



PATIENT PRESENTING CLINICAL SIGNS

Hotie Rhoades

History: Vomiting for 1 week. Good appetite but can't keep food down No vomiting since starting Cerenia
PO Heart murmur grade 2/6 Well controlled hyperthyroidism Current Medications Cerenia 8mg PO
Q24hrs, 5mg methimazole Q12hr transdermal Radiographic Findings Thickened loops of bowel in cranial
abdomen. Significant amounts of gas in colon

SPECIES

Feline

Abnormal PE/Chem/CBC/UA Results: 2-27-22 Cbc - wnl Chemistry- wnl T4 - wnl

BREED

DSH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

SEX

Spayed Female

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Nondependent particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

AGE

13 Years

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pyelectasia was present. Mild medullary mineral was present. The left kidney measured 3.9 cm in length. The right kidney measured 3.6 cm in length.

WEIGHT

2.62 kg

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.43 cm width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.31 cm width.

IMAGING PERFORMED BY

Jenna Walsh, CVT

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

HOSPITAL NAME

Banfield of South
Frisco

REFERRING VET

Dr. Garretson

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

INVOICE

14145

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained a mild amount of retained echogenic fluid and chyme. The pylorus wall measured 0.28 cm.

DATE

3/2/22



PATIENT	The intestinal walls exhibited intact wall layers with altered to inverted 1:3 muscularis / mucosa ratio, owing to generalized marked muscularis hypertrophy. No overt evidence of loss of intestinal wall layering or intestinal masses. The jejunum wall measured 0.37 cm.
Hotie Rhoades	
SPECIES	Normal visible colon wall layers were present with apparent formed feces in lumen.
Feline	Pancreas
BREED	The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.
DSH	
SEX	Free Abdomen
Spayed Female	Intermittent, mildly prominent to uniformly hypoechoic jejunocolic lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 1.0 cm x 0.38 cm. Subtle evidence of perilymphatic and periintestinal reactive mesentery noted. No free fluid present.
AGE	
13 Years	
WEIGHT	ULTRASONOGRAPHIC FINDINGS
2.62 kg	<ul style="list-style-type: none"> • Enteropathy, exhibiting altered to inverted wall layering secondary to generalized marked muscularis layer hypertrophy. Minor retained gastric fluid/chyme, mild potential for gastric hypomotility • Associated jejunocolic lymphadenopathy- hyperplasia or reactive lymphadenitis suspected • Concurrent, probable low-grade pancreatitis • Bilateral mild chronic renal changes with mild medullary mineral • Mild urinary bladder sediment
INTERPRETED BY	
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	
IMAGING PERFORMED BY	
Jenna Walsh, CVT	
HOSPITAL NAME	INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS
Banfield of South Florida	The small intestine presentation is consistent with infiltrative enteropathy. Considerations may include inflammatory infiltrative enteropathy (such as IBD/eosinophilic enteritis) or neoplastic infiltrative enteropathy with round cells (such as lymphoma, mast cell neoplasia or other). Dry form FIP is considered a less likely differential diagnosis.
REFERRING VET	Full thickness intestinal biopsies would be required for a definitive diagnosis. Further assessment may include GI panel to include PLI, TLI, cobalamin and folate. If biopsies are not elected or possible, empirical IBD protocol, which may include as needed gastrointestinal support/antiemetic medications, cobalamin supplementation, hydrolyzed diet trial and prednisolone (at lowest effective dose) to control clinical signs with assessment of clinical response. Sonographic monitoring of the gastrointestinal tract and pancreas could be considered if persistent/progressive signs of IBD or pancreatitis despite conservative therapy.
Dr. Garretson	
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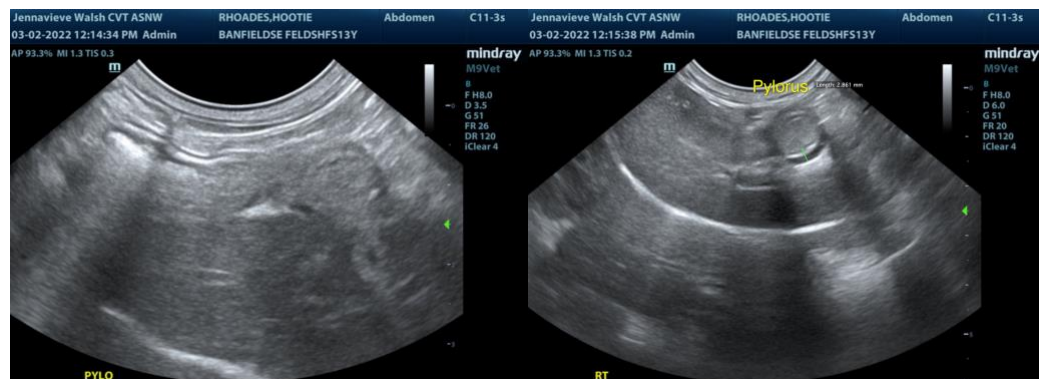
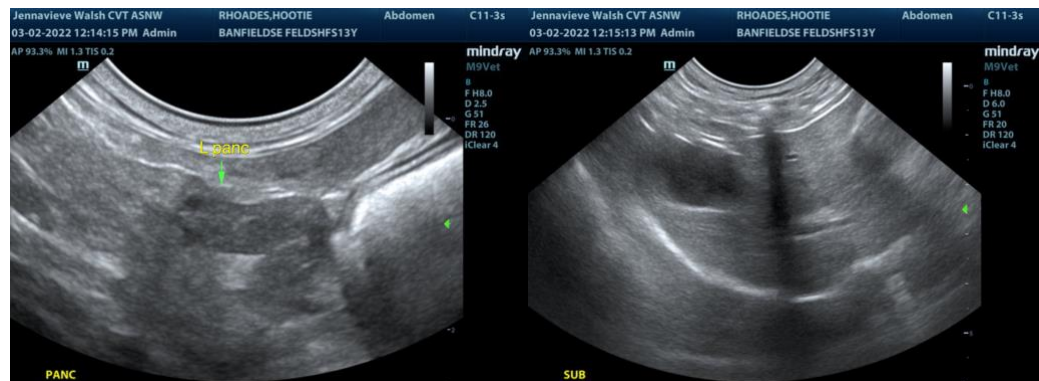
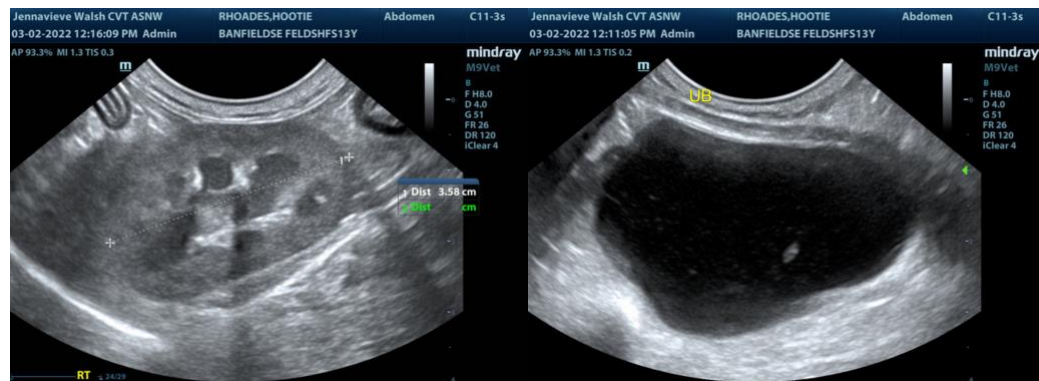
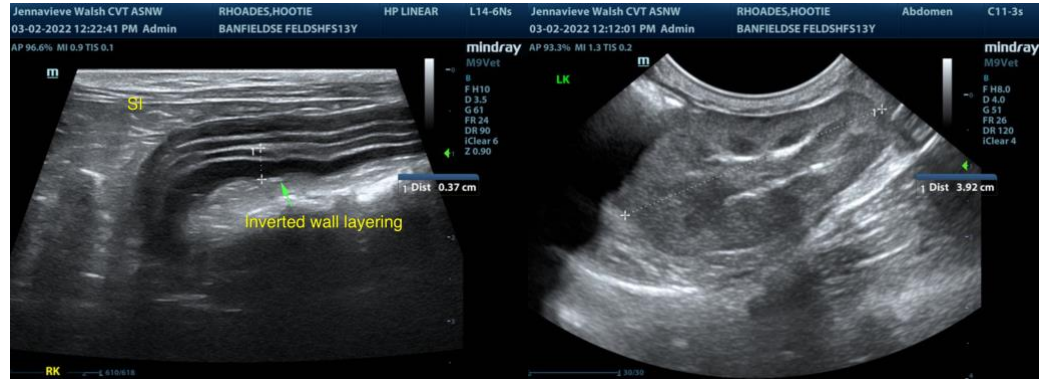
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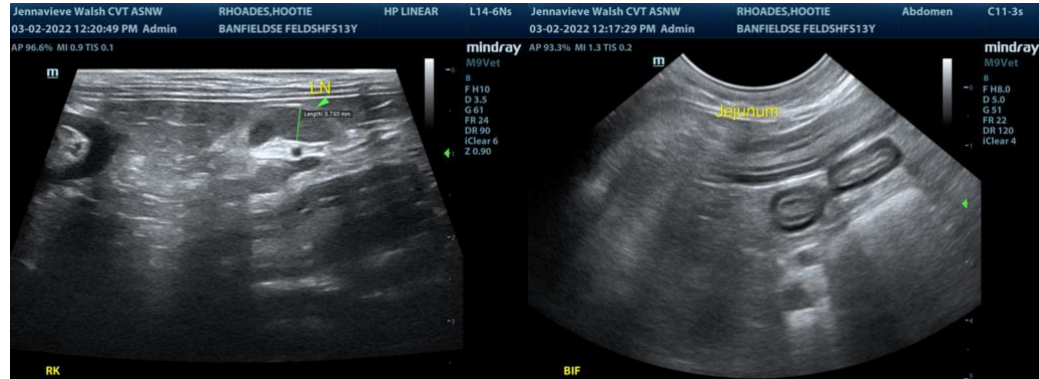
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
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