



PATIENT

Addie Miller

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9 Years

WEIGHT

7.1 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Sheldon

HOSPITAL NAME

Advanced Pet Care of
Oakland

REFERRING VET

Dr. Sheldon

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DATE

8/23/22

PRESENTING CLINICAL SIGNS

Went to the ER 10 days ago for vomiting, inappropriate urination she was treated with gabapentin for pain. Bloodwork and urine done then, high calcium noted and some hematuria. Now she is acting pretty normal. Owner thinks her appetite might be slightly decreased and she thinks she might of lost a little weight but not really sure. She seems slightly less energetic. Owner gave the gabapentin a few times but stopped because there has been no more inappropriate urination that they know of. 2 boxes, 2 cats. Uncovered.

Abnormal PE/Chem/CBC/UA Results: CBC/chem: unremarkable except for an elevated Ca 11.6
Urinalysis: SG 1.050, 3 + blood, 1 + protein, PH 8, no bacteria or crystals seen. Calcium panel pending.
Urine and urine culture pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.2 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 (3.3 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 0.27 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.64 cm in width at the level of the hilus), 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 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.



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Gastrointestinal

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The stomach is distended with a large amount of fluid/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. Jejunum wall measured 0.16 cm.

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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.

Pancreas

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The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

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Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

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- Echogenic/mineralized debris visualized in the urinary bladder – correlate findings with abdominal radiographs, urinalysis and culture (I believe this pending).
- Stomach distended with large amount of fluid/ingesta – correlate with feeding history and abdominal radiographs. If the patient was adequately fasted, consider the possibility of delayed gastric emptying or partial outflow tract obstruction (none clearly visualized).

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized in the GI tract to explain the vomiting and inappetence reported. The stomach is large and distended with fluid/ingesta. Correlate with feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying, an outflow tract obstruction, etc. No obstruction is visualized, but this cannot be definitively ruled out. Unfortunately, there are many causes for vomiting and inappetence that cannot be definitively diagnosed by abdominal ultrasound alone.

REFERRING VET

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- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.

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- If symptoms persist, consider obtaining GI biopsies.

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

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There is a large amount of suspended echogenic debris in the urinary bladder. Some of this could be mineralized and sandy debris/small stones. Correlate with abdominal radiographs to determine if any mineralizations can be visualized. This could be secondary to the hypercalcemia reported.

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Recommend a hypercalcemia of malignancy panel to Michigan State for an ionized calcium, PTH, and PTHrP level. Additionally, recommend thorough oral exam, rectal exam, etc., looking for any mass lesion.

