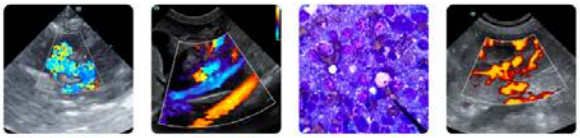


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Sophie Babb

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

14 Years

WEIGHT

3.66 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Waterloo West Animal Hospital

REFERRING VET

Dr. Makkapati

INVOICE

75501

DATE

5/28/26

PRESENTING CLINICAL SIGNS

Anorexia, vomiting, lethargy, drooling; has been in diabetic remission for the last few months; has been presenting with IBD similar flare-ups off and on; pet is on hypoallergenic diet; on exam, intestinal loops feel thickened; presented on Tuesday and 1 mg/kg trial with Prednisolone was started for IBD; pet is on Cerenia PO as needed. Current Medications: Prednisolone 1mg/kg SID, Cerenia 6mg SID

Abnormal PE/Chem/CBC/UA Results: ABNORMAL Labwork Values increased pancreatic lipase for the last few months Radiographic Findings inconclusive radiographs; gas-filled stomach; porous fecal material in colon Primary Question to Be Answered in This Exam cause for anorexia and vomiting; obstruction vs neoplasia

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

The right kidney has a normal shape and size (3.78 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.49 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.

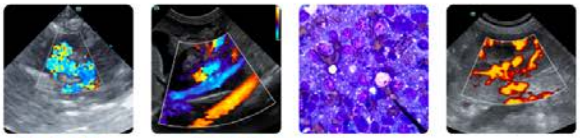
The right adrenal gland is not clearly visualized.

Spleen

The spleen is subjectively normal in size (0.84 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.

Liver

The liver is subjectively normal in size, and echogenicity with slightly irregular peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The vasculature appears normal. The intrahepatic bile ducts appear somewhat dilated. There are numerous ill-defined hyperechoic nodules. Some more defined hyperechoic nodules in the parenchyma measure 1.24, 1.68, and 1.47 cm.



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The gall bladder is large with a moderate amount of debris. The gallbladder has a hyperechoic, thickened wall measuring at 0.22 cm, with adhered debris. The bile duct appears dilated and tortuous with a thickened wall, measuring up to 0.91 cm with the wall measuring 0.28 cm, with a large amount of intraluminal mucoid debris.

Gastrointestinal

The stomach contains mild fluid. 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 measures 0.30 cm. Jejunum wall measures 0.20 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 left limb of the pancreas is mildly prominent and mottled, and the right limb is hypoechoic and mottled. There is no evidence of nodules or cystic lesions. There is reactive mesentery in the right cranial abdomen in the region of the pancreas.

Free Abdomen

There is scant free fluid in the cranial abdomen. There is a mild mesenteric lymphadenopathy with some prominent lymph nodes near the ileocecal junction. An example measures 0.88 cm. A large, hypoechoic, rounded lymph node in the cranial abdomen measures 1.32 cm. The omentum is hyperechoic and reactive in the right cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with mild/moderate chronic active pancreatitis. A neoplastic process cannot be excluded in the right limb.
- Heterogeneous liver with dilated intrahepatic bile ducts and hyperechoic nodules – Findings are concerning for hepatobiliary disease. The hyperechoic nodules have an appearance most consistent with cystadenomas and cystadenocarcinomas. Other differentials are possible.
- Gallbladder changes most consistent with cholecystitis and partially obstructive biliary disease (mucoduct).
- Mild diffuse thickening of the small intestine with prominent muscularis layer – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Significant cranial abdominal lymphadenopathy with more caudal reactive lymph nodes – Findings could be consistent with highly reactive or early neoplastic lymph nodes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

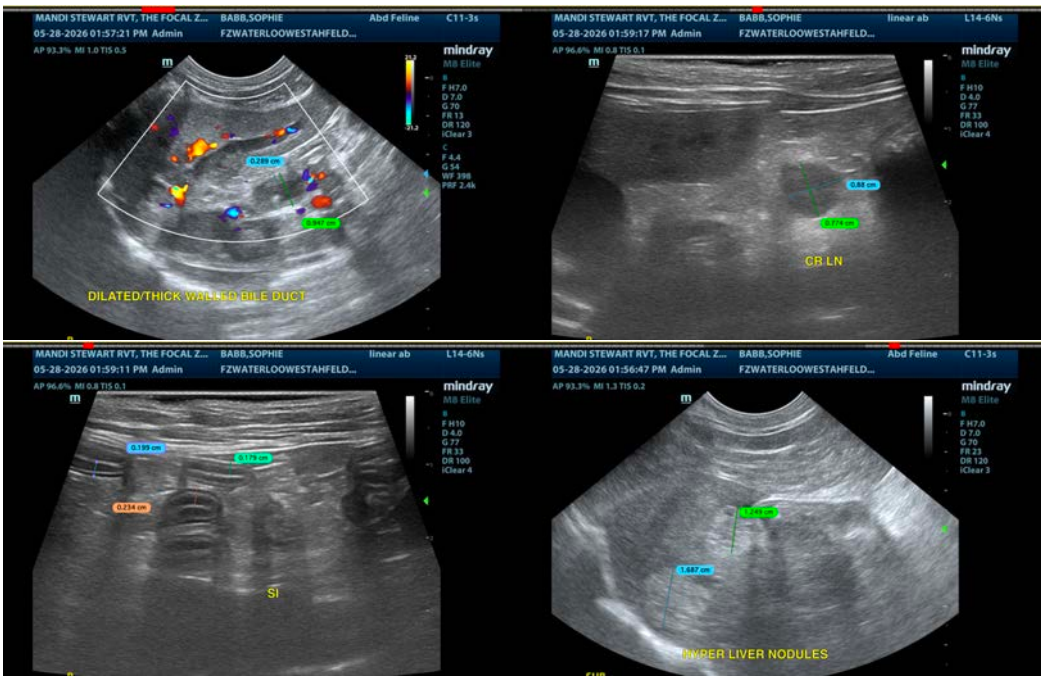
The gallbladder appears thickened with a thickened wall and intraluminal debris. Additionally, there is dilation of the intrahepatic bile ducts, and the common bile duct is dilated, tortuous and thickened with mucoid debris. Findings are concerning for significant cholangiohepatitis. A definitive focal obstruction is not observed. Recommend aggressive therapy with Ursodiol, Denamarin, antibiotics, and supportive therapy with continued monitoring of liver values and the gallbladder with ultrasound. There is scant free fluid in the cranial abdomen but no evidence of a rupture at this time.

There is inflammation and abnormal tissue in the right cranial abdomen, with some areas of the pancreas appearing prominent and hypoechoic, most consistent with pancreatitis. Additionally, lymph nodes in the area are likely reactive, but an early neoplastic process cannot be ruled out.

The small intestine appears mildly thickened, most consistent with inflammatory type change +/- mild IBD. If surgery is necessary and/or pursued, biopsies of the GI tract would be strongly recommended.

The combination of changes involving the biliary tract, pancreas and GI tract could be consistent with triaditis.

If there is no response to treatment, ultimately advanced imaging of the region may be necessary to better evaluate for a more focal lesion, a small mass effect, etc. Consider reduction of the steroids to an anti-inflammatory dose at the highest (0.5 mg/kg per day) and close monitoring for return of diabetes, as insulin therapy may become necessary again.



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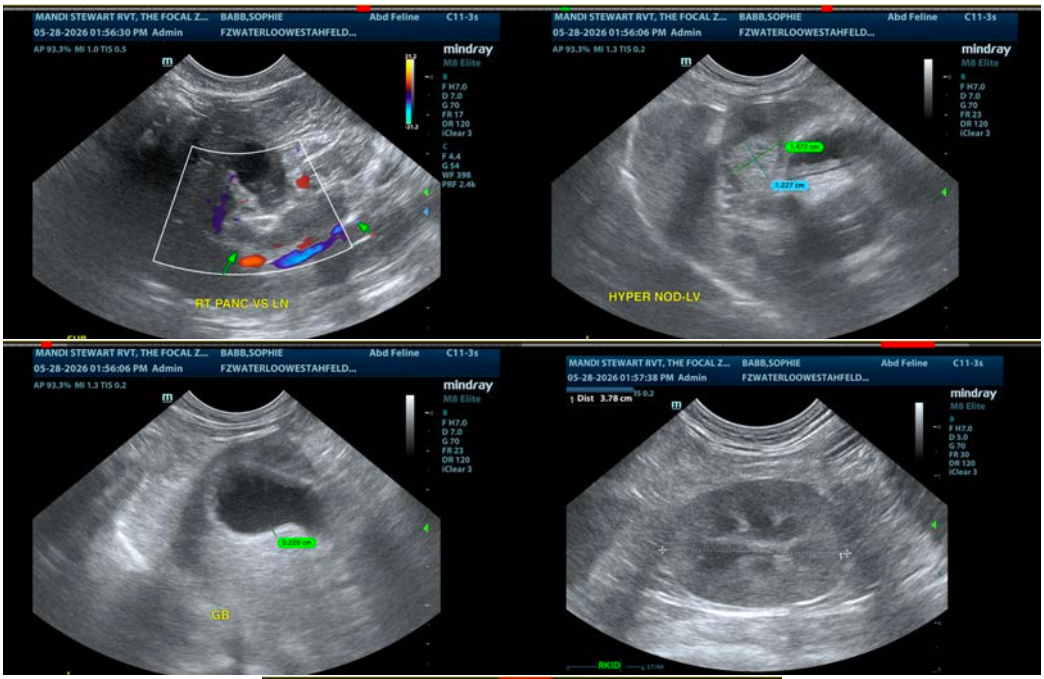

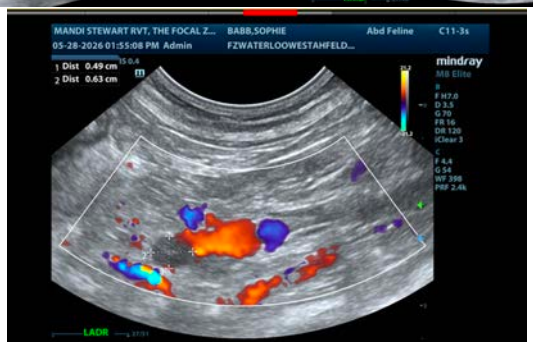

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com