



**PATIENT**

Tiffany McClain

**SPECIES**

Feline

**BREED**

DLH

**SEX**

Spayed Female

**AGE**

4 Years

**WEIGHT**

10.25 Pounds

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Dr. Judy Schroeder

**HOSPITAL NAME**

Animal Health  
Associates

**REFERRING VET**

Dr. Judy Schroeder

**INVOICE**

36283

**DATE**

3/17/22

**PRESENTING CLINICAL SIGNS**

Patient was seen 3/1 for acute onset of vomiting, high fever, lethargy. BW at that time showed leukocytosis. Snap fPL was abnormal. Radiographs showed decrease contrast in cranial abdomen, suggestive of mild effusion. Patient was treated with IV fluids, antibiotics, pain medication and anti-nausea meds and did well until 3/10 when she began vomiting again, and vomited a hair ball and an ingested syringe cap from her oral buprenex. She seemed to improve, but 3 days ago began vomiting again. Fever has not returned.

Abnormal PE/Chem/CBC/UA Results: Vomiting, mild weight loss. 3/1 Neutrophils 14590/ul, bands suspected Lymphocytes 990/ul Snap fPL Abnormal Mild increase in blood glucose.

**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 (3.71 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 (3.78 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 0.26 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 0.29 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 (0.81 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 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 primarily anechoic. The bile duct is visualized and appears slightly dilated at 0.42 cm. No focal obstruction is visualized.

**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 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 0.23 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 prominent and hypoechoic as compared to the surrounding isoechoic 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. There are occasional prominent mesenteric lymph nodes measuring 0.30, 0.35, 0.34 cm. The omentum is of normal echogenicity.

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10.25 Pounds

**ULTRASONOGRAPHIC FINDINGS**

**INTERPRETED BY**

Kathleen Sennello DVM,  
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(Small Animal Internal  
Medicine)

- Prominent hypoechoic pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Prominent muscularis layer to 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.
- Prominent dilated bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).
- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There are no large focal bowel lesions observed on today's scan. There is a slightly prominent pancreas, and a dilated bile duct, but no abnormal is visualized, and a focal obstruction is not observed. The small intestine has a prominent muscularis layer, and there are prominent mesenteric lymph nodes, which could indicate a level of small intestinal inflammation. Possible differentials would include dietary intolerance/food allergy, dietary indiscretion, dysbiosis, pancreatitis, IBD, and less likely intestinal neoplasia.

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- Consider a hydrolyzed protein/novel protein diet.

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- Consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas.

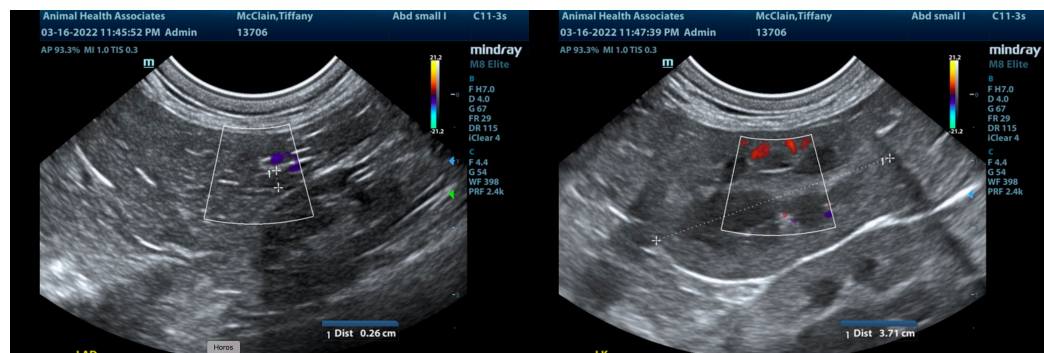
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- Correlate findings with abdominal radiographs, as there is a history of foreign body ingestion.
- If there is no response to symptomatic therapy, consider obtaining GI biopsies.