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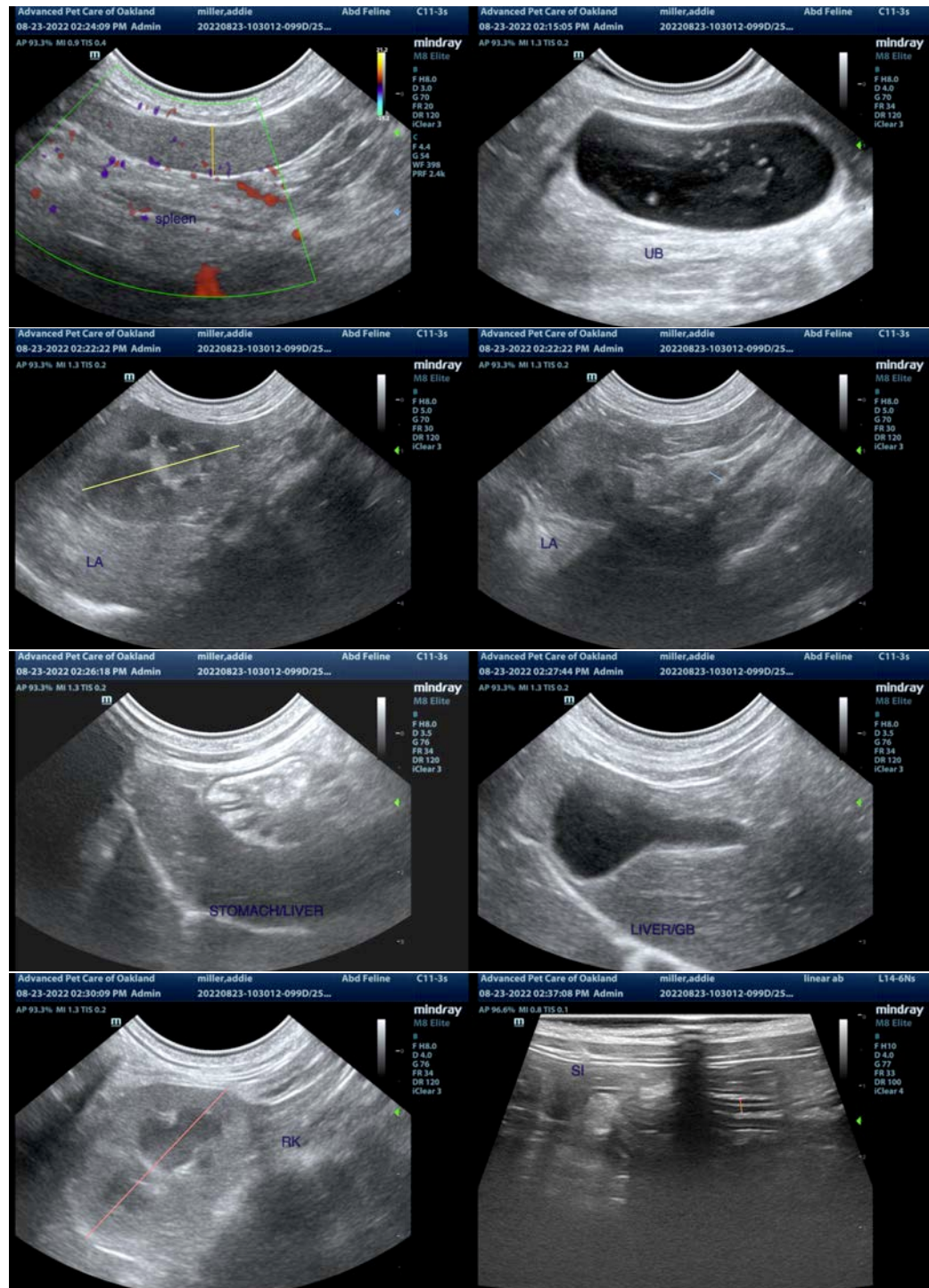
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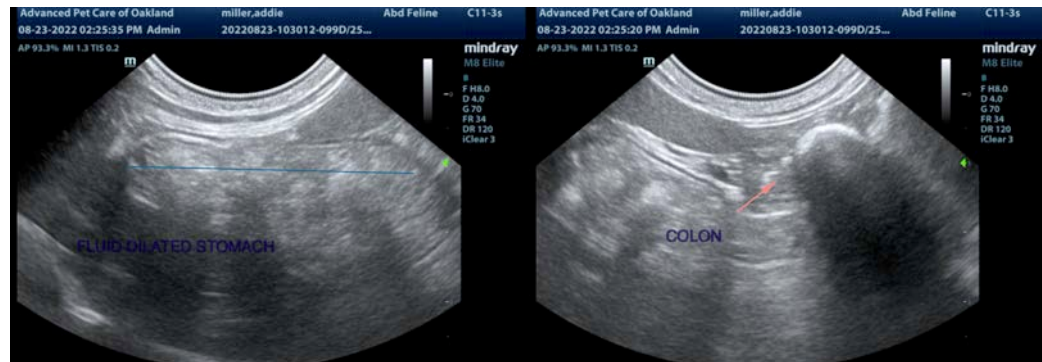
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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