



## PATIENT

CaptainTony Brickley

## PRESENTING CLINICAL SIGNS

### SPECIES

Feline

### BREED

DSH

### SEX

Neutered Male

### AGE

15 Years

not sedated- extremely painful and squirmy Breed: DSH Pt evaluated 3/8/22 for decreased appetite and pawing at his face, weight loss. HR 100, appearance of recent weight loss, pt resents cranial abdominal palpation, pt rubs face and mouth after abdominal palpation and oral exam. Pt only has 3 teeth, gingival recession noted canines. Blood panel sent to the lab yesterday: BUN 80, Creat 5.1, Ca 10.9, CHO 252, TG 67, Amyl 2614, PSL 105, Hct 26%, Neut 9450, lympho 525, proteinuria 1+, Pt vomiting blood clots once he returned home. Pt returned for hospitalization, on IV LRS, cerenia, famotidine, sucralfate, buprenorphine, mirtazapine HEART RATE AND RHYTHM: Heart Rate: 103 bpm Rhythm: Isorhythmic AV dissociation ECG AND CLINICAL ASSESSMENT: The overall heart rate is low, and there appears to be no relationship between the P waves and QRS complexes, consistent with atrioventricular (AV) dissociation. In cats, the differentials for this finding include age related degeneration of the AV node, metabolic disturbances (especially hyperkalemia), systemic hypertension, cardiomyopathy, and hypothermia. DIAGNOSTIC RECOMMENDATIONS: Thoracic radiographs are recommended. If cardiomegaly is noted on radiographs, an echocardiogram is recommended. Recommend a blood pressure if not previously performed. O opts to wait on cardiac work up pending ultrasound results and response to treatment

### WEIGHT

10.4 Pounds

### 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.

### INTERPRETED BY

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

The left kidney is small (2.6 cm) and very irregular in shape (likely due to previous infarcts), with pyelectasia at 0.12 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 or hydroureter. Renal vasculature is normal.

### IMAGING BY

Loetitia Saint-Jacques,  
LVT

The left kidney is small (3.72 cm) and very irregular in shape (likely due to previous infarcts), 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 or hydroureter. Renal vasculature is normal.

### HOSPITAL NAME

Brighton Greens VH

### Adrenal Glands

The left adrenal gland is normal/borderline large in size measuring 0.53 cm at the cranial pole, 0.32 cm at the caudal pole, and 1.2 cm in length. It is observed in its normal position cranial to the left renal artery. It is somewhat abnormal in appearance, in that the cranial pole is enlarged and somewhat hyperechoic, creating the impression of a cranial adrenal nodule. There is no evidence of vascular invasion or significant deviation of the normal adrenal shape.

### REFERRING VET

Dr. Amber Murphy

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.

### INVOICE

36001

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### **Spleen**

The spleen is subjectively normal in size (0.87 cm in height 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 cystic and common bile ducts are normal/not visible.

### **Gastrointestinal**

The stomach contains minimal luminal contents. In general the stomach wall appears normal, measuring at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. In the area of the pylorus, the gastric wall becomes more pronounced and hypoechoic with loss of layering and increased thickness. In this region, the gastric wall measures at 0.65 cm. Findings could be consistent with a focal mass, an ulcer, etc.

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. The duodenum measured as normal (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) 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**

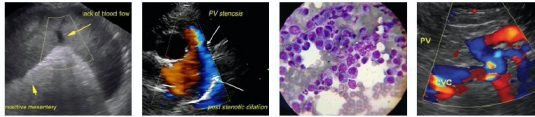
The pancreas is large, hypoechoic and irregular with surrounding hyperechoic mesentery and a dilated pancreatic duct. Findings are most consistent with moderate to severe pancreatitis or pancreatic neoplasia.

### **Free Abdomen**

There is no free fluid. There is a mild mesenteric lymphadenopathy noted with a mesenteric lymph node measuring 0.45 cm. The omentum is of increased echogenicity around the pancreas and the cranial abdomen.

## ULTRASONOGRAPHIC FINDINGS

- Large, hypoechoic, irregular pancreas – consistent with moderate to severe pancreatitis or infiltrative pancreatic disease.
- Focal gastric wall thickening with loss of layering in the area of the pylorus – could be consistent with infiltrative neoplasia, edema, benign mass effect, ulceration, etc.



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- Bilaterally irregular and small kidneys with pyelectasia and reduced corticomedullary distinction – 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.
- Hyperechoic, enlarged cranial pole of the left adrenal gland – Left adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.
- Mild mesenteric lymphadenopathy and cranial abdominal inflammation.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

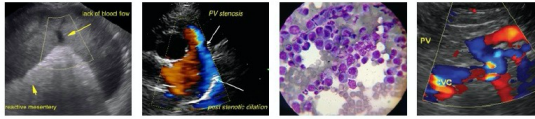
The pancreas is very large and hypoechoic with an almost “meaty” appearance. Recommend a fine needle aspirate of the pancreas as well as an fPLI level. Additionally, there is focal wall thickening in the stomach with loss of layering. This is in the region of the pancreas, so this could be inflammation, edema, etc. secondary to the pancreatic disease, or this could be concerning for primary neoplasia, ulceration, etc. If possible, consider fine needle aspirate of the gastric wall. I suspect it will be too deep to easily reach.

Both kidneys are very irregular and small with dilated renal pelvises. This is consistent with chronic progressive renal disease and previous insult. Recommend blood pressure evaluation, urinalysis and culture.

The cranial pole of the left adrenal gland is enlarged. This could be an incidental finding, or it could represent a neoplastic lesion. Recommend the aforementioned blood pressure evaluation. If signs of Cushing’s are present, you could consider adrenal function testing when this cat is feeling better. Recommend continued monitoring with ultrasound, as some adrenal lesions can be aggressive and change rapidly.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

If you are unable to obtain a diagnosis cytologically, then consider surgical biopsies if the renal function can be stabilized.



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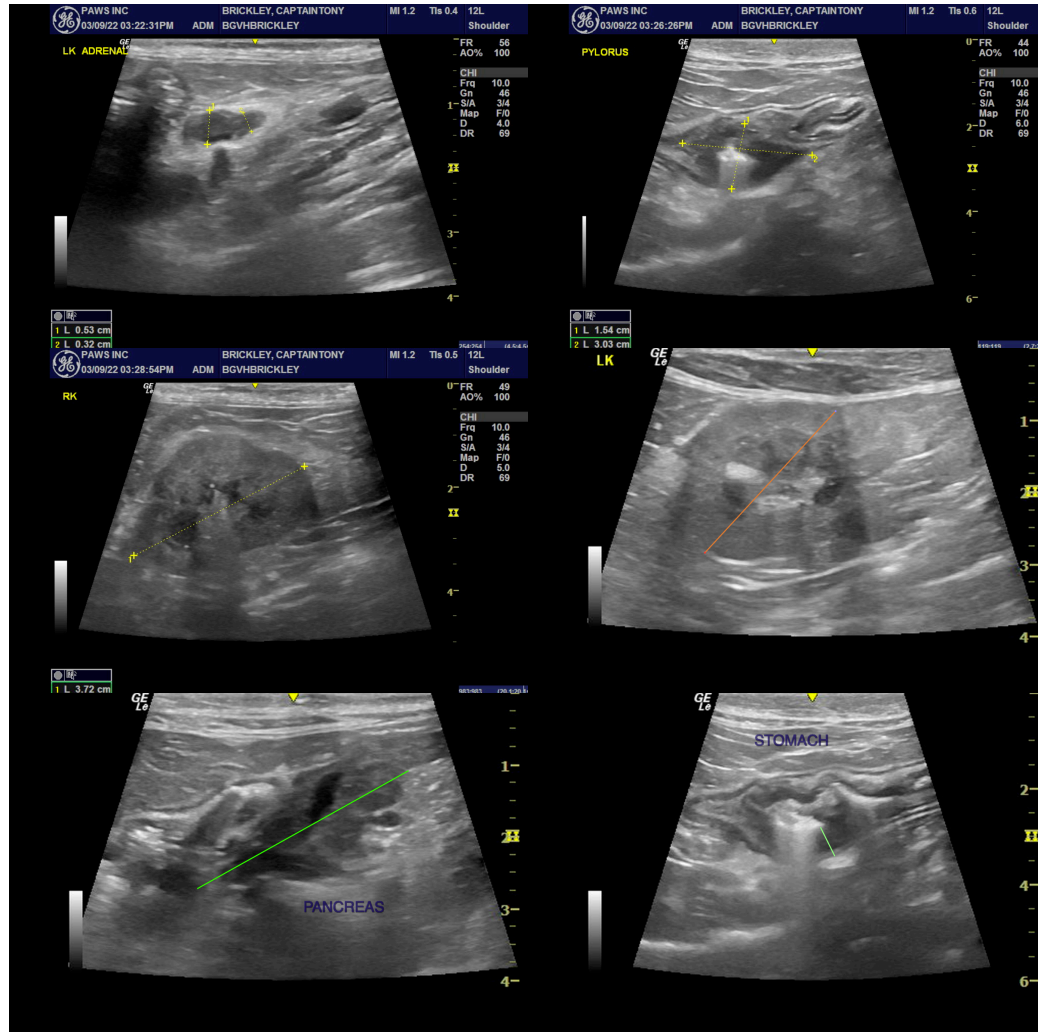
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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