**PATIENT**

Biji Racila

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

9 years

WEIGHT

11.4 lbs

INTERPRETED BYLisa Carioto, DVM,
DVSc, Diplomate
ACVIM**IMAGING
PERFORMED BY**

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Bies

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DATE

5/10/22

PRESENTING CLINICAL SIGNS

History: Chronic intermittent vomiting. NPO since 8pm night before scan. Has not vomited since Sunday.

Abnormal PE/Chem/CBC/UA Results: Bloodwork and exam WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder is well distended with anechoic contents. The wall is smooth and regular. No abnormalities are present with the trigone or proximal urethra. A small amount of free floating sediment is present, however, there is no evidence of cystoliths, polyps or a mass.

Kidneys

The **left** kidney measures 4.21 cm (3.80-4.40 cm). The capsule is smooth. The cortex is very mildly hyperechoic i.e. it is isoechoic to the spleen. The overall architecture, including the definition of the cortico-medullary junction, is preserved. A trivial amount of mineralization of the diverticulae is present. There are no signs of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

The **right** kidney measures 4.45 cm (3.80-4.40 cm). The capsule is smooth. The overall architecture, including the definition of the cortico-medullary junction, is preserved. A trivial amount of mineralization of the diverticulae is present. There are no signs of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

Aortic bifurcation/trifurcation

No abnormalities observed.

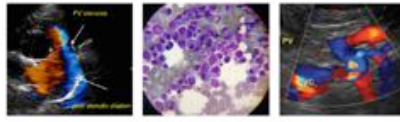
Adrenal Glands

The **left** adrenal gland measures 0.45 cm at the cranial pole, 0.35 cm at the caudal pole and 1.30 cm in length. The cranial pole is "plump" and a discrete nodule is noted. The nodule does not disrupt the echotexture or echogenicity of the gland. There is no evidence of a mass. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

The **right** adrenal gland measures 0.33 cm at the cranial pole, 0.33 cm at the caudal pole and 1.45 cm in length. The caudal pole is slightly "plump". No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Spleen

The spleen is within normal limits in size, echotexture, and echogenicity. The capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

**PATIENT****Liver**

Biji Racila

There are no obvious signs of hepatomegaly and its borders are smooth and sharp. The liver's echotexture is homogeneous. It is mildly hyperechoic, i.e. it is isoechoic to the falciform fat. No abnormalities are observed with the hepatic vessels visualized.

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The gallbladder wall is within normal limits in thickness and echogenicity. A small amount of inspissated echogenic material is present within the GB. The inspissated sludge forms a well-defined nodule, measuring 4.9 mm in diameter x 7.0 mm. The cystic duct is mildly torturous and the common bile duct is dilated it measures 5.6 mm at the duodenal papilla. An obvious obstruction is not observed.

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Gastrointestinal**SEX**

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A large amount of ingesta and fluid, as well as a small amount of gas, are present in the lumen of the stomach despite having been fasted since last night. This is suggestive of delayed gastric emptying. The stomach appears dilated and flaccid. The gastric wall is within normal limits in thickness and the wall layers are well defined.

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The small intestinal wall thickness, including the duodenum, is within normal limits and the definition of the wall layers is preserved. No abnormalities are observed with the ileo-cecal-colic junction. Abnormally dilated loops of bowel are not observed.

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The colonic wall is not thickened and mural detail is considered normal. Formed stools are present within the colon.

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Pancreas

No overt abnormalities are observed with the echogenicity or echotexture of the left or right limbs. There is no evidence of hyperechogenicity of the surrounding mesentery, i.e., signs of active pancreatitis are not present.

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Other**Lymph nodes**

Mesenteric LNs are within normal limits in echogenicity, echotexture, shape and size.

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Abdominal effusion is not visualized.

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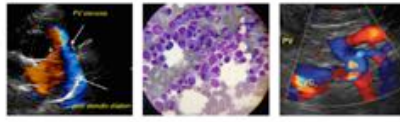
ULTRASONOGRAPHIC FINDINGS**INVOICE**

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- A marked delay in gastric emptying is present as Biji was fasted for the ultrasound. Although overt abnormalities are not observed with the architecture of the stomach or intestinal tract, one cannot exclude underlying diseases, such as inflammatory bowel disease or food intolerance, as the cause of her chronic vomiting episodes. Chronic, intermittent pancreatitis may cause intermittent vomiting. Other diseases, such as hyperthyroidism, are also possible.

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- The diffuse hyperechogenicity of the liver may be due to a vacuolar hepatopathy. However, other causes of a diffusely hyperechoic liver, such as cholestasis and cholangitis/cholangiohepatitis, cannot be excluded. Furthermore, cholecystitis must be considered based on the gallbladder findings.

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- There are no obvious signs of active pancreatitis. Signs of neoplasia are not appreciated.
- The discreet nodule at the cranial pole of the left adrenal gland is an incidental finding and most likely clinically insignificant. A benign adenoma is the most likely cause. There are no signs of neoplasia.

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- The renal changes are very mild. They are suggestive of mineralization and possibly early signs of degeneration. Glomerulonephritis cannot be excluded based on the mild hyperechogenicity of the cortices. Pyelonephritis is unlikely, but cannot be excluded despite the absence of classical sonographic signs.

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- The free floating sediment within the lumen of the urinary bladder is most likely composed of mucus, crystalline material and exfoliated cells. The debris is likely clinically insignificant given the lack of inflammatory changes to the bladder wall, however, findings should be correlated with clinical signs and a urinalysis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Inflammatory bowel disease, inflammatory and immune-mediated hepatic diseases and pancreatitis, i.e. "triaditis" cannot be excluded as the cause of Biji's intermittent vomiting.

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Deworming with a broad spectrum dewormer, such as fenbendazole, is suggested even if Biji does not go outdoors.

A veterinary prescription brand hypoallergenic diet, whether hydrolyzed or novel protein, may be tried. Multiple diets may be required, including only canned food, as some individuals cannot digest dry. The kibble may be soaked if an all canned diet is cost prohibitive.

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Small, frequent meals are suggested.

Treatment for pancreatitis is suggested, including analgesics, such as buprenorphine, as well as supportive care, such as maropitant, during vomiting episodes.

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A TLI, vitamin B12, and folate may be performed, as cats suffering from IBD and pancreatitis may suffer from cobalamin deficiencies. If the test is cost prohibitive, supplementation with vitamin B12 is suggested.

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Cholestasis, cholangitis/cholangiohepatitis and cholecystitis cannot be excluded, despite the absence of abnormalities with liver enzyme activities on blood work. Secondary ascending bacterial infections are common. Although indiscriminate use of antibiotics is not normally recommended, one could start treatment with a broad-spectrum antibiotic.

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If the above diagnostic tests or empirical therapy are unsuccessful, further diagnostics, such as endoscopy and biopsies.

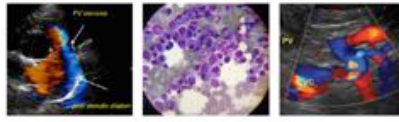
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A urinalysis, +/- urine culture and sensitivity, is suggested, if not already performed. If an infection is not evident, a urine protein: creatinine ratio is suggested to exclude proteinuria (due to the mildly hyperechoic renal cortices).

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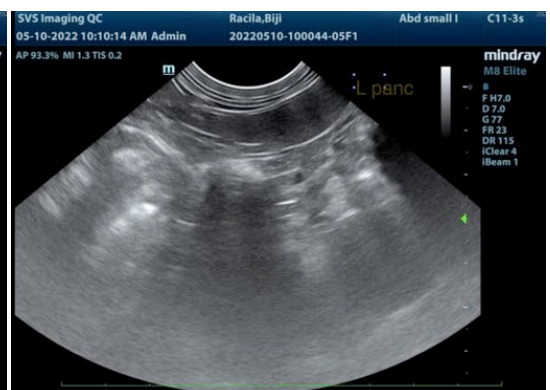
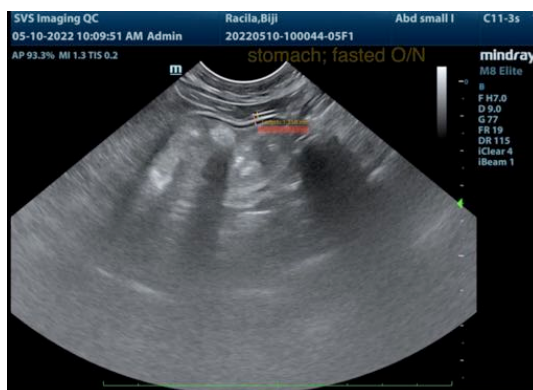
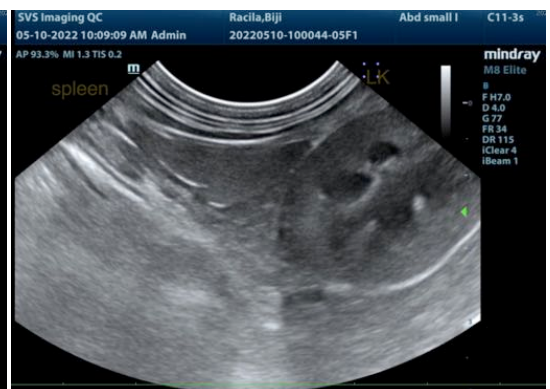
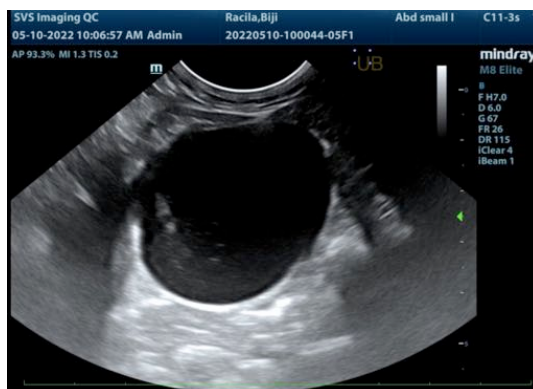
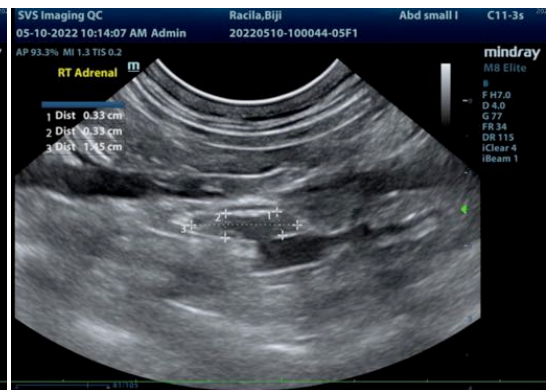
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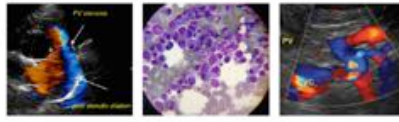
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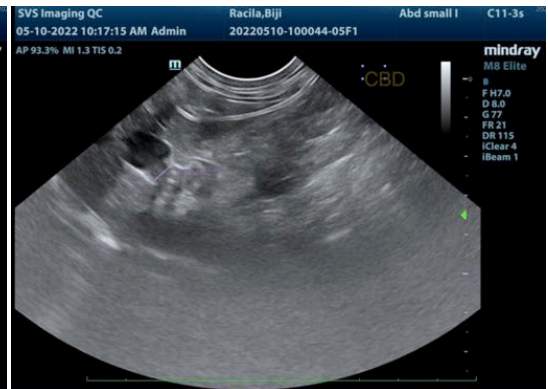
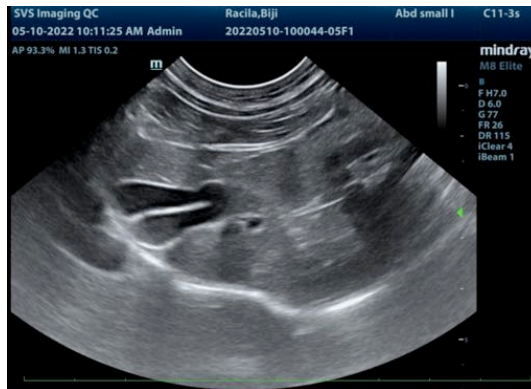
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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