PATIENT

Sammie Chapman

SPECIES

Feline

BREED

Persian

SEX

Neutered Male

AGE

10 Years

WEIGHT

7.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS, Certified Vet Sonographer

HOSPITAL NAME

All Friends Animal Hospital

REFERRING VET

Elizabeth Friday, DVM

INVOICE

75969

DATE

6/17/26

PRESENTING CLINICAL SIGNS

Geriatric feline with known CKD has new finding of ALT elevation (367). On NF diet.

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 (3.18 cm) with mild pyelectasia at 0.25 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (0.33 cm) with pyelectasia at 0.28 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.41 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 0.38 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 normal in size and shape, measuring 0.62 cm in width at the level of the hilus. The blood flow through the hilus and splenic parenchyma appears normal. There is a hypoechoic nodule in the spleen measuring 0.58 cm x 0.44 cm.

Liver

The liver is large in size, and hyperechoic with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened (0.14 cm) and has a smooth mucosal surface. In the dependent portion of the gallbladder there is shadowing mineralized material most consistent with numerous calculi/mineralized debris. This area measures 0.79 cm. The bile duct appears somewhat dilated and tortuous proximally, measuring at 0.23 cm. Distally it is difficult to differentiate the pancreatic duct from the bile duct.

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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 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 0.32 cm. Jejunum wall measures 0.28 cm. Visualized peristalsis appears appropriate. The small intestine generally has a "ropey", thickened appearance with a prominent muscularis layer. The duodenal papilla is visualized and appears enlarged, measuring at 0.66 cm with an associated dilated pancreatic and bile duct.

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 hypoechoic and mottled in both limbs. The pancreatic duct is variably dilated, measuring up to 0.50 cm in some areas, with too numerous to count variably sized (some large – up to 0.40 cm) calculi noted within the pancreatic duct in both limbs of the pancreas. A large stone is visualized near the duodenal papilla measuring 0.65 cm. The pancreatic duct in this region measures 0.33 cm.

Free Abdomen

There is scant free fluid visualized in the region of the gallbladder, the urinary bladder, and mid abdomen. No significant lymphadenopathy noted. The omentum is hyperechoic in the cranial abdomen in the regions of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with bilateral pyelectasia – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the kidneys could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Hypoechoic nodule in the spleen – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Pancreatic changes consistent with chronic pancreatic remodeling and chronic pancreatitis as well as too numerous to count variably sized (some large) stones in the pancreatic ducts.

- Large, heterogeneous, hyperechoic liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.

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- Choleliths visualized in the gallbladder with a dilated tortuous bile duct – 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). A definitive obstructive cholelith is not visualized at this time.
- Diffusely thickened small intestine with a 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.
- Large duodenal papilla – Findings could be consistent with inflammation or early neoplastic change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are stones visualized in the gallbladder, and too numerous to count stones within the pancreatic duct. A large stone is visualized in the distal aspect of the pancreatic duct just proximal to the duodenal papilla, which appears enlarged. No definitive stones are visualized in the biliary tract, but it is difficult to differentiate the dilated bile duct from the dilated pancreatic duct in some areas. Findings are suggestive of chronic pancreatic disease/pancreatitis, as well as inflammatory +/- infectious hepatobiliary and pancreatic disease. This is often associated with underlying gastrointestinal disease, which is supported by the appearance of the thickened small intestine with a prominent muscularis layer. The significance of the enlarged duodenal papilla is uncertain. This could represent a benign or early neoplastic changes.

Initially recommend an fPLI level to assess for pancreatitis, treatment for pancreatitis, and ideally cytology and cultures from the gallbladder via cholecystocentesis. A fine needle aspirate of the liver should be performed, as it is large, hyperechoic and heterogeneous. There could be concern for underlying round cell neoplasia or similar (confirm normal coagulation parameters first).

This likely will represent a chronic condition for this individual with management of suspected gastrointestinal disease as well as pancreatic and biliary issues. If possible, referral to a veterinary internist for management may be helpful. In some situations, advanced imaging and/or biopsies are very helpful to help manage the situation. If this is not an option, then consider management for pancreatitis and cholangiohepatitis with periodic ultrasonographic monitoring. Fine needle aspirate of the liver and the splenic lesion is strongly recommended, looking for possible underlying round cell neoplasia, as the appearance of the duodenal papilla is abnormal.

Additionally consider a novel protein/hydrolyzed protein prescription diet, a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, and chronic probiotic therapy in addition to the treatment for pancreatitis and likely treatment with Denamarin, Ursodiol +/- antibiotics and +/- treatment for IBD. If this is confirmed, caution with use of steroids without a diagnosis, as ascending infections can occur.

The renal changes are significant. If not already done, recommend a urinalysis, culture, blood pressure evaluation as a baseline.

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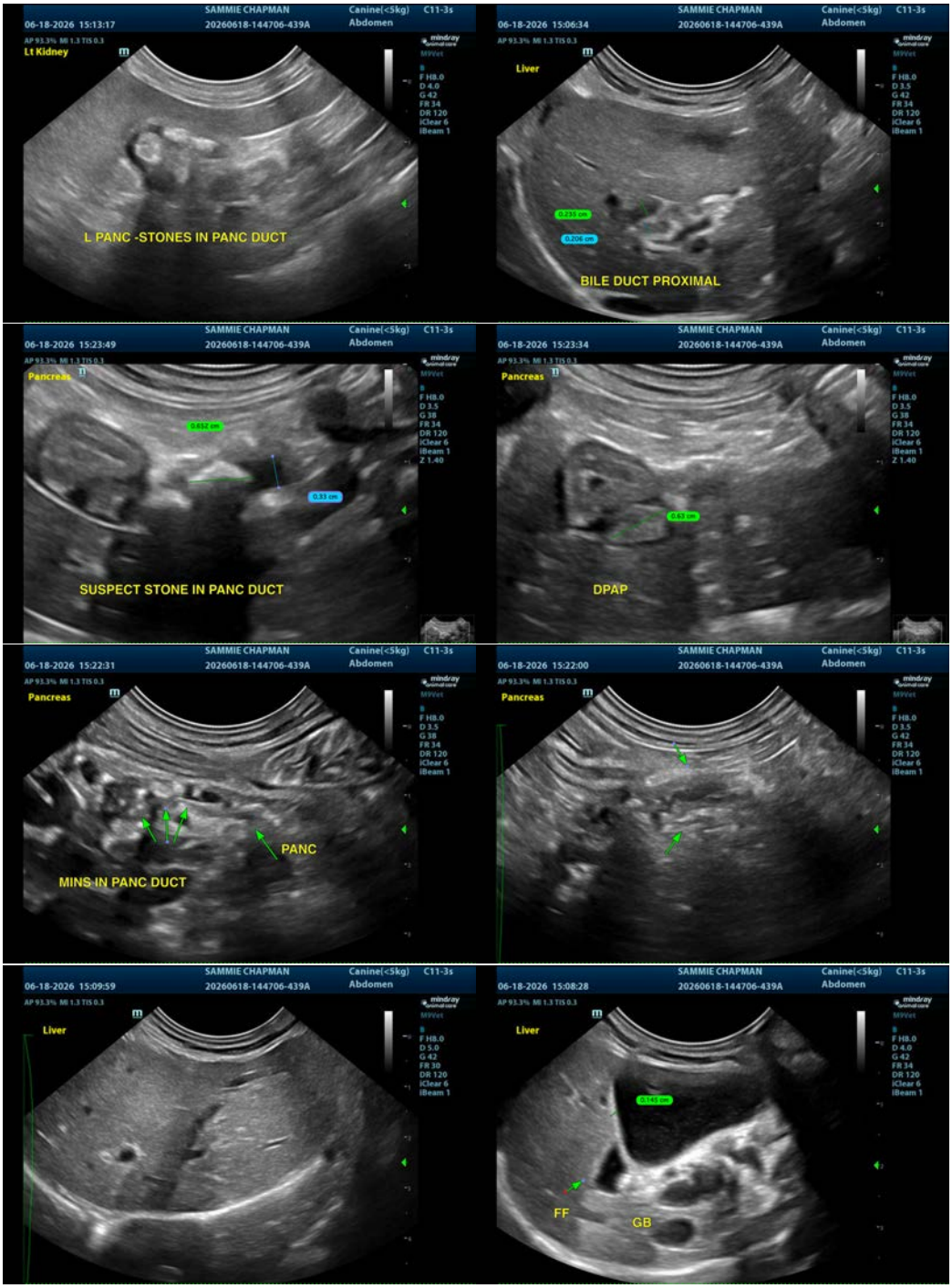

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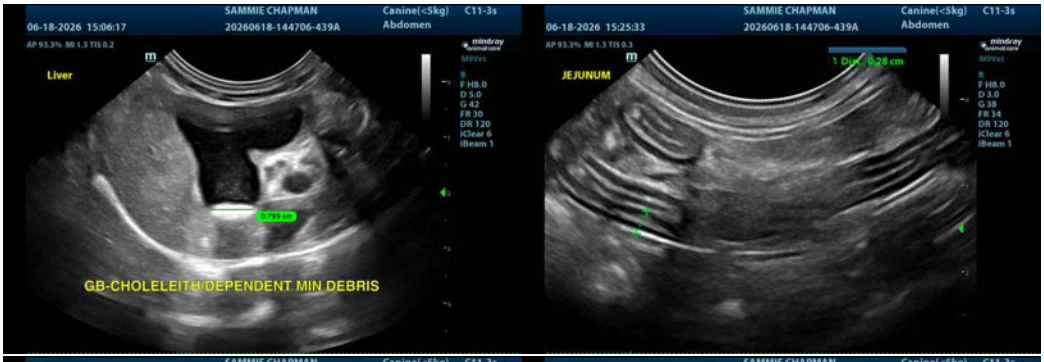

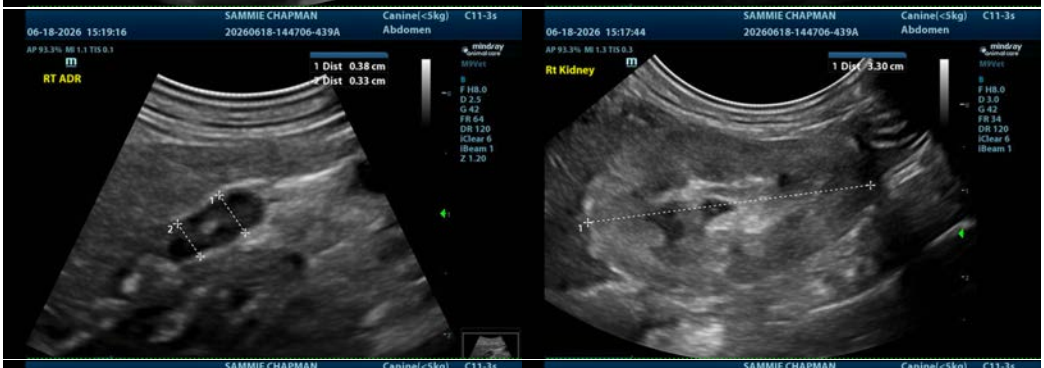

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com