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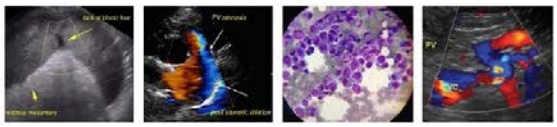


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Scuffs Sendrowski

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

3.7 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Simcoe AH

REFERRING VET

Dr. Kennedy

INVOICE

39941

DATE

7/28/22

PRESENTING CLINICAL SIGNS

2-3 week history of decreased appetite Scratched the left side of her mouth into a large wound, but healing well weight loss no abdominal masses palpable Can only palpate left kidney In one week has become almost completely anorexic- ate a couple of Temptations today only meds: Zeniquin 12.5mg q 24 hours, Mirtazepine 2mg q 48 hours
Abnormal PE/Chem/CBC/UA Results: CBC shows mild pancytopenia-all cell lines at lowest end of normal or just below Biochemistry shows increased SDMA at 17 ug/dL (0-14) Globulins increased at 66g/L (28-51) TT4 normal at 44 nmol/L (10-60) FeLV/FIV negative Please see attached 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 (4.17 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.

The right kidney has a normal shape and size (2.88 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.26 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 0.30 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

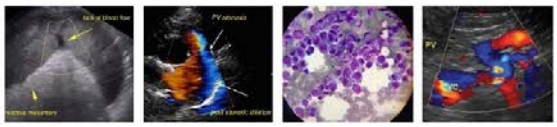
The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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. There is a small 0.89 cm hyperechoic nodule visualized in the liver.

The gallbladder 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.

Gastrointestinal



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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 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

There is an area of hypoechoic, irregular, almost nodular tissue medial to the spleen, surrounded by hyperechoic mesentery, most consistent with the left limb of the pancreas. There is no surrounding fluid, but there is evidence of surrounding hyperechoic mesentery.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes medial to the spleen, and in the region of the ileocecal junction. One of these lymph nodes measures 0.45 cm. The omentum is hyperechoic medial to the spleen and around the left limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic, almost nodular tissue medial to the spleen in the region of the left limb of the pancreas – most concerning for acute pancreatitis.
- Hyperechoic nodule visualized in the liver – The significance of this nodule is unclear, as this could represent a benign or neoplastic lesion. Consider a fine needle aspirate.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a lot of inflammation and abnormal tissue with enlarged lymph nodes and inflamed mesentery medial to the spleen. This appears most consistent with inflamed pancreas, although some loops of bowel are passing through this area as well. Recommend a quantitative fPLI, TLI, cobalamin and folate (GI panel to Texas A&M) to further evaluate the pancreas and small intestine. Recommend treatment for acute pancreatitis with pain medications, nausea medications, IV fluids, etc. If symptoms are not improving, consider a fine needle aspirate of the pancreas in this region.

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

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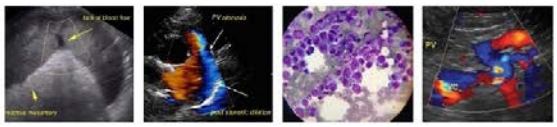

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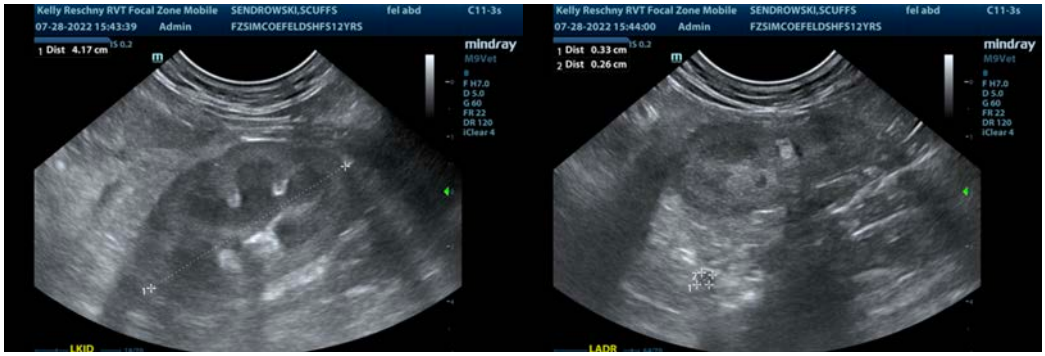

