

PATIENT PRESENTING CLINICAL SIGNS

Percy Carroll

History: no sedation - slightly tense.

SPECIES

Diet: variety of wet and dry but recently switched to Royal Canin PR. Vomiting pretty much daily
Echo done in Feb 2023 (HCM, normal ECG)

Feline

Abnormal PE/Chem/CBC/UA Results: LABS WNL- attached

BREED

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Sphynx

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.

SEX

Neutered Male

The left kidney has a normal shape and size (4.42 cm). Overall echogenicity is normal with adequate 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.

AGE

5.11.18

WEIGHT

5.45 kg

The right kidney has a normal shape and size (4.57 cm). Overall echogenicity is normal with adequate 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.

INTERPRETED BY

Andrea Nicastro,
DVM, Diplomate ACVIM
(Small Animal Internal
Medicine)

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.

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

The right adrenal gland is normal in size measuring 0.40 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.

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Spleen

The spleen is subjectively normal in size (0.76), 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.

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Dr Sandra Carroll

Liver

The liver is subjectively normal in size, slightly irregular in shape, with normal echogenicity and 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.

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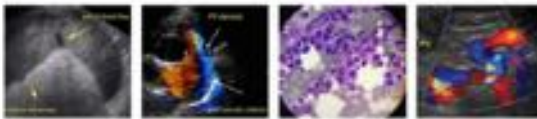
The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

DATE

7.21.23

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.36 cm with some variability due to the



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presence of rugal folds. The distinction of the gastric wall layering 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 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 (0.22 cm) and the jejunum measured as normal (0.19 cm) 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 mottled in the left and right limb, 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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes and a small cluster of lymph nodes near the ileocecolic junction. Examples measure at 0.33, 0.30 and 0.50 cm. The omentum is generally of normal echogenicity.

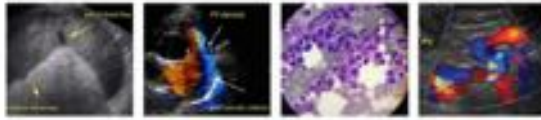
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Prominent mottled left and right limb of the pancreas, with mildly prominent mesentery surrounding – 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 mild pancreatitis.
- Hypoechoic heterogenous liver - The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The significance of this is unclear in the absence of liver enzyme elevations.
- Moderate ingesta within the gastric lumen – Correlate with the feeding history if the patient was adequately fasted and ingesta persists, consider possible delayed gastric emptying or a partial outflow tract obstruction (none observed).
- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas is prominent with very mildly reactive mesentery surrounding in both limbs. Of primary concern would be pancreatitis, although the fPLI level is normal, so some of these changes could be due to previous episodes of pancreatic inflammation and remodeling. Regardless, I would recommend empirical treatment for pancreatitis.



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The liver appears slightly irregular in shape, hypoechoic and heterogenous. This could represent normal anatomic variation. The significance of this is uncertain in the absence of elevated liver enzymes values.

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No focal lesions are visualized associated with the gastrointestinal tract to explain the vomiting reported. There is a moderate amount of ingesta visualized within the gastric lumen, despite recently vomiting (per the history). This could be due to lack of full evacuation, or could be associated with delayed gastric emptying, overextension of the stomach, etc. No evidence of an outflow tract obstruction is observed, but this cannot be definitively ruled out. Ultimately, this could represent delayed gastric emptying, which is often a sequela to primary gastrointestinal disease, pancreatitis, etc.

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The mesenteric lymph nodes are slightly prominent. Most are too small to sample. There is one mesenteric lymph nodes midabdomen which could be a candidate, but likely would be a challenge.

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

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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 despite the treatment for pancreatitis, and a primary enteropathy is strongly suspected, consider obtaining GI biopsies.

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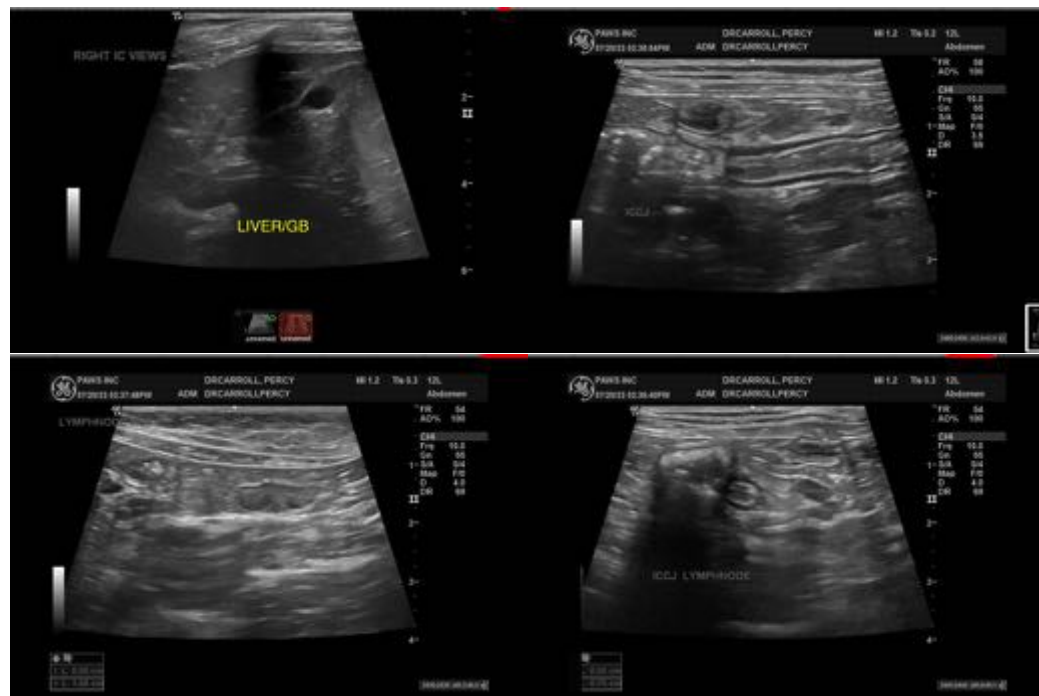
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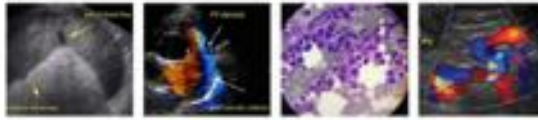
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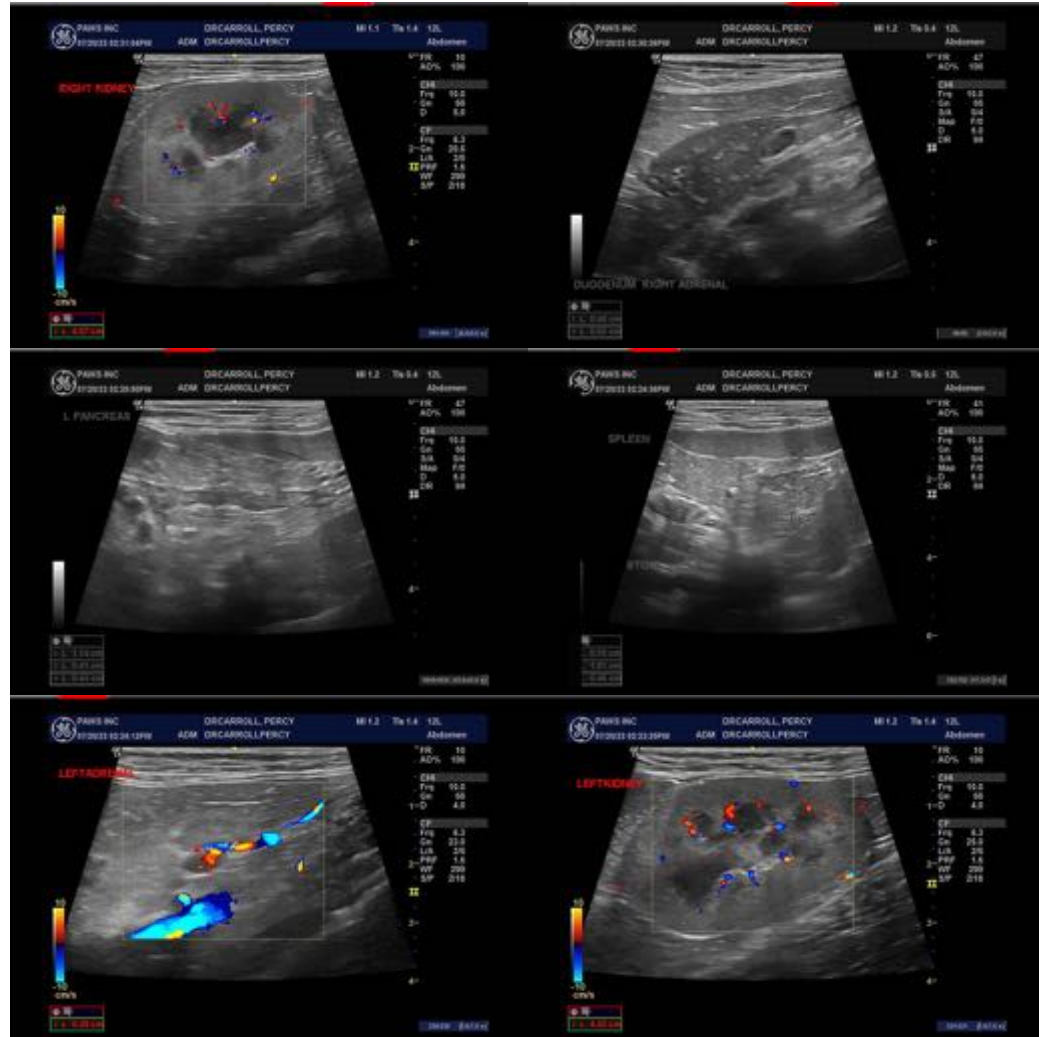
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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