



PATIENT PRESENTING CLINICAL SIGNS

Cream Miller

Presented for Hyporexia, weight loss, abdominal pain and vomiting. Patient is an IRIS stage 2 CKD kitty who was initially sent home with gabapentin and cerenia on 6/23/23. fPL was abnormal in house and sent out for quantification (47.5ug/L; RI 0-3.5). Recommend US due to marked elevation. Currently on Hill's K/D diet.

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

Abnormal PE/Chem/CBC/UA Results: CBC mild thrombocytopenia with normal PCT suspect secondary to clumping. Eosinophilia. Chem - SDMA 24(0-14) Creatinine 189(71-212)prev 220 in Feb Urea 12.8(5.7-12.9) prev 15.7 in Feb Mild hypochloremia, elevated lipase, T4 WNL although high end of normal, fPL abnormal U/A SP grav- 1.019, pH 6.0 Dipstick WNL, sediment quiet. Urine culture - no growth.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

AGE

15 Years

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.

WEIGHT

5.58 kg

The left kidney has a normal shape and size (3.89 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.

INTERPRETED BY

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

The right kidney has a normal shape and size (3.67 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.

IMAGING PERFORMED BY

Crystal Hill

Adrenal Glands

HOSPITAL NAME

Upper Canada AH

The left adrenal gland is normal in size measuring 0.40 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.

REFERRING VET

Dr. Rossi

The right adrenal gland is normal in size measuring 0.45 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.

INVOICE

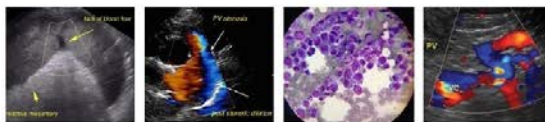
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Spleen

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.

DATE

6/27/23



PATIENT *Liver*

Cream Miller 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. No focal nodules or cystic lesions are observed.

SPECIES

Feline 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.

BREED

DSH ***Gastrointestinal***

SEX

Neutered Male 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.

AGE

15 Years 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 0.27 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

WEIGHT

5.58 kg 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.

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Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with moderate pancreatitis.

IMAGING PERFORMED BY

Crystal Hill

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. No significant lymphadenopathy. The mesentery is severely hyperechoic in the cranial abdomen, particularly caudal to the stomach.

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ULTRASONOGRAPHIC FINDINGS

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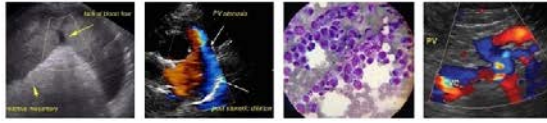
- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Prominent, hypoechoic left limb of the pancreas with significant inflammation visualized in the cranial abdomen caudal to the stomach – The pancreatic changes are most consistent 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.