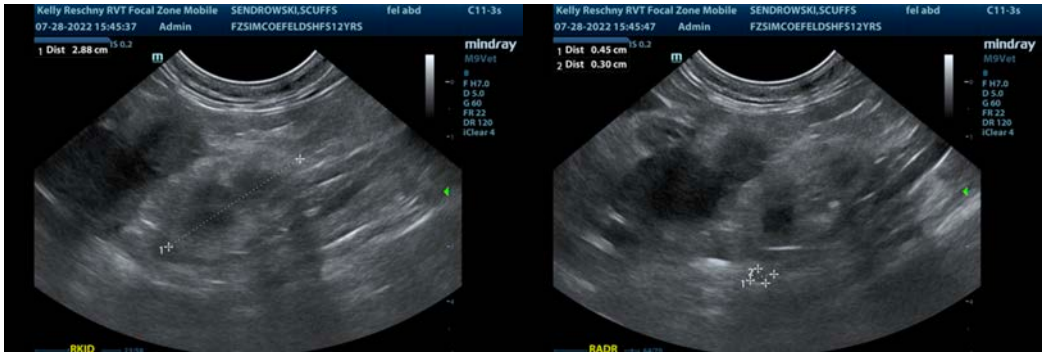

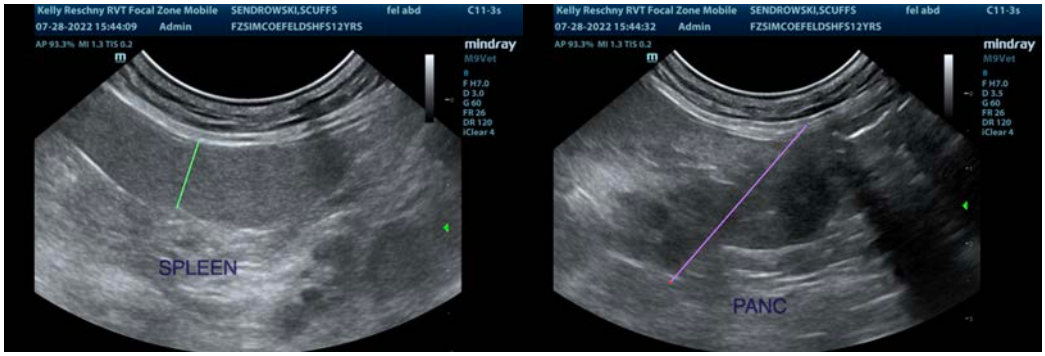

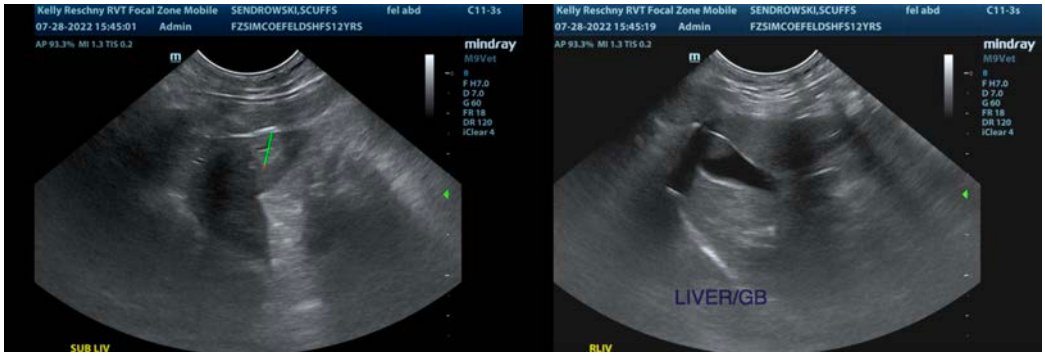

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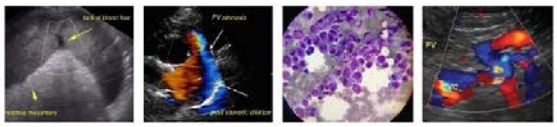

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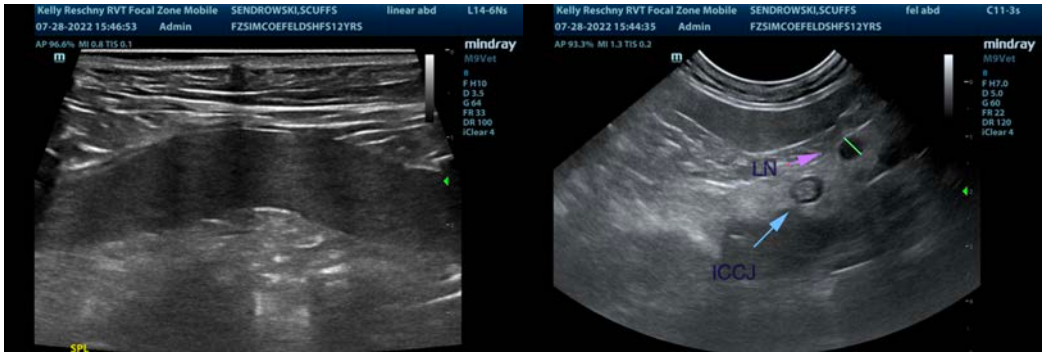

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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