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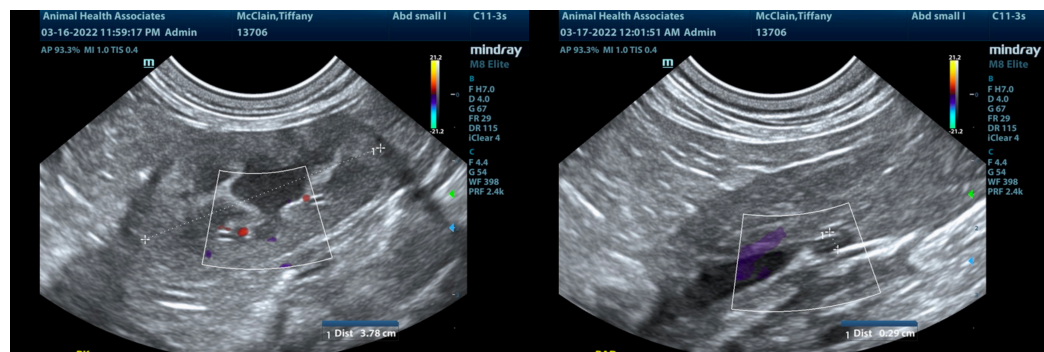
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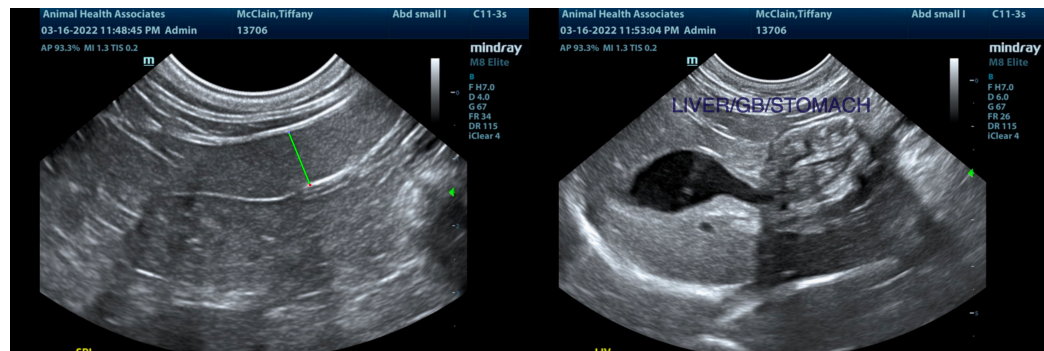
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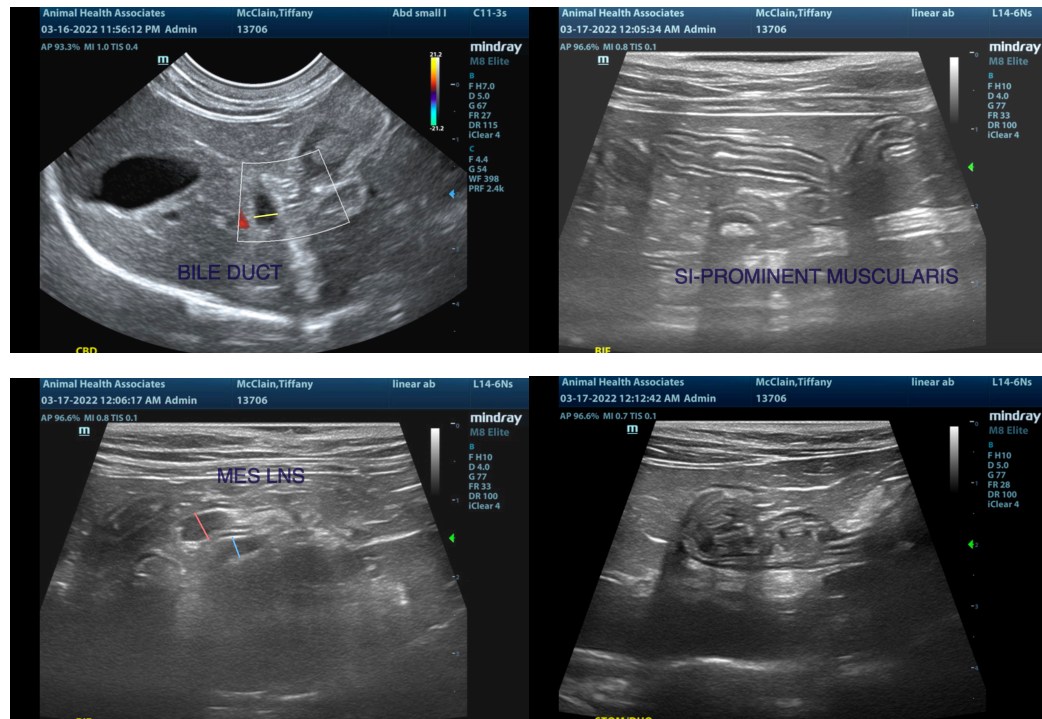
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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