

**PATIENT**

Leo Grace

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6 years, 1 mo

WEIGHT

11.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Carri Underwood

HOSPITAL NAME

SVS Imaging MI-2

REFERRING VET

Alsager Animal
Care Ctr

INVOICE

14054

DATE

8.11.23

PRESENTING CLINICAL SIGNS

History: Seen at VES 7/23-7/24/2023 for vomiting, not eating, swollen abdomen. Still lethargic. T= 102.0

Abnormal PE/Chem/CBC/UA Results: GLU 181 74 - 159 mg/dL HIGH BUN/CREA 19 GLOB 5.3 2.8 - 5.1 g/dL HIGH ALT 716 12 - 130 U/L HIGH LIPA 2491 100 - 1400 U/L HIGH K 3.4 3.5 - 5.8 mmol/L LOW concern for feline "triaditis" syndrome- elevated liver values and cpl at ER, improved with medications.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder is minimally distended with anechoic urine. There is a small amount of echogenic debris suspended in the dependent portion of the urinary bladder. No focal lesions are visualized. Evaluation of the urinary bladder is hindered by lack of urine distention. The bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.03 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 (4.16 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 (0.32 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 (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.

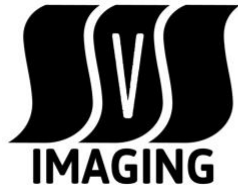
Spleen

The spleen is subjectively normal in size (0.65 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. The gall bladder lumen is moderately distended with a small amount of hyperechoic, mineralized dependent debris. 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 0.37 cm 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 (0.29 cm) and the jejunum measured as normal (0.21 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. The colonic wall measures 0.14 cm.

Pancreas

The pancreas is mildly 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.

Free Abdomen

Evaluation of the peritoneal cavity reveals scant free abdominal fluid. There is a small cluster of large hypoechoic lymph nodes near the sublumbar region (measuring 0.53, 0.30 and 0.34 cm in diameter) with hyperechoic mesentery in the region.

ULTRASONOGRAPHIC FINDINGS**Primary Findings**

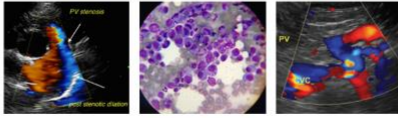
- Mildly prominent/visible right limb of the pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Small amount of dependent mineralized debris in the gallbladder and proximal bile duct – The significance of this is uncertain. Biliary mineralization can be associated with inflammatory processes.
- Scant free abdominal fluid
- Small cluster of prominent/inflamed lymph nodes near the sublumbar region – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

Secondary Findings

- Minimally distended urinary bladder with a small amount of echogenic debris – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the liver to explain the elevation in ALT reported. There

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are some mild changes visualized associated with the gallbladder. The significance of this is uncertain. This could be incidental or possibly consistent with mild inflammatory disease. Consider the following:

- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc.
- Recommend thyroid evaluation (if not already done)
- Consider screening for toxoplasmosis.
- If not already done, consider pre and post prandial bile acids to evaluate liver function.
- Consider fine needle aspirate if round cell neoplasia is on your differential list (25 g needle, normal coags)
- If cytology is not helpful and there is no response to therapy, consider liver biopsy with samples obtained for histopathology and culture.
- If "triaditis" is suspected (chronic GI signs, concurrent pancreatic changes on US) consider therapy for cholangiohepatitis (fluids, ursodiol, probiotics, +/- steroids/antibiotics), testing for pancreatitis and evaluation for IBD (GI panel to Texas A&M GI lab)
- Consider a feeding tube if patient is not eating for a prolonged period of time.

Empirical treatment for cholangiohepatitis could be considered but if there is no response to therapy and the ALT elevation persists, liver biopsies may be necessary.

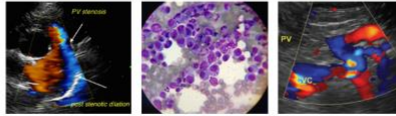
There are minimal changes visualized associated with the GI tract. If "triaditis" is strongly suspected, you could consider a GI Panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, looking for support of evidence of underlying GI disease. Similarly, the changes to the pancreas are very mild. But given the PLI elevation, empirical treatment for pancreatitis is warranted.

The significance and cause for the cluster of enlarged lymph nodes in the sublumbar region is uncertain. Evaluate the pelvic limbs, rectal area, etc. Continued monitoring is warranted. A fine-needle aspirate could be considered if a safe window is visualized away from the great vessels.

