

**PATIENT**

Harley Lynde

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

15 Years

**WEIGHT**

8.5 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**Cat Care of  
Rochester Hills**INVOICE**

39029

**DATE**

6/23/22

**PRESENTING CLINICAL SIGNS**

Chronic pancreatitis; stopped eating Sunday 6-19-22 Currently on Prednisolone 2.5 mg q12 hr (I just increased to 5 mg q12 h on 6-22), Mirataz 1" T.D. q24h, and Cerenia 8 mg q24h, Miralax 1/4 tsp q 24 h, buprenorphine 0.06 mg q 8-12 hrs. 12.5 mg Zeniquin q 24 hrs  
Abnormal PE/Chem/CBC/UA Results: Will email labs.

**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 (2.83 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 (3.76 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 0.36 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 visualized due to patient discomfort.

**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 large in size, and normal in echogenicity 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 and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic duct and common bile duct appear dilated and tortuous, measuring 0.31 cm proximally with some intraluminal mucoid debris.

**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 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. The duodenum measured as normal (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) 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 to the surrounding mesentery. It appears significantly mottled with numerous cystic regions, the largest of which measures 1.4 cm in diameter. The surrounding mesentery appears hyperechoic. Findings are most consistent with chronic pancreatic disease and moderate acute pancreatitis.

**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.

**PRIMARY FINDINGS**

- Hypoechoic mottled cystic pancreas with surrounding hyperechoic mesentery – The pancreatic changes are most consistent with moderate 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.
- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Mild gallbladder debris 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).

**SECONDARY FINDINGS**

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

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The pancreas appears prominent, cystic and inflamed. Additionally, there is discomfort reported on scanning over this region. I suspect there have been previous episodes of pancreatitis as well. Recommend aggressive medical management for pancreatic disease. If the patient is not feeling better, you may consider aspirating/draining some of the larger nodules and aspirating the pancreas to rule out underlying neoplastic disease.

Additionally, the liver is heterogeneous and there is some debris in the gallbladder and mild/moderate bile duct dilation. This bile duct dilation could be secondary to pancreatitis (post-hepatic partial obstruction) or due to mucoïd debris, etc. Consider starting Ursodiol and continuing to monitor liver values and the appearance of the bile duct/gallbladder. If liver enzymes are elevated, consider a fine

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needle aspirate of the liver. I would caution in this case with increasing the Prednisone dose significantly, as I am concerned there is risk for the development of pancreatitis with the chronic pancreatic disease present.

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Although the GI tract appears relatively normal, there is the possibility of a Triaditis like syndrome involving the liver, pancreas, +/- small intestine. If this patient is not responding to medical management, you could consider obtaining biopsies of the GI tract, liver and pancreas in addition to placement of a feeding tube, etc.

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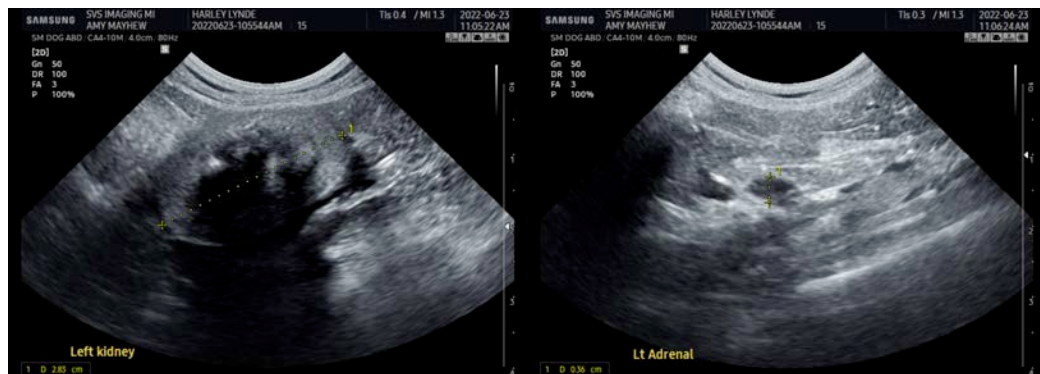
Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

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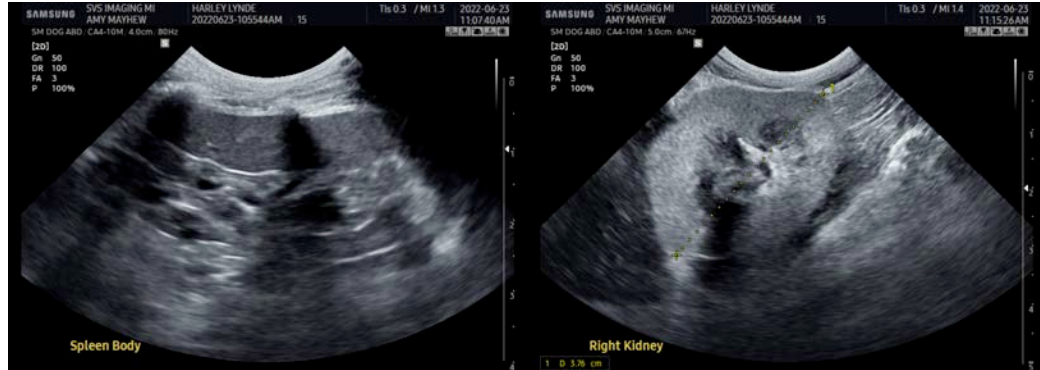
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com