**PATIENT**

Morrolan Slaon

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

15 Years

**WEIGHT**

13 Pounds

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

Amy Mayhew, LVT

**HOSPITAL NAME**

SVS Imaging Michigan

**REFERRING VET**

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**PRESENTING CLINICAL SIGNS**

Pancreatitis- bout of inappetence last couple of weeks; weight loss Pancreatic value increased but liver values improving Rad- intestines subjectively thickened. Had US in early 12-2021, want to see what has changed 1) Cerenia 24 mg- 1/2 T PO SID (Since Nov 2021) \*Did not do well on 8 mg SID 2) Ursodiol 90 mg PO SID (since mid-Dec 2021) 3) Denamarin Advanced- mostly 1 T PO SID (just started) 4) Gabapentin 30-50 mg PO SID to BID (just started, will taper to PRN) 5) Miralax 1/8-1/4 tsp PO SID 6) Benefiber 1/4 tsp PO SID 7) Cosequin 2 C PO SID 8) Revolution Plus monthly  
Abnormal PE/Chem/CBC/UA Results: Lateral radiograph, BW, prior AUS report attached for comparison.

**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 (4.29 cm) with pyelectasia at 0.24 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.7 cm) with pyelectasia at 0.21 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.45 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 0.35 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.

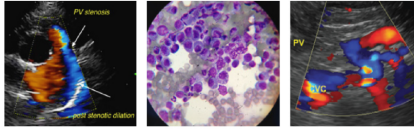
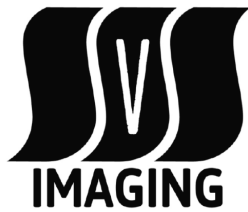
**Spleen**

The spleen is normal/borderline large in size (1.0 cm at the level of the hilus). The spleen echotexture is heterogenous and mottled, 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 bile duct appears tortuous and mildly dilated at 0.30 cm. No intraluminal material is 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. 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. Duodenum wall measured 0.47 cm. Jejunum wall measured 0.32 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. This presentation appears more pronounced than the previous scan (12/2021).

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 mottled 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.

***Free Abdomen***

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes noted. A lymph node near the ileocecal junction measures 0.38 cm. The omentum is slightly increased in echogenicity generally.

**ULTRASONOGRAPHIC FINDINGS**

- Decreased corticomedullary distinction in both kidneys with mild pyelectasia – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left/right kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Borderline large, mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis. The spleen is likely within normal limits, as this is a large cat. The spleen appears similar to the previous scan (12/2021).
- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation. (Pancreas appears similar to previous scan)
- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. (Liver appears similar to previous scan)
- Mildly dilated common bile duct – There is no apparent intraluminal material or inflammation associated with the bile duct.
- Thickened small intestine with prominent muscularis – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.

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- Occasional prominent mesenteric 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**

Most of the lesions observed on today's scan are similar to the previously visualized lesions reported in the scan from 12/2021. This includes renal change consistent with chronic renal disease, a mottled/nodular spleen, a prominent mottled pancreas, and a large heterogeneous liver. These findings are most likely consistent with chronic progressive renal disease, pancreatic remodeling, and a primary hepatopathy. Depending on how the patient is doing clinically, you could consider a fine needle aspirate of the spleen and liver if this was not previously done.

The GI tract does appear markedly thickened with a prominent muscularis layer. This appears stable to increased in severity. If not already done, consider:

- GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas, small intestine, etc.
- A novel protein/hydrolyzed protein prescription diet.
- Chronic probiotic therapy.
- If a diagnosis is desired, then it is likely that obtaining GI biopsies would be necessary.

These findings could be consistent with Triaditis and intermittent flare ups. If possible, management of the GI inflammation as well as Denamarin and Ursodiol chronically +/- probiotics, etc. can be helpful.

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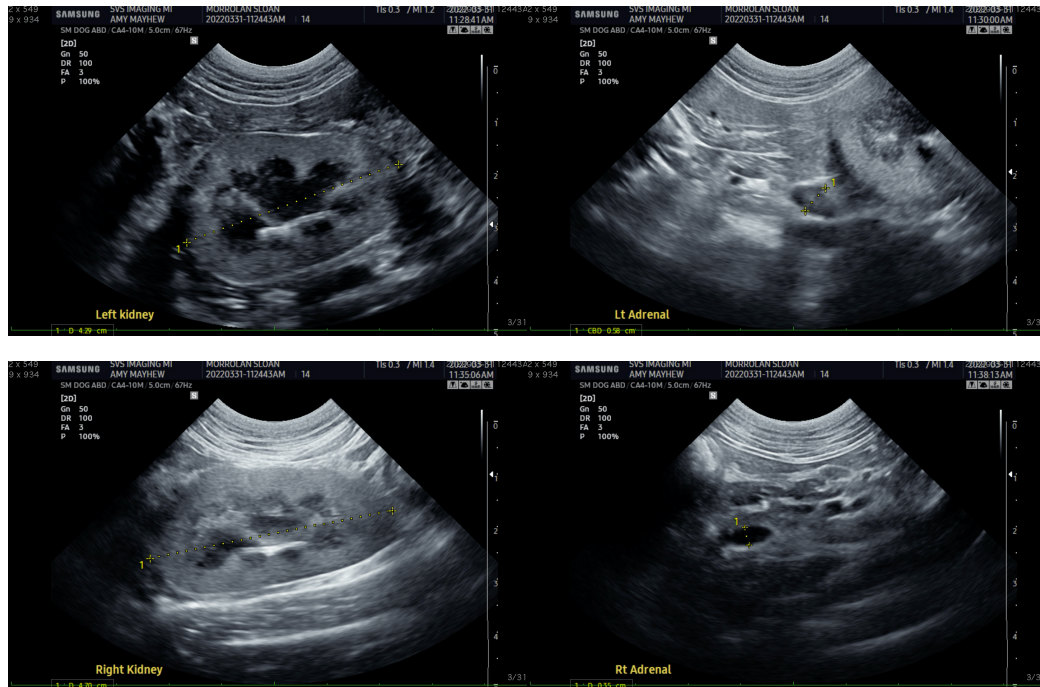
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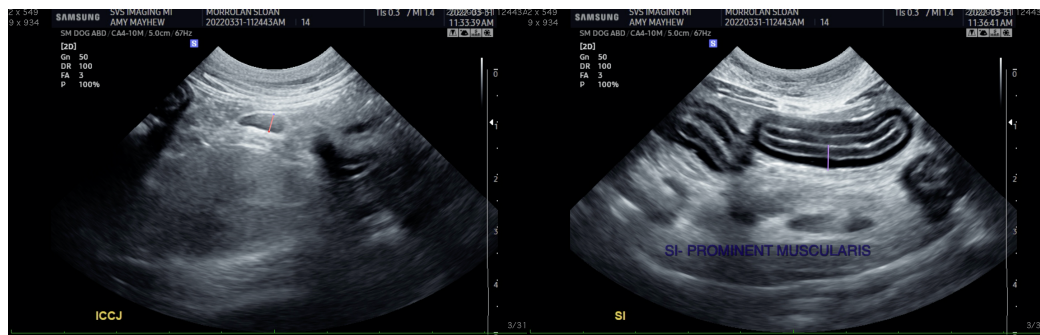
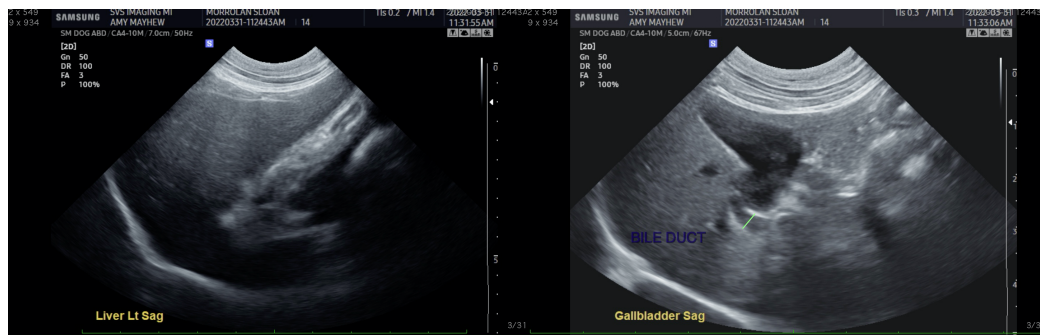
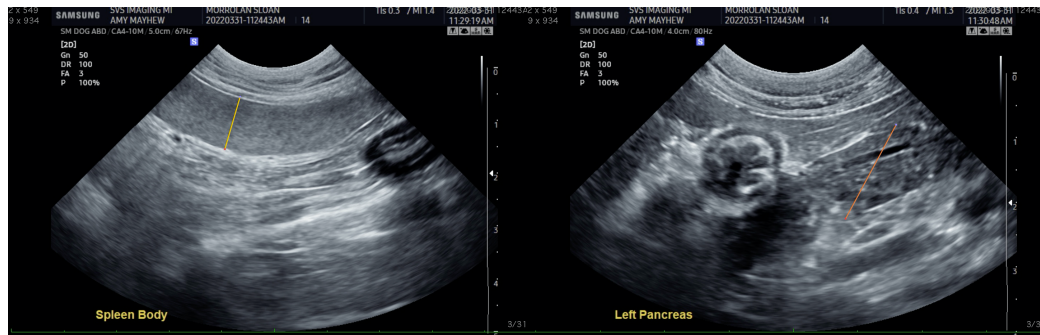
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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