



PATIENT

Meow Leavelle

SPECIES

Feline

BREED

Siamese; Snowshoe

SEX

MN

AGE

10 years

WEIGHT

13.7 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

VCA Salem AH

REFERRING VET

Dr. Allen

INVOICE

13950

DATE

5/25/22

PRESENTING CLINICAL SIGNS

Lethargy, Inappetence and vomiting on/off since 5/14. *Dental disease: Supereruption, tartar accumulation, resorptive lesions, gingival recession, gingivitis index 1 *Indoor/outdoor and doesn't use the litterbox so she isn't sure about elimination Lab Work- WNL Current Medications Gabapentin, Revolution monthly Radiographic Findings 5/14/22: 3V abdominal radiographs: good serosal detail, formed material in colon, no overt obstructive pattern, no overt foreign material, there is a defined round structure in cranial left abdomen which is likely an empty stomach (empty stomach confirmed on brief ultrasound), there is an opacity overlaying the urinary bladder on the left lateral view, but it is not consistent in the other views and it can be traced to a loop of intestine so is considered likely an intestinal loop that happens to be turning around in the region of the urinary bladder (no stones seen on brief ultrasound); not submitted to AIS. Primary Question/Differential to Be Answered in This Exam Cause of vomiting/inappetence--rule out oral pain vs. primary GI vs. neoplasia vs. IBD vs. open

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. Moderate nondependent to mildly congealed urinary bladder sediment was present without evidence of calculus formation. The bladder was otherwise normal in structure and tone. 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.

Normal renal size with asymmetrical margination were present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. The left kidney measured 4.4 cm in length. The right kidney measured 4.6 cm in length.

Adrenal Glands

No overt pathology was noted in the area of the left adrenal gland. 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 borderline enlargement with a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Subtle areas of medial capsule asymmetry were noted. 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 1.0 - 1.1 cm width. No splenic masses or nodules were 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.

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 gastric body wall width measured 0.26 cm.

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 0.22 cm. The jejunum wall width measured 0.24 cm. No overt pathology was noted in the area of the ileocolic junction.

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

Pancreas

The left pancreas was normal in size and contour with subtly heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Intermittent mildly prominent mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of a lymph node measured 1.9 cm x 0.53 cm.

ULTRASONOGRAPHIC FINDINGS

- Moderate urinary bladder sediment
- Nonspecific chronic renal changes / interstitial nephrosis renal pattern
- Overtly normal gastrointestinal tract
- Subtle heterogeneous pancreas
- Borderline splenomegaly - nonspecific, patient variant, benign hyperplasia, hematopoiesis, possible incidental splenitis suspected, no overt evidence of splenic neoplastic criteria

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended. Periodic monitoring of renal parameters is recommended.



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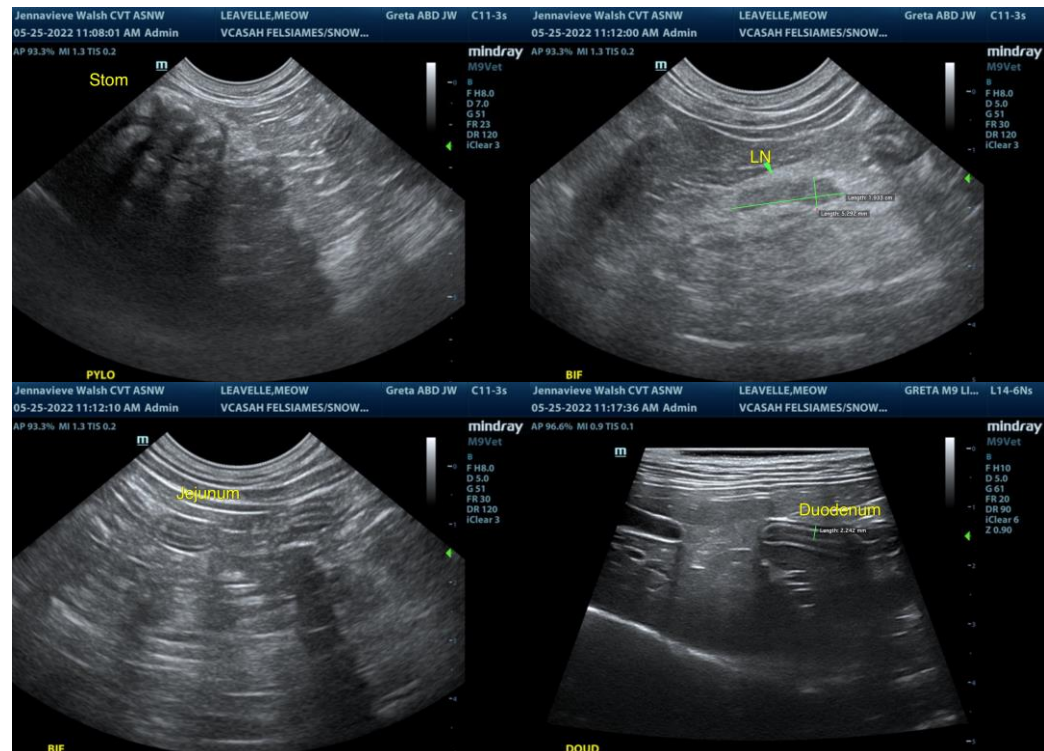
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Without evidence of overt gastrointestinal or pancreatic inflammatory changes or pathology, a definitive cause of the patient's inappetence and vomiting was not definitively evident. Dietary intolerance / food hypersensitivity, mild to low grade pancreatitis, structurally insignificant to possible emerging inflammatory enteropathy, both of which may present sonographically unremarkable, could be considered. Low-grade to chronic pancreatitis would be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation. Correlation with a Spec fPL or full GI panel to include PLI/TLI/Cobalamin/Folate to assess for occult pancreatic / gastrointestinal disease could be considered.

Three view chest radiographs are suggested if not done to rule out occult thoracic or esophageal pathology as contributing factors to the patient's clinical signs. No evidence of intraabdominal neoplastic criteria was present.

If persistent evidence of splenomegaly and assuming normal clotting status, ultrasound-guided FNA of the spleen using a 25-gauge needle could be considered primarily to ensure only benign changes are present, especially if evidence of weight loss.





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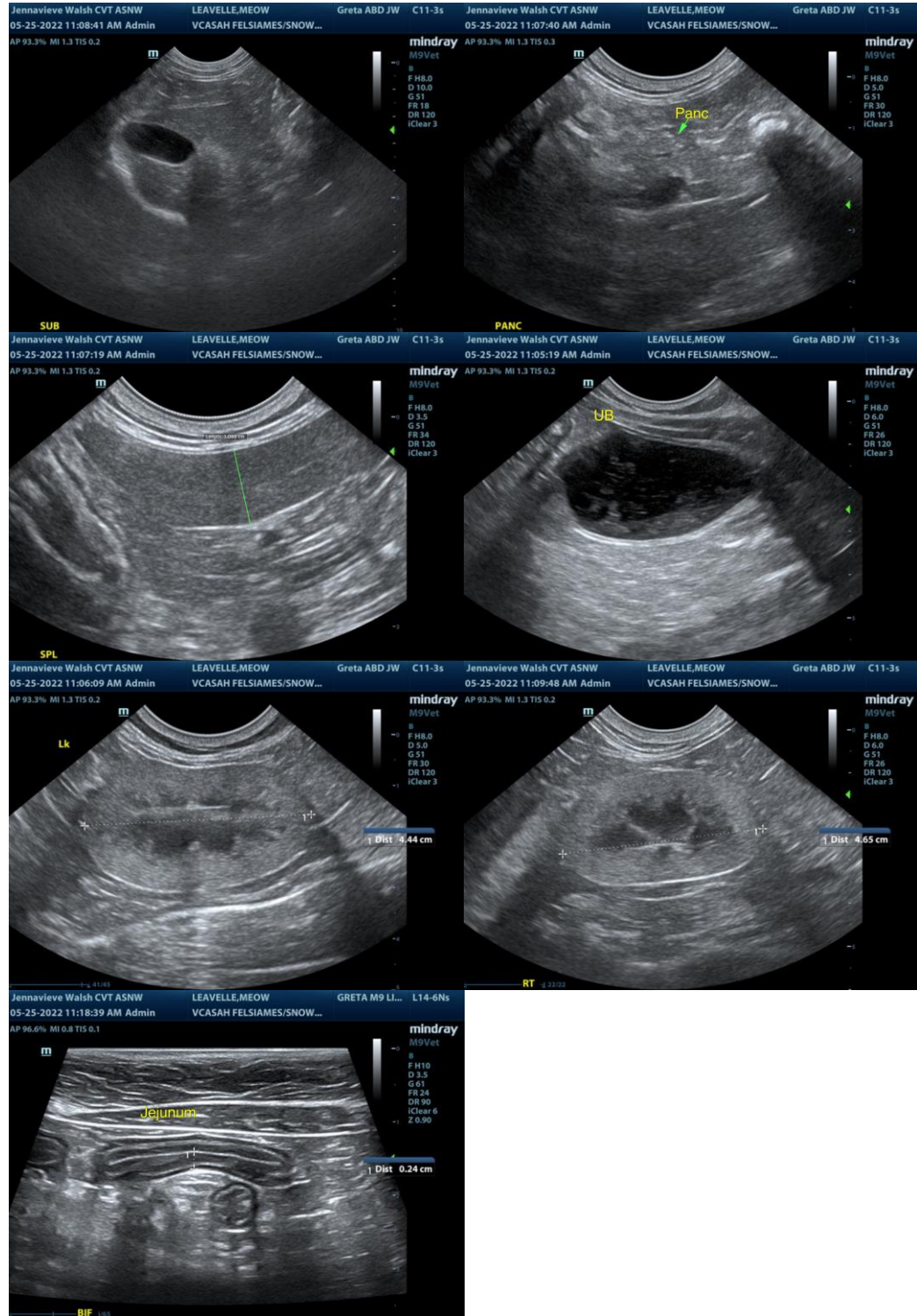
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