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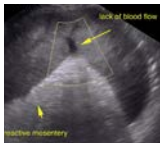
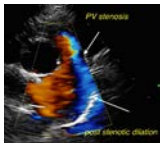
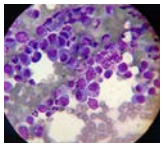
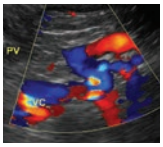

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1-800-838-4268 info@sonopath.com

**PATIENT**
Bella Sherrer

**SPECIES**
Feline

**BREED**
DSH

**SEX**
Spayed Female

**AGE**
13 Years

**WEIGHT**
10.5 Pounds

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

**IMAGING PERFORMED BY**
Val Shumskaya

**HOSPITAL NAME**
Mount Olive VH

**REFERRING VET**
Dr. Logan

**INVOICE**
43098

**DATE**
6/13/23

## PRESENTING CLINICAL SIGNS

GI dz Current meds: Metro, probiotics, had depo medrol on 26 May
Abnormal PE/Chem/CBC/UA Results: WBC 34.1, pHs 82 (clumped) neut 20266, creat 0.4, Na/K ratio 28, Chol 279

## 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 (3.64 cm). Overall echogenicity is slightly hyperechoic with poor 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 (4.08 cm). Overall echogenicity is slightly hyperechoic with poor 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 0.46 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/borderline enlarged, measuring 0.77 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 (0.46 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 mildly enlarged in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in 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.

### *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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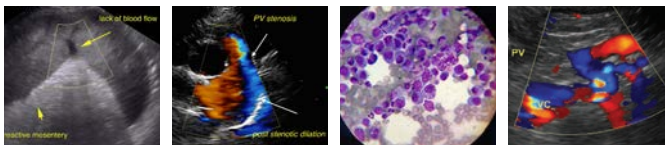

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measures 0.16 cm. Visualized peristalsis appears appropriate. Some areas of small bowel appear slightly corrugated, consistent with irritation/enteritis.

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*

There is a small amount of free abdominal fluid. No significant lymphadenopathy is noted. The omentum appears hyperechoic and somewhat irregular, almost nodular in some regions, particularly in the areas of the pancreas.

## PRIMARY FINDINGS

- Hypoechoic, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Borderline large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. In the absence of liver enzyme elevations, the significance of this is uncertain.
- Free abdominal fluid with irregular hyperechoic mesentery – Findings are most consistent with peritoneal inflammation.

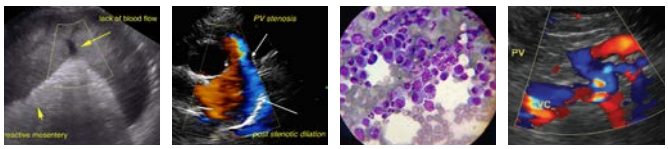
## SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Slightly prominent/enlarged right adrenal gland – The significance of this is uncertain. Recommend continued monitoring. The adrenal appears normal in all other aspects.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the gastrointestinal tract to explain the chronic GI signs noted. There is generalized inflammation in the abdomen with some free abdominal fluid and irregular mesentery. Correlate these findings with a quantitative fPLI level. There are areas where the pancreas is somewhat prominent and mottled, but a definitively inflamed pancreas is not identified. Additionally, consider the possibility that a steroid administration could be masking some previously visible changes in the small bowel. There is some mild corrugation evident, most consistent with enteritis/inflammation.

Unfortunately, there are many causes for gastrointestinal disease that cannot be definitively diagnosed by ultrasound alone.



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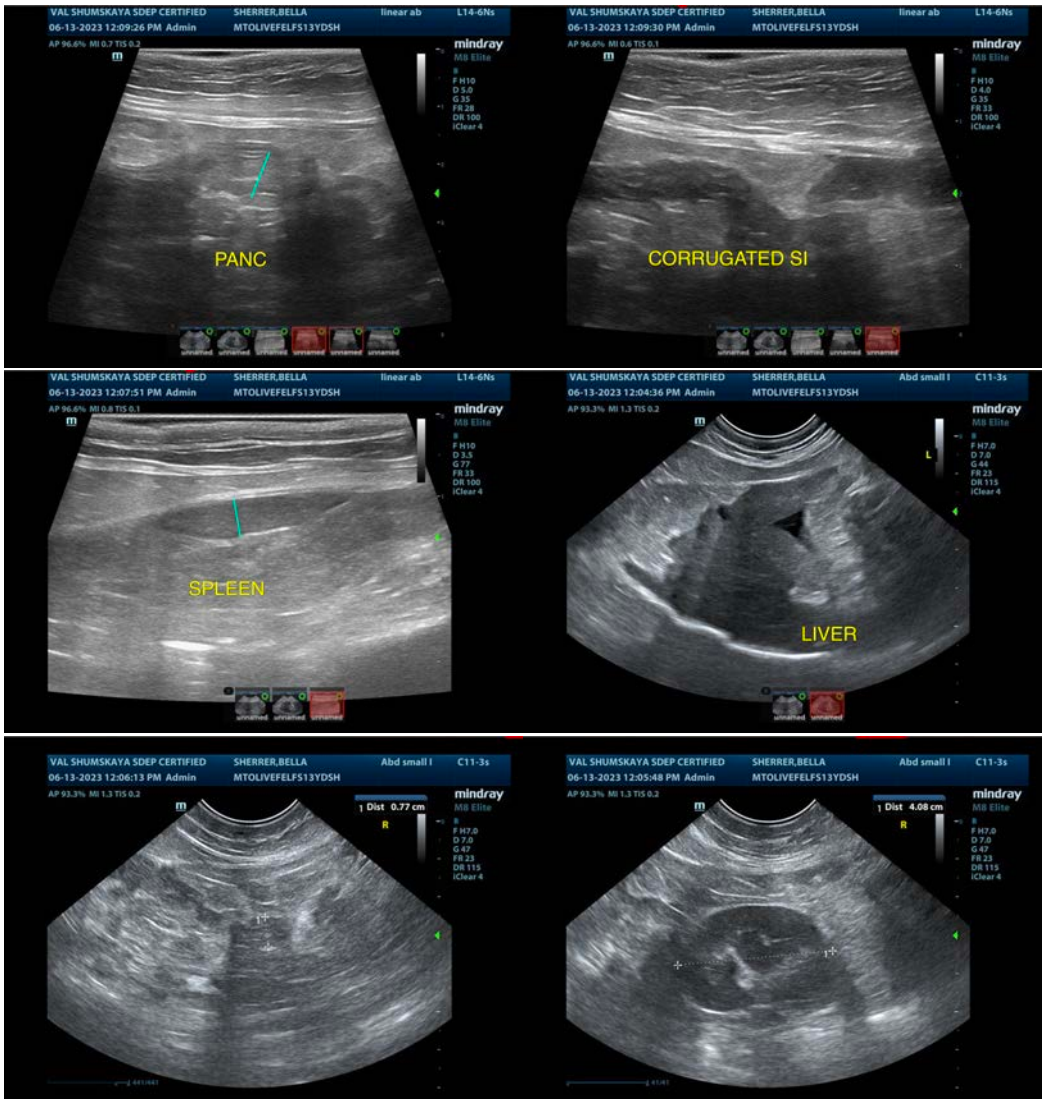
Consider such differentials as food allergy/dietary intolerance, GI parasitism, pancreatitis, dysbiosis, recurrent dietary indiscretion, IBD and less likely neoplasia, etc….

- 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 symptoms are persistent and primary gastrointestinal disease is thought likely, consider obtaining GI biopsies.

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



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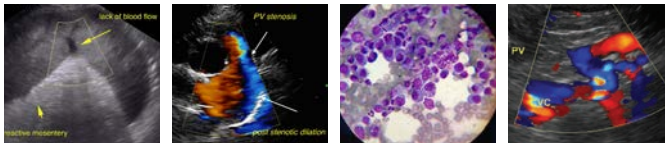

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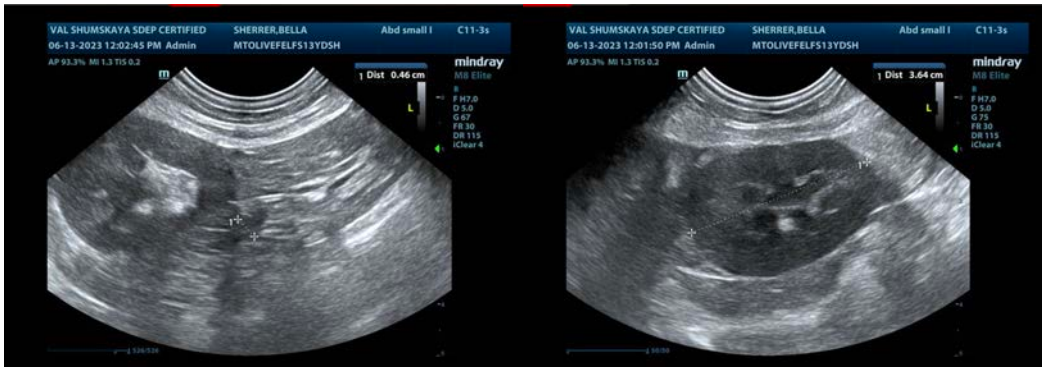


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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)

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