

**PATIENT**

Emily Brill

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

10 Years 9 Months

**WEIGHT**

8.76 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**

Dr. Taylor

**INVOICE**

44185

**DATE**

7/20/23

**PRESENTING CLINICAL SIGNS**

Hyporexia (stopped eating dry food a couple weeks prior to presentation) and weight loss (2.32 lbs in 6 months). Possibly some level of chronic vomiting, may have a hairball every couple of weeks. Does have dental disease but doesn't appear severe enough to cause inability to eat. Dental may be pursued if no other cause to hyporexia found. Treated with Cerenia and Convenia injection, Mirataz and is now back to normal appetite.

Abnormal PE/Chem/CBC/UA Results: UA - USG > 1.050, 2+ cocci on manual with little inflammatory response. Urine culture - no growth CBC: Retic hgb 14.9 L, rest of RBC wnl Chem: Creat 1.3 ALP 87 H T4 2.4 fPL 0.5 BP taken in Jan 2023 154 mm Hg

**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 (3.29 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 (3.76 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 0.38 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 0.35 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 (0.79 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 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.

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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.

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***Gastrointestinal***

The stomach contains mild shadowing ingesta. 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. Duodenum wall measures 0.26 cm. Jejunum wall measures 0.29 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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. Colon wall measures 0.15 cm.

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***Pancreas***

The left limb of 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.

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***Free Abdomen***

There is scant free abdominal fluid. There are prominent hypoechoic mesenteric lymph nodes surrounded by hyperechoic mesentery. A set of two lymph nodes visualized measure at 0.45 cm and 0.54 cm in diameter. A pancreaticoduodenal lymph node measures at 0.39 cm.

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**ULTRASONOGRAPHIC FINDINGS**

- Prominent, mottled left limb of the pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Small amount of soft shadowing material visualized within the gastric lumen – This could be consistent with ingesta, a hairball, etc. Correlate with clinical history and feeding history.
- Prominent/hypoechoic mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS****INVOICE**

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There are some clusters of prominent hypoechoic lymph nodes surrounded by hyperechoic mesentery. These are concerning for inflammatory nodes, but an underlying neoplastic change cannot be definitively ruled out. Consider a fine needle aspirate of a mesenteric lymph node.

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There is a small amount of soft shadowing material visualized within the gastric lumen. This could represent some retained ingesta, etc. but could also be a hairball. Consider hairball remedy if there is a history of hairballs and the patient was adequately fasted.

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The left limb of the pancreas appears slightly prominent but not overtly inflamed. This could be consistent with pancreatic remodeling, mild pancreatic inflammation, etc.

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Based on the history and lack of evidence of concurrent metabolic disease, primary gastrointestinal disease seems most likely. Consider the following:

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- 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.

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There is reported to be a response to symptomatic therapy. Continue this in the case of possible pancreatic inflammation, etc. If symptoms are persistent or do not respond to the above therapies, then consider obtaining GI biopsies (provided an answer is not obtained based on aspirates of the mesenteric lymph nodes).

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

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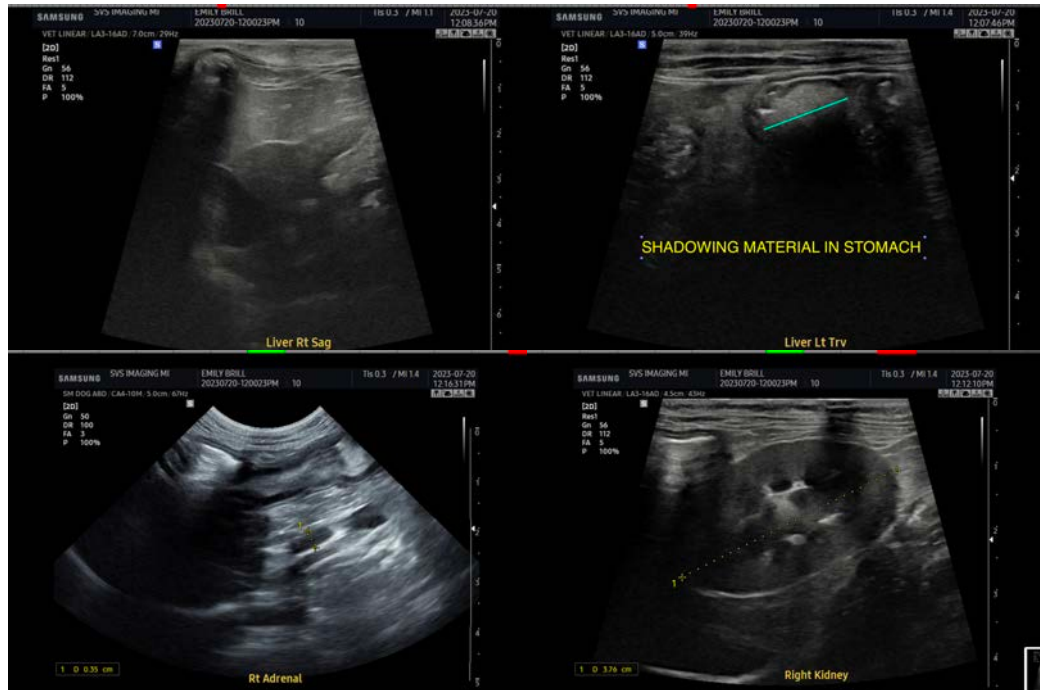
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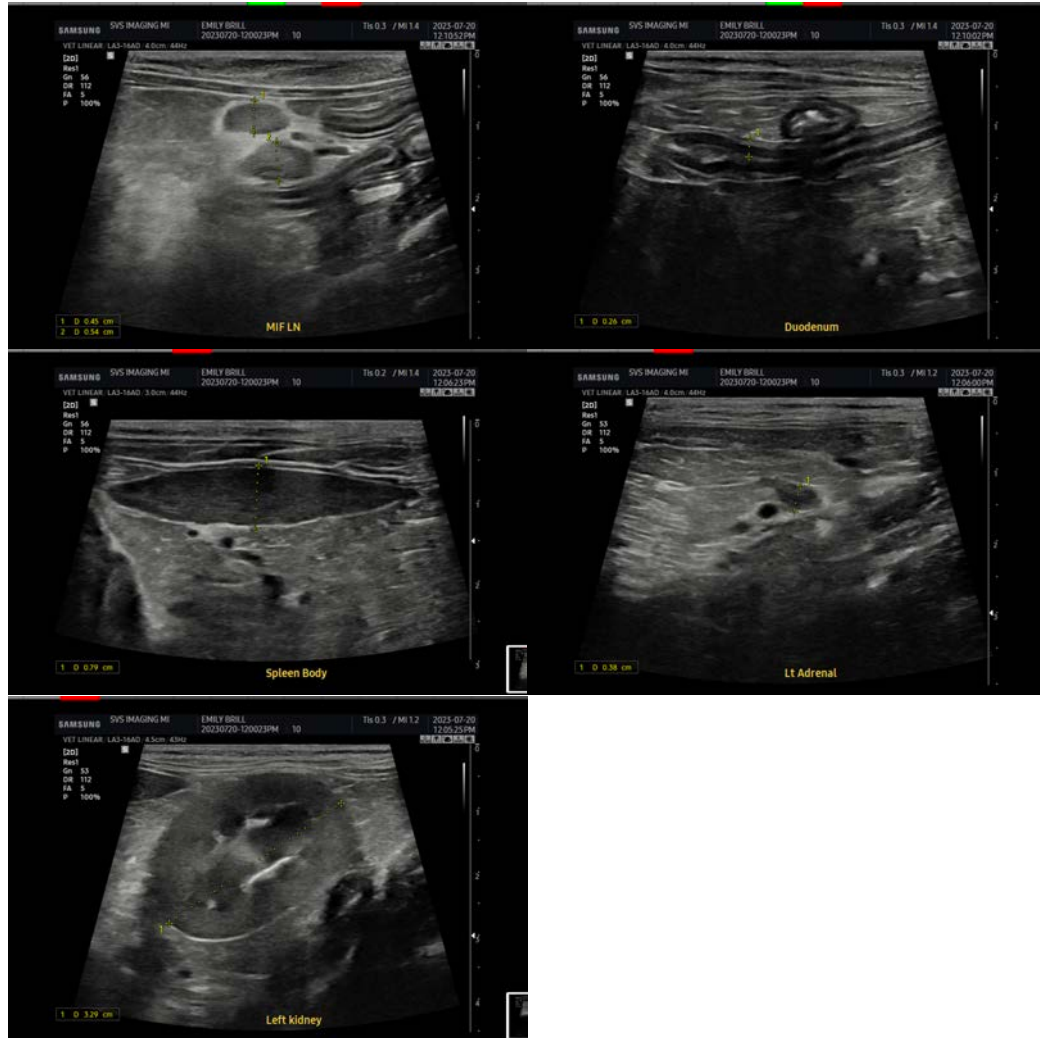
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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