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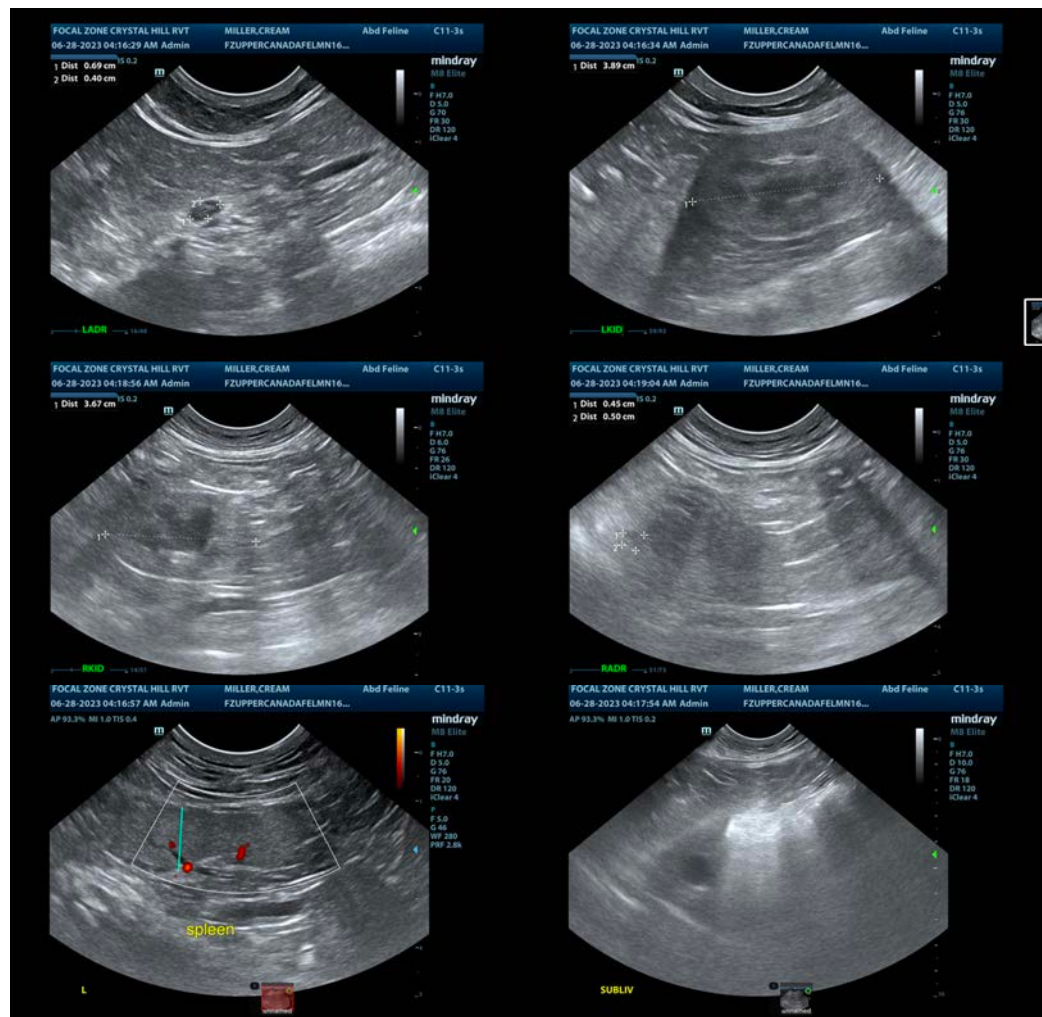
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a significant amount of inflammation visualized in the cranial abdomen caudal and dorsal to the stomach. This is in the region of the pancreas. The left limb of the pancreas appears somewhat prominent. The amount of inflammation present is significant and appears slightly more significant than I would expect for the appearance of the pancreas, but the severity of the ultrasonographic findings does not always correlate with the severity of the clinical signs associated with the pancreatic inflammation present. Recommend symptomatic treatment for pancreatitis with IV fluids, pain medications, nausea medications, etc. If the patient is not improving as expected, consider repeat imaging to reevaluate.





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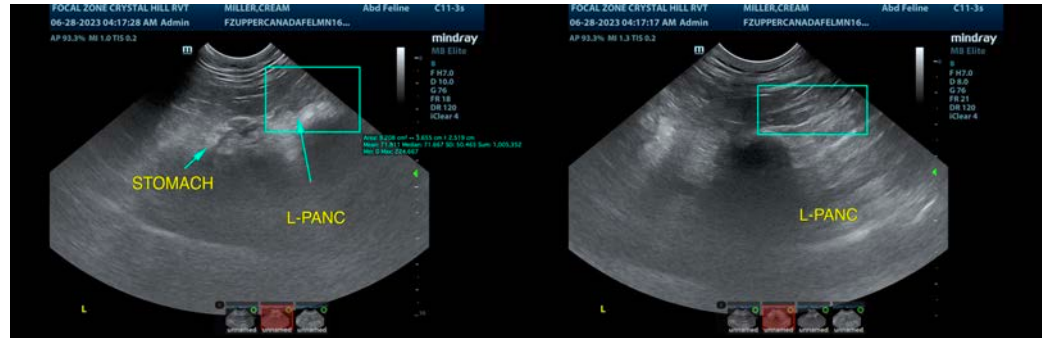
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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