



**PATIENT**

Halo Cooper

**SPECIES**

Feline

**BREED**

DLH

**SEX**

FS

**AGE**

1 year

**WEIGHT**

3.8 kg

**PRESENTING CLINICAL SIGNS**

resented initially 13 days ago for anorexia, lack of drinking and lethargy. Is an indoor cat only. The problem is intermittent. Just in the last couple of days has been vomiting a slight amount of clear fluid every once in a while

Abnormal PE/Chem/CBC/UA Results: Mild dehydration There was a mild hyperglobulinemia with a mild elevation in GGT. Unremarkable hemogram/leukogram. Abdominal radiographs were unremarkable

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**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. Mild, primarily non-dependent, hyperechoic sediment, which may indicate cellular debris / protein, crystalline debris, lipid, or mucus, 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.

The area of the aortic trifurcation was free of pathology.

**INTERPRETED BY**

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

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 3.1 cm in length. The right kidney measured 3.2 cm in length.

**IMAGING PERFORMED BY**

Dr. Alastair Westcott

**Adrenal Glands**

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.28 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.28 cm width.

**HOSPITAL NAME**

Dr. Alastair Westcott,  
DVM

**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.

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**Liver/ Gallbladder**

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.



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***Gastrointestinal***

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, ingesta, fluid, or foreign material. The pylorus wall width measured 0.20 cm.

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Feline

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no evidence of small intestinal mechanical / metabolic ileus, foreign material, or loss of intestinal wall layering. The duodenum wall measured 0.25 cm width. The jejunum wall measured up to 0.23 cm width. The ileocolic wall measured 0.29 cm width.

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Sonographically normal visible colon wall layers were present with semi to soft fecal matter.

FS

***Pancreas***

**AGE**

1 year

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

**WEIGHT**

3.8 kg

***Free Abdomen***

Intermittent, mildly prominent to hypoechoic mesenteric lymph nodes were present. A normal width: length ratio was maintained (<0.5). Mild perilymphatic peri gastrointestinal to peripancreatic hyperechoic omentum was evident. No evidence of peritoneal effusion was noted. An example of a mesenteric lymph node measured 0.60 cm diameter.

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**ULTRASONOGRAPHIC FINDINGS**

- Mild gastroenterocolitis pattern, normal Intact gastroenterocolic wall layering
- Intermittent mild to hypoechoic mesenteric lymphadenopathy - suspect mild lymphadenitis owing to inflammatory bowel episode
- Possible low-grade pancreatitis

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Overall, no sonographic evidence of significant structural disease was noted. Given recurrent or persistent gastrointestinal signs in this patient, the possibility of emerging IBD or less likely infiltrative intestinal neoplasia in combination with low-grade pancreatitis is possible. Potential emerging Triad Disease cannot be definitively excluded.

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Urine C/S is suggested if evidence of inflammatory sediment on urinalysis.

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Empirically, a hydrolyzed diet trial with potential long-term dietary therapy, as-needed gastrointestinal support +/- empirical antibiotic trial such as Metronidazole / Zithromax combination, given the potential for low-grade mesenteric lymphadenitis, and assessment of gastrointestinal response may prove beneficial. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Sonographic reassessment of the gastrointestinal tract, pancreas, and lymph node is suggested if evidence of progressive gastrointestinal signs and/or weight loss.



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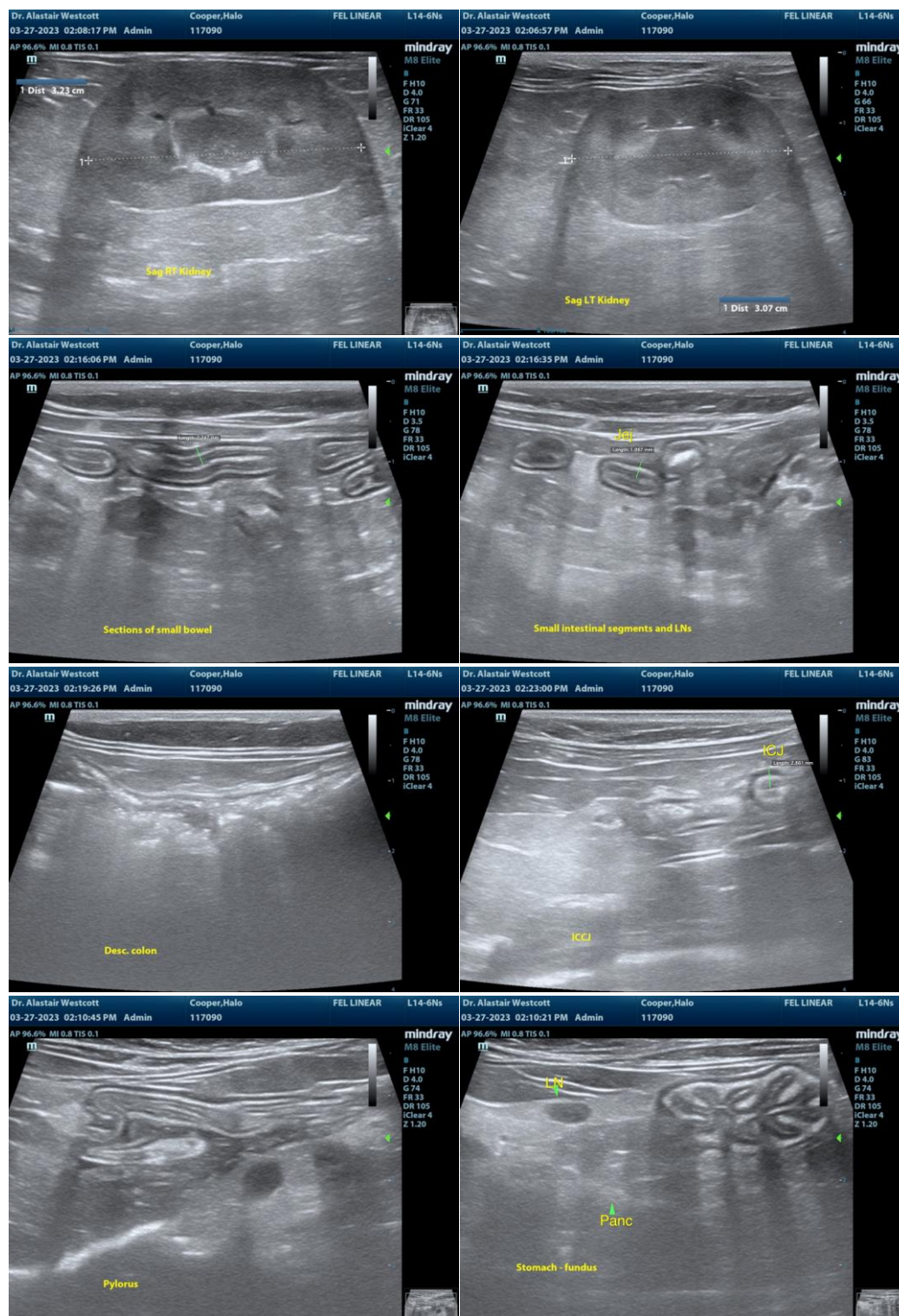
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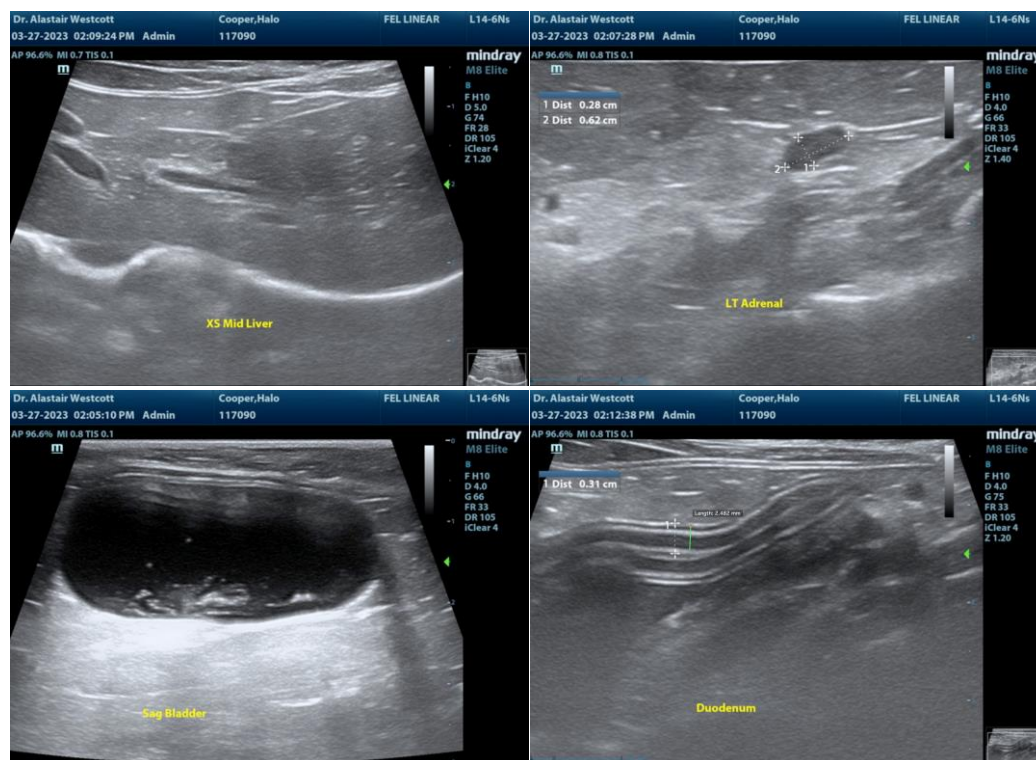
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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