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

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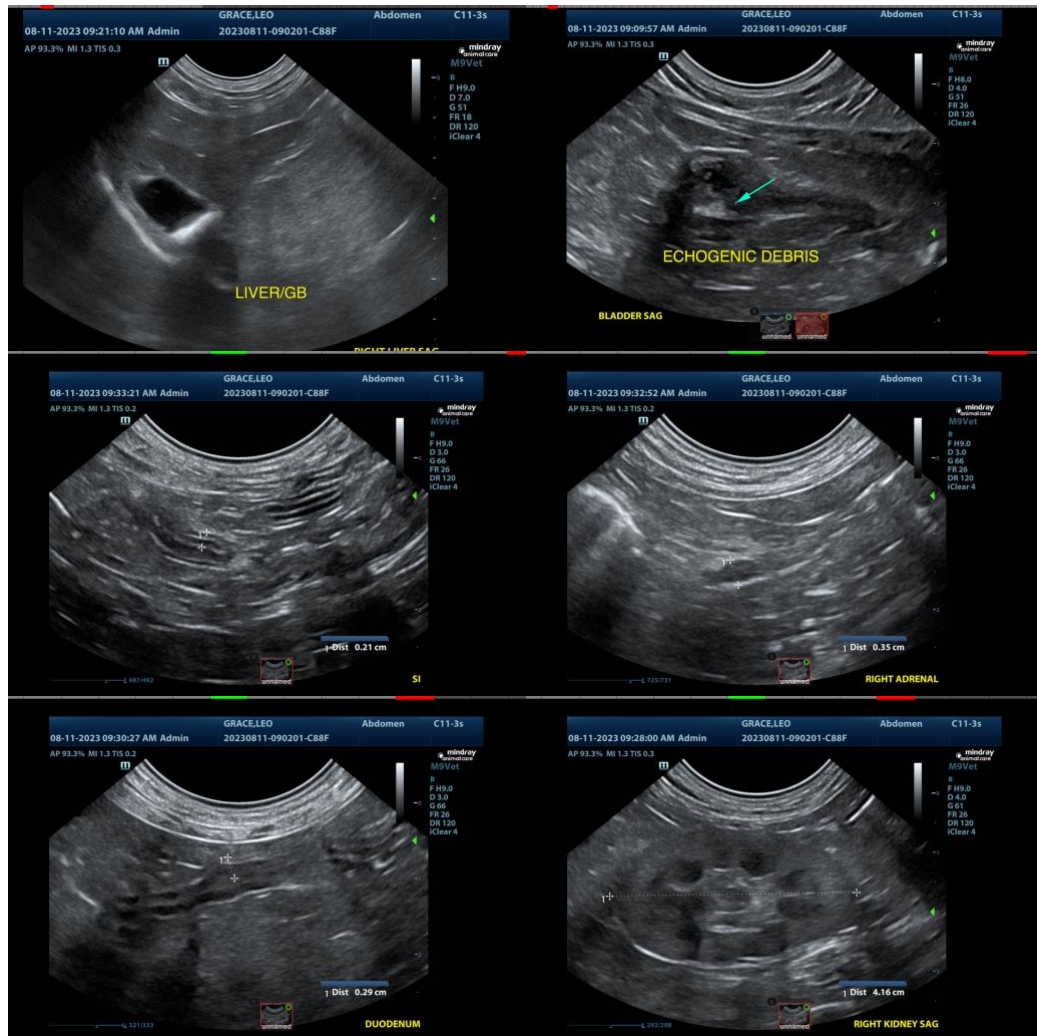
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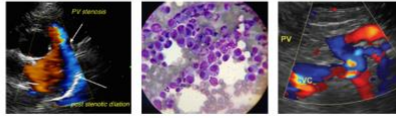
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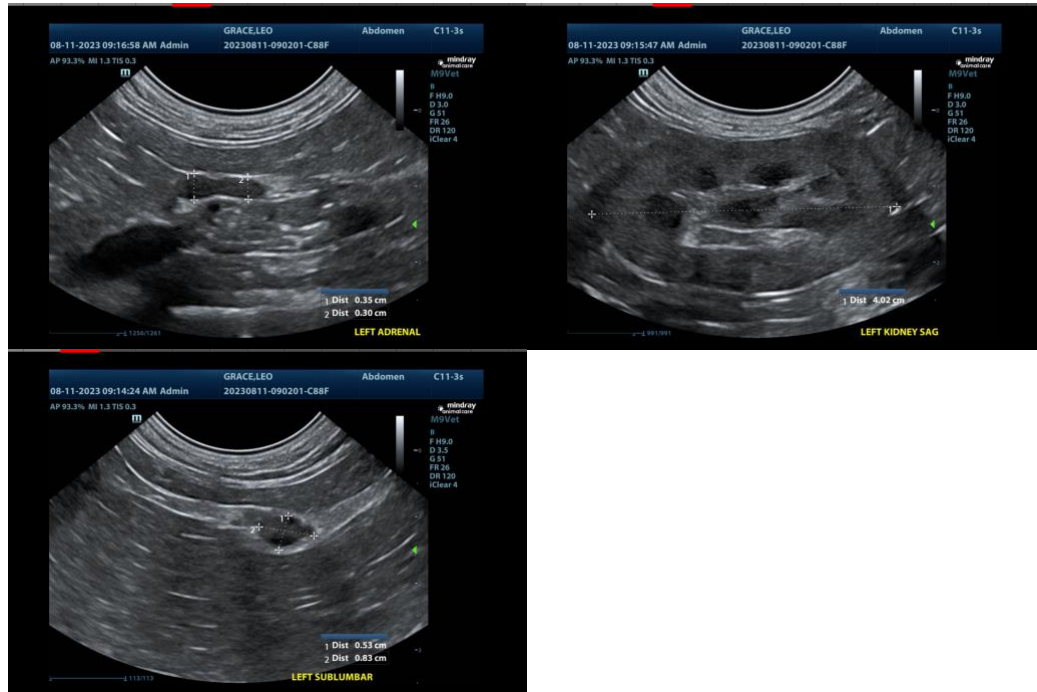
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small animal Internal Medicine)
info@SonoPath.com