**PATIENT**

Mr. Kitty Willemse

**SPECIES**

Feline

**BREED**

DLH

**SEX**

Neutered Male

**AGE**

16 Years

**WEIGHT**

7.46 Pounds

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

Amy Mayhew, LVT

**HOSPITAL NAME**

SVS Imaging MI

**REFERRING VET**Patterson Dog & Cat  
Hospital**INVOICE**

37628

**DATE**

5/12/22

**PRESENTING CLINICAL SIGNS**

Chronic soft stool/ diarrhea for about a year, bloody mucous in stool noted as well Exam findings and abnormal lab values: Incomplete assessment due to aggression.

**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 (3.68 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.65 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.27 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 0.34 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.

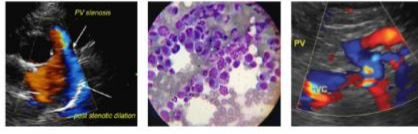
**Liver**

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. There is an ill-defined, hypoechoic nodule visualized within the parenchyma measuring 0.58 cm.

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 proximal bile duct appears significantly dilated and tortuous. It tapers as it reaches the duodenal papillae and measures at approximately 0.33 cm. No point of obstruction is observed.

**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.

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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 0.24 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 nonformed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering. Colon wall measures 0.23 cm.

**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. Prominent pancreatic duct noted at 0.23 cm.

**Free Abdomen**

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mild diffuse mesenteric lymphadenopathy visualized with mesenteric lymph nodes measuring 0.36 and 0.46 cm. There is a caudal colic lymph node measuring 0.46 cm.

**PRIMARY FINDINGS**

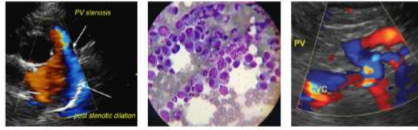
- Prominent, mottled pancreas with dilated pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Hypoechoic hepatic nodule – This nodule is subtle and small, and could represent a benign or early neoplastic process.
- Tortuous, dilated common bile duct with no visible obstruction – 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 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.
- Diffuse mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

**SECONDARY FINDINGS**

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There is evidence of generalized abdominal inflammation with prominent small intestine with a thickened muscularis layer, prominent wall to the colon, and a diffuse mesenteric lymphadenopathy. These changes are consistent with the chronic diarrhea reported. Likely differentials would include



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good allergy/dietary intolerance, GI parasitism (less likely with your testing done), dysbiosis, chronic pancreatitis, IBD, and less likely intestinal neoplasia.

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- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider chronic probiotic therapy.
- Recommend a GI panel with a qualitative fPLI, TLI, cobalamin and folate to rule out exocrine pancreatic insufficiency, and to further evaluate the pancreas and small intestine.
- If symptoms persist despite dietary changes, etc., recommend obtaining GI biopsies.

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There is a significant lymphadenopathy present, so a fine needle aspirate of a lymph node would be helpful to look for underlying lymphoma (a fine needle aspirate was performed at the time of exam). Additionally, consideration of the concurrent pancreatic and biliary changes could indicate signs of early Triaditis.

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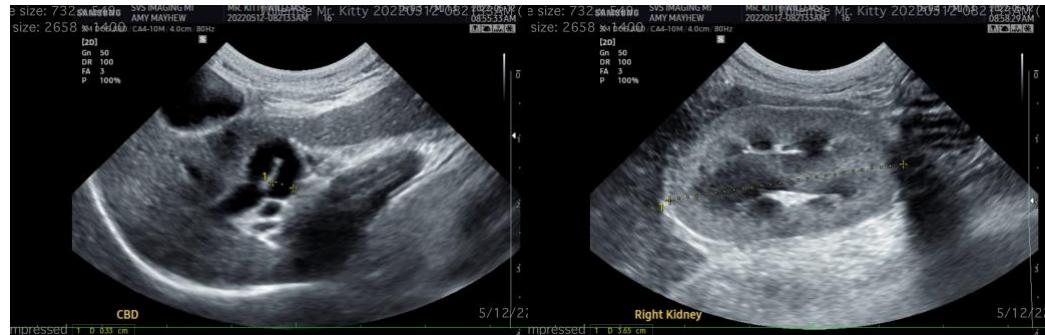


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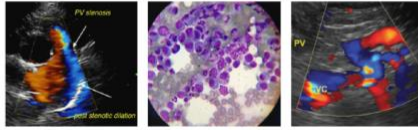
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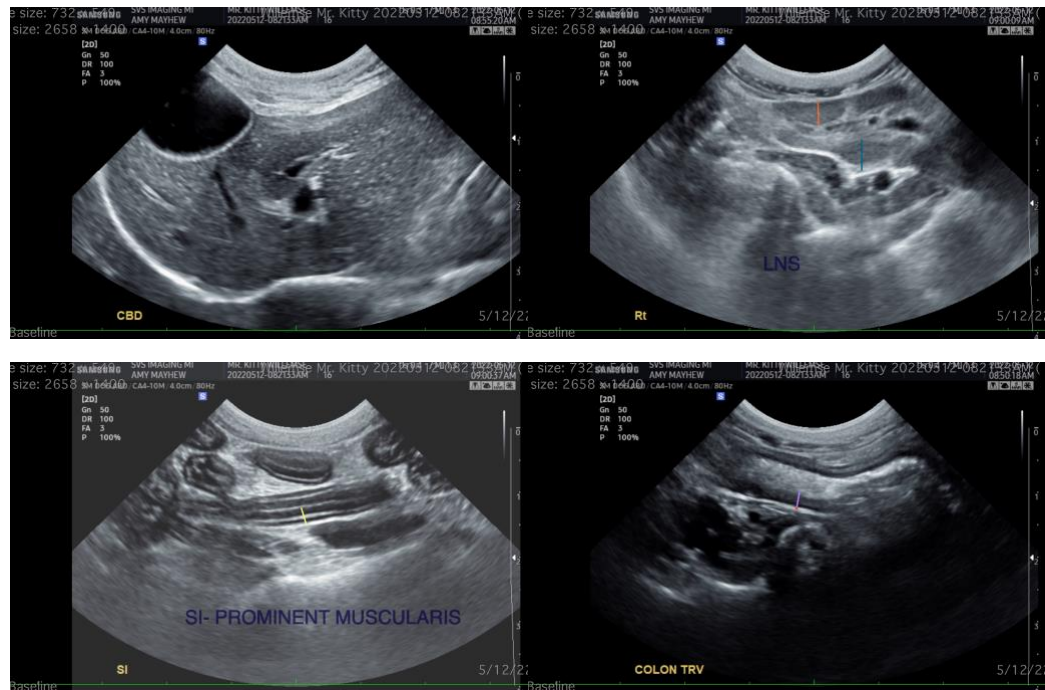
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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