



PATIENT

Oscar Watson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

11.4 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

All Creatures Great &
Small Vet Clinic

REFERRING VET

Dr. Beth Marszewski

INVOICE

46660

DATE

4/13/23

PRESENTING CLINICAL SIGNS

Hx of chronic intermittent vomiting. Acute onset dribbling urine

Abnormal PE/Chem/CBC/UA Results: Moderate MCS atrophy dorsum, painful on bladder palpation, otherwise NSF on PE Lateral abdominal radiograph: significant formed feces colon; bridging spondylosis @ L7-S1 w/ multiple narrowed disc spaces. Bladder large. BW/UA: CBC: HCT (30), PLT (167) adequate on slide, stress leukogram Chem: TP (9.4), Glob (6.4), BUN (48), Crea (2.4), SDMA (17.5) U/A: USG (1.015), Protein 1+ (UPC 1.2) IS

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is significantly 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 (4.13 cm) with mild pyelectasia at 0.14 cm. Overall echogenicity is normal with 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.79 cm) with mild pyelectasia at 0.22 cm. Overall echogenicity is normal with 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

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.

The right adrenal gland is normal in size measuring 0.42 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 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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.



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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 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 0.21 cm. Jejunum wall measures 0.15 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 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.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Mild bilateral pyelectasia – Pyelectasia of the kidney(s) could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the gastrointestinal tract to explain the chronic vomiting reported. The pancreas does appear somewhat prominent. Correlate these findings with a qualitative fPLI level, but I suspect these findings are most consistent with previous episodes of pancreatic inflammation. Unfortunately, there are many differentials for chronic vomiting that cannot be diagnosed by ultrasound alone.

Consider such differentials as food allergy/dietary intolerance, GI parasitism, chronic pancreatitis, IBD and less likely neoplasia, etc..

- 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.
- If vomiting persists despite taking these measures, consider obtaining GI biopsies.



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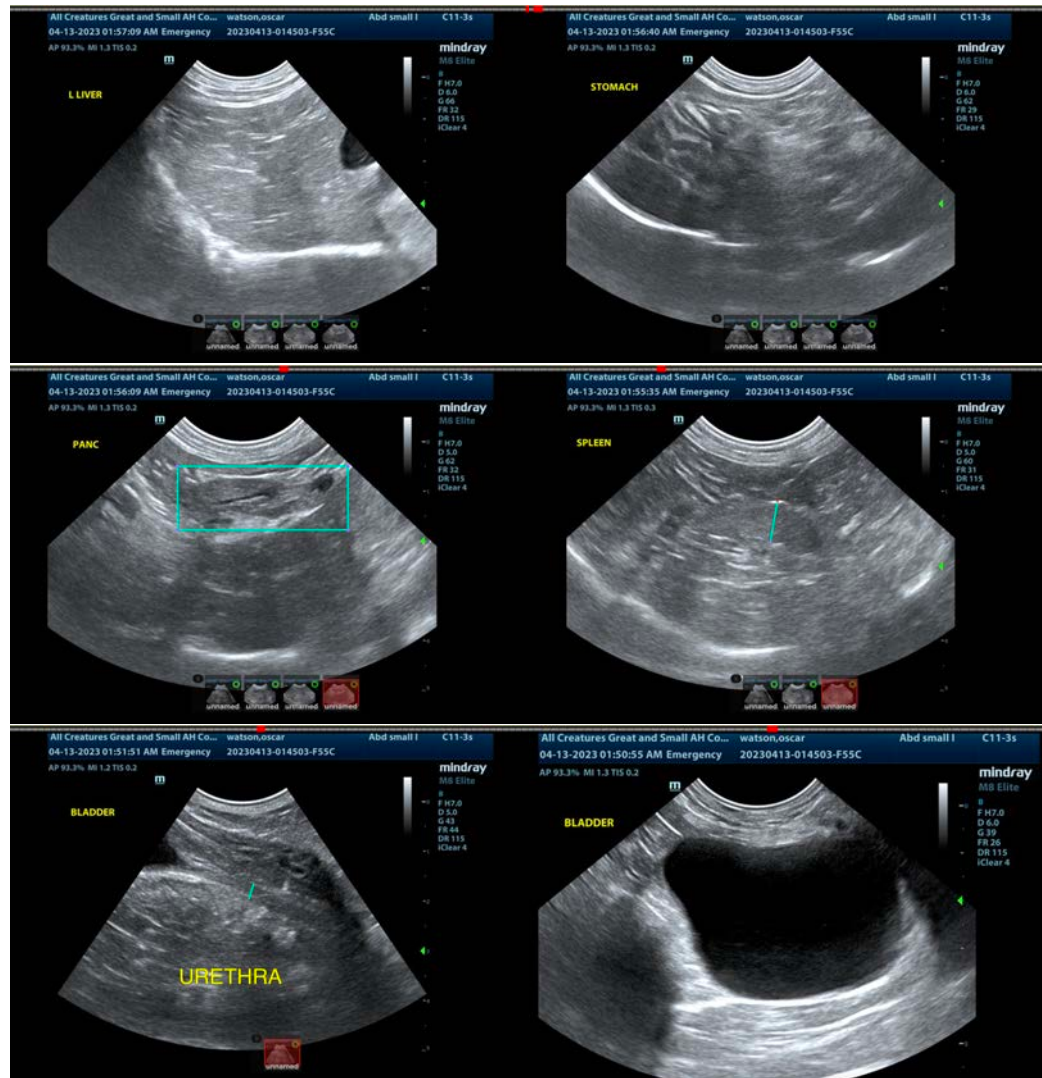
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The urinary bladder is distended and large. The trigone region and the visible urethra appear free of any obvious anatomic obstructions. Concern would be for a possible functional obstruction due to an upper motor neuron bladder. Consider consultation with a veterinary neurologist. If this is the case, medications to relax the sphincter may be necessary. Additionally, possible workup for a spinal lesion could be considered.

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

There is mild pyelectasia visualized associated with both kidneys. Recommend a urinalysis and culture, looking for evidence of infection. Additionally, this could be due to increased resistance if it is difficult to empty the urinary bladder.





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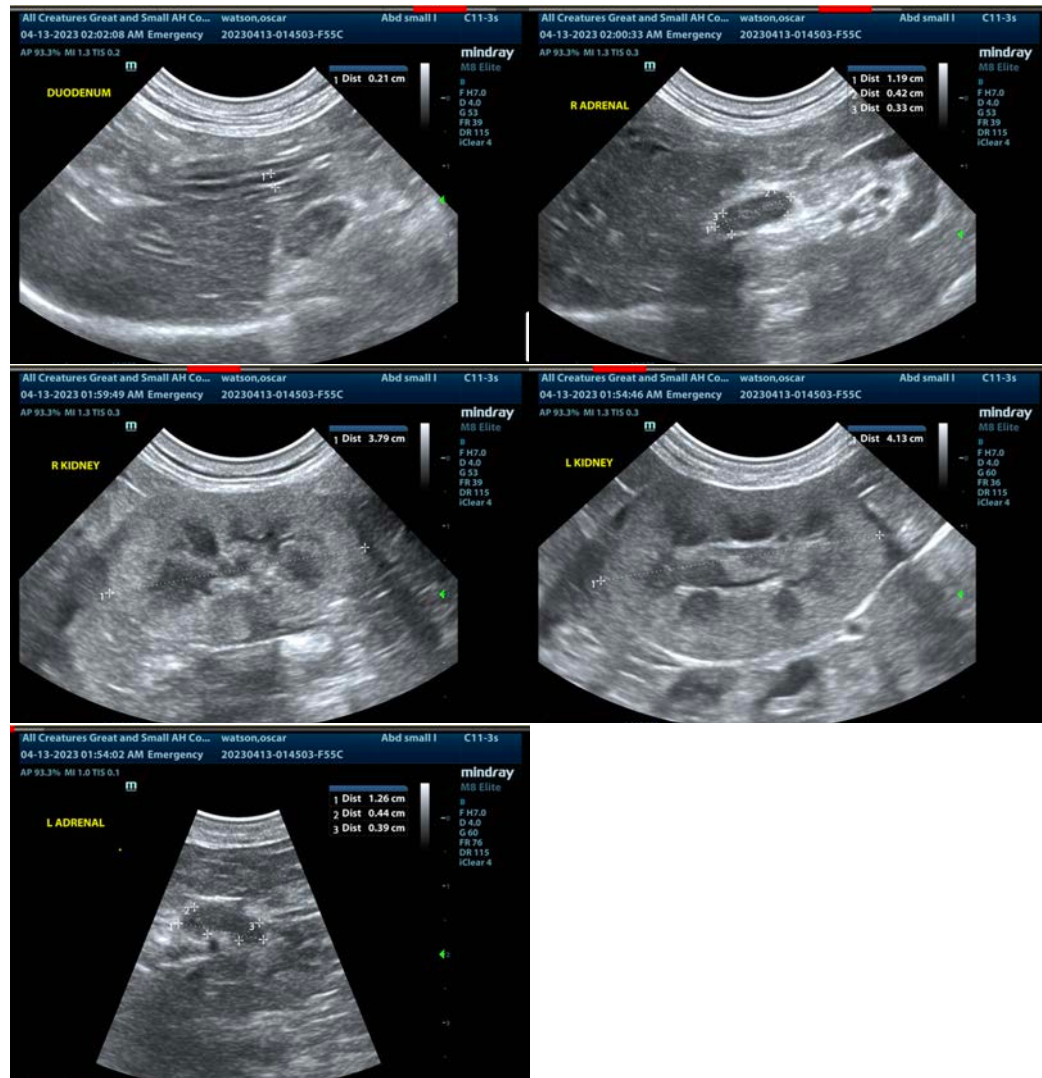
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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