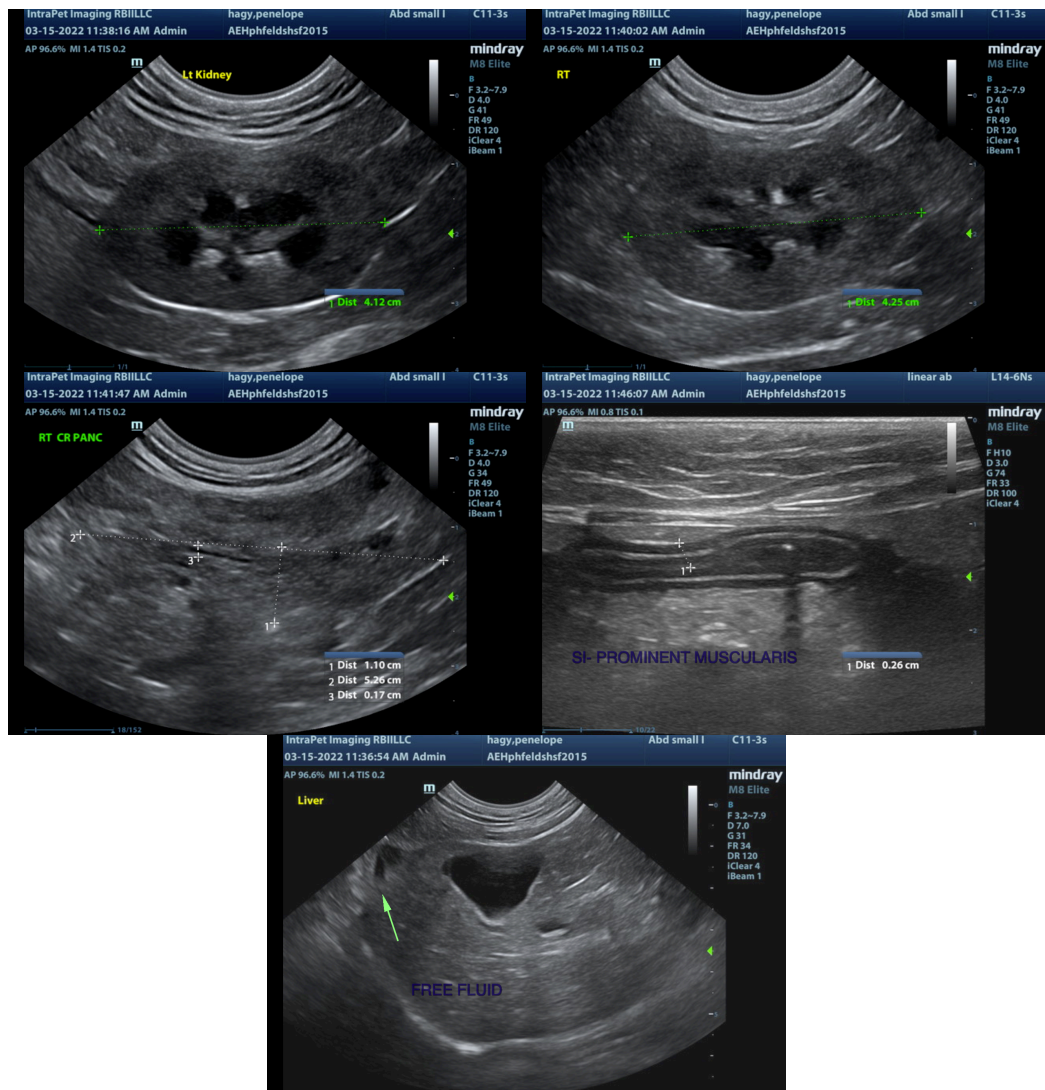
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal mass lesions are visualized. The pancreas appears prominent. This could be consistent with a previous episode of pancreatitis, or current mild pancreatitis. Additionally, the muscularis layer is very prominent in the small intestine, which can be an indicator of inflammation. Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to obtain more information regarding the pancreas and small intestine.

The liver is large and heterogeneous with no significant biliary lesions observed. This is most consistent with a primary hepatopathy. It is uncertain if this cat stopped eating due to liver disease, or if it stopped eating due to underlying GI disease and then developed lipidosis, etc.

- Recommend a fine needle aspirate of the liver if coagulation parameters permit this safely.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

It is imperative that nutritional support I started in this patient. Options moving forward include a more aggressive path where biopsies of the small intestine, liver and pancreas are obtained while placing a feeding tube. A more conservative route would be a fine needle aspirate of the liver, treatment for pancreatitis +/- cholangiohepatitis, IBD (no steroids), and placement of an esophagostomy tube. Close monitoring is warranted.



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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