Pennsylvania Mobile
VETERINARY ULTRASOUND SERVICES

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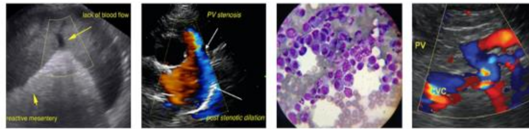


SonoPath
Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Tinkerbell Koch

SPECIES
Feline

BREED
DSH

SEX
FS

AGE
2006

WEIGHT
7.25

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

IMAGING PERFORMED BY
Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME
Lehigh Valley AH (Allen)

REFERRING VET
Dr. Hersh

INVOICE
16630

DATE
4/18/23

PRESENTING CLINICAL SIGNS

Weight loss, anorexia, lethargy

Unremarkable CBC, BUN 60, Creatinine 2.2, SDMA 17, Urine specific gravity 1.014, tract protein, T4 4.3
Negative urine C/S

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

A normal 1:3 cortex / medulla ratio was maintained in the kidneys. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation or pyelectasia was present. Mild dystrophic medullary mineral was noted. The left kidney was subnormal in size measuring 2.6 cm in length. The right kidney was below normal in size measuring 3.3 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.36 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.37 cm width.

Spleen

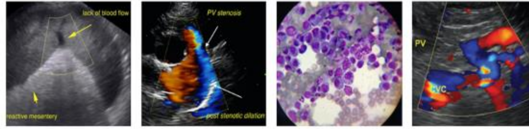
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.65 cm width at the level of the hilus.

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.

Gastrointestinal

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, or foreign material. The pylorus wall width measured 0.27 cm.



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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The duodenum wall width measured 0.24 cm. The jejunum wall width measured 0.21 cm.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was normal in size exhibiting capsule asymmetry with nonhomogeneous, mildly hypoechoic parenchyma compared to adjacent nonreactive or inflamed omentum. Generalized mild to moderate pancreatic duct dilation was noted.

Free Abdomen

No omental masses, lymphadenopathy, or evidence of peritoneal effusion were noted.

ULTRASONOGRAPHIC FINDINGS

- Chronic to chronic active pancreatitis pattern
- Structurally unremarkable gastrointestinal tract
- Moderate chronic renal changes exhibiting mild medullary mineral, subnormal left kidney size

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of intraabdominal neoplastic criteria was noted.

Assessment for evidence of cranial abdominal or subxiphoid discomfort on palpation, which may coincide with chronic to chronic active pancreatitis is suggested. No overt evidence of gastrointestinal mural pathology, although structurally insignificant gastrointestinal disease as a contributing factor is possible.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. Three-view chest radiographs are suggested to rule out occult thoracic pathology. Chronic Triaditis is considered less likely, given no evidence of hepatic enzyme elevations or hepatic parenchymal pathology.

Empirically, as-needed gastrointestinal support and therapy for chronic to chronic active pancreatitis would be reasonable. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. CKD therapy pending further renal workup with monitoring of systemic BP going forward is suggested.

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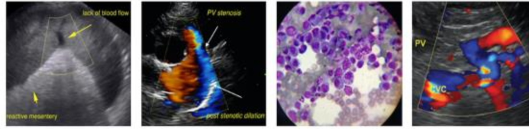

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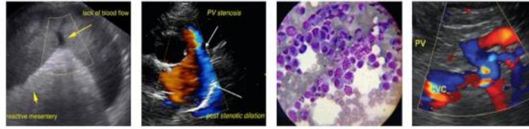

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com