

PATIENT PRESENTING CLINICAL SIGNS

Mr. Gray Sagonas 1.5lb recent weight loss from 17-15.5lbs- Weight Loss- FIV positive- Hx of lethargy and vomiting-

SPECIES Abnormal PE/Chem/CBC/UA Results: HCT 26%, BW: WBC lines: Lymphs, monocytes, Eosins, all are very low Chem WNL- LABS done 2 mths ago
Feline

BREED ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

DLH **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.

SEX

Neutered Male

AGE

12 Years

The left kidney is normal/borderline large in size, measuring 4.19 cm. It is hyperechoic and irregular in shape with a mottled cortex but adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is mild pyelectasia visualized at 0.44 cm. There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

WEIGHT

15.5 Pounds

The right kidney is normal/borderline large in size, measuring 4.37 cm. It is hyperechoic and irregular in shape with a mottled cortex but adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths or hydroureter. Renal vasculature is normal.

INTERPRETED BY

Kathleen Sennello DVM,
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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. Pinpoint mineralizations are noted.

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Loetitia Saint-Jacques,
LVT

The right adrenal gland is normal in size measuring 0.52 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

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The spleen is subjectively normal in size (0.67 cm), 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.

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Liver

The liver is large with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. There are two cystic lesions visualized in the parenchyma, one measuring 1.25 cm x 2.08 cm, the other measuring 0.75 cm in diameter.

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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The bile duct is prominent and tortuous with surrounding hyperechoic tissue. No focal obstruction is visualized and no stones are visualized.



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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. The pylorus appears somewhat prominent with mildly reduced detail of wall layering, measuring at 0.40 cm.

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. Duodenum wall measures 0.38 cm. Jejunum wall measures 0.22 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

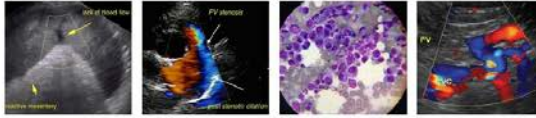
The pancreas is large and hypoechoic to surrounding mesentery, particularly in the left limb. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a prominent pancreaticoduodenal lymph node measuring 0.76 cm in diameter. The omentum is hyperechoic around the pancreas, stomach, and the bile duct.

ULTRASONOGRAPHIC FINDINGS

- Borderline large, hyperechoic kidneys with mottled irregular cortices (possibly due to previous infarcts) and mild left-sided pyelectasia – Findings are most consistent with interstitial nephritis +/- previous infarcts. The left-sided pyelectasia could be secondary to PU/PD or pyelonephritis. No evidence of obstruction is visualized.
- Hypoechoic, prominent pancreas with surrounding 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 hyperechoic liver with numerous small cysts – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Dilated prominent, tortuous bile duct with surrounding hyperechoic mesentery – Findings could be consistent with inflammation (cholecystitis), partial obstruction, etc. Additionally, this is a common finding in some normal older cats.
- Prominent pylorus – Findings could be consistent with inflammation, edema, or much less likely neoplastic infiltration.



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- Prominent pancreaticoduodenal lymph node – 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 is significant inflammation in the cranial abdomen, which appears to be focused around the pancreas and stomach region. Additionally, the bile duct is dilated and tortuous, possibly secondary to inflammation and mild post-hepatic obstruction due to the inflamed pancreas. Consider treatment for mild pancreatitis and consider treatment for primary gastrointestinal disease with:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- Recommend current bloodwork with pathologist review of a blood smear, looking to confirm a pancytopenia and looking for atypical cells, etc. If atypical cells or a non-regenerative anemia is present, which is though in excess of an anemia of chronic disease, consider a bone marrow aspiration.

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The significance of the renal changes is uncertain. Recommend a blood pressure, urinalysis and culture to obtain a baseline, and continued monitoring of urinalysis and renal values.

The changes in the liver are likely most consistent with fatty infiltration (big cat +/- lipidosis secondary to weight loss). If round cell neoplasia is a concern, you could consider a fine needle aspirate (provided coagulation parameters are normal).

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The pylorus appears somewhat thickened and prominent. This can be normal in some individuals or could represent inflammation, early neoplastic change, etc. Recommend continued monitoring.

Additionally, the local lymph node is prominent (pancreaticoduodenal). This is likely too deep to easily sample.

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It seems reasonable that this patient could have vomiting and lethargy secondary to pancreatic inflammation, but there is a fair bit going on, and continued monitoring is warranted for progression of some of these lesions.

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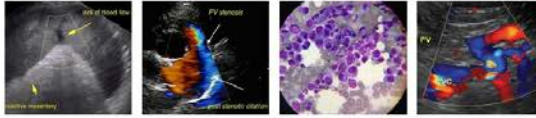
Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

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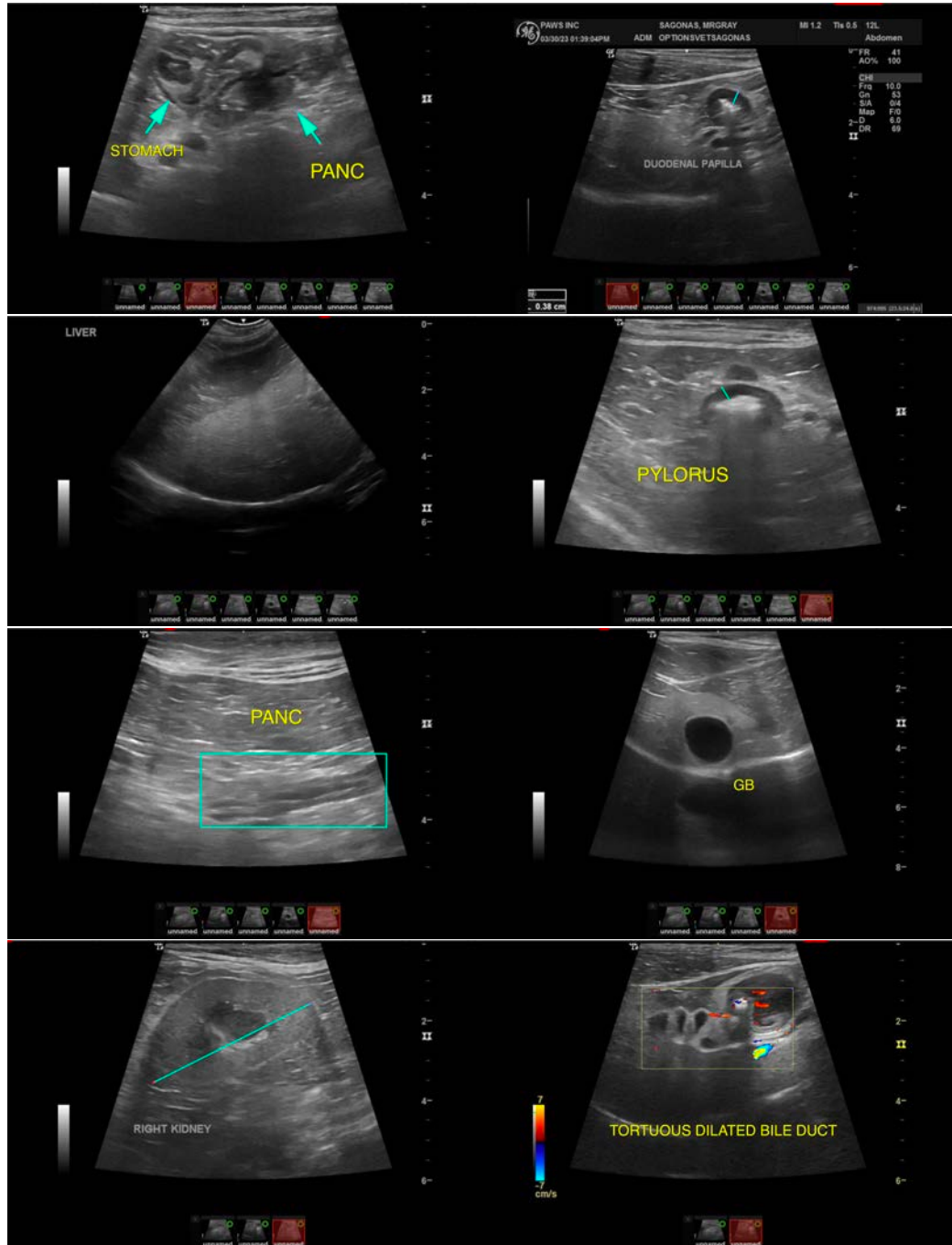
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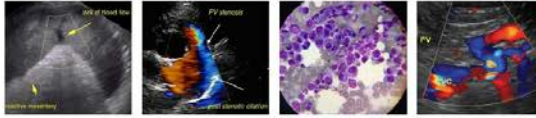
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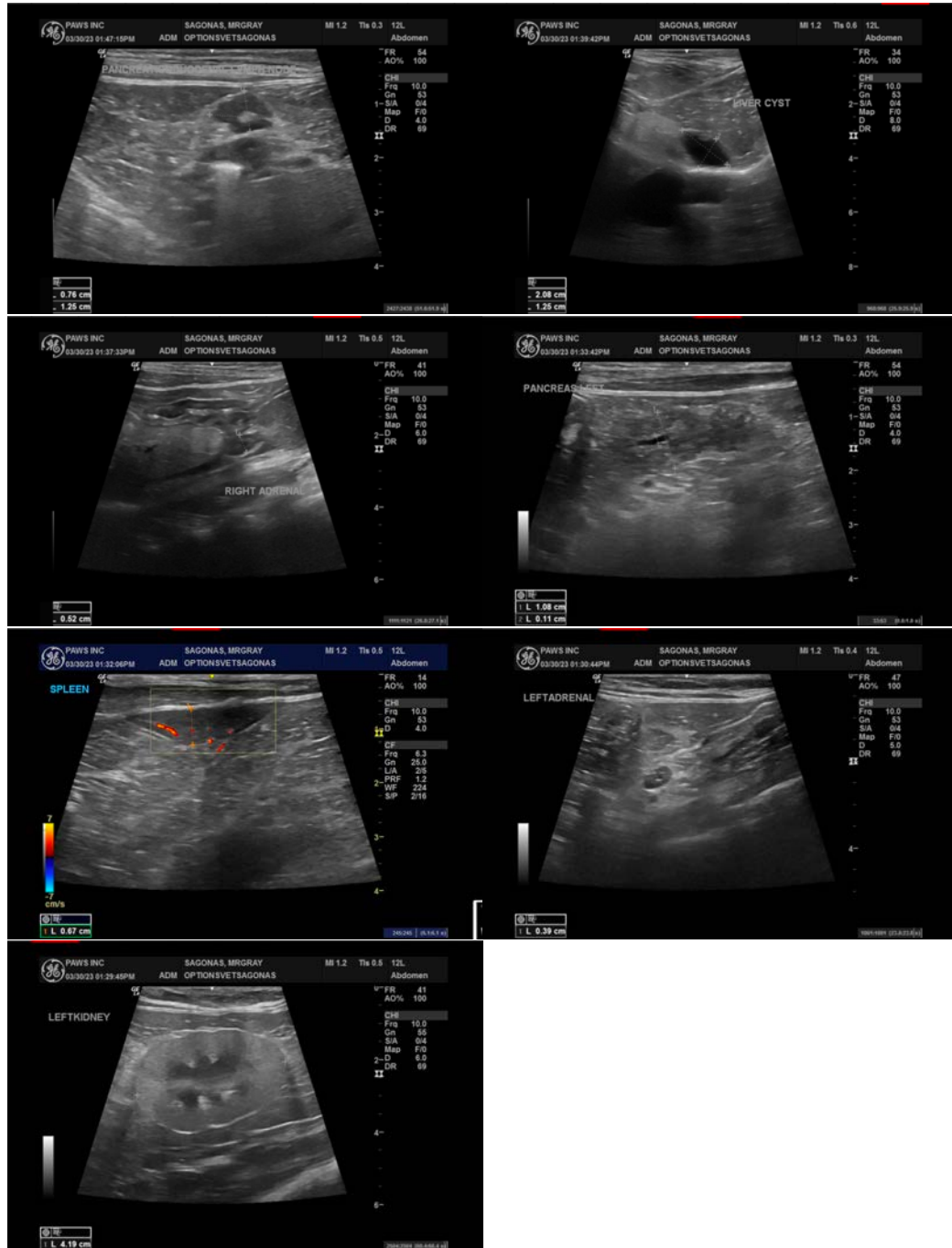
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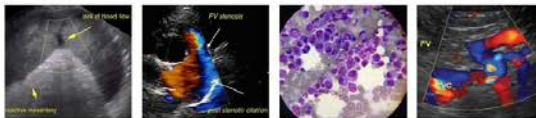
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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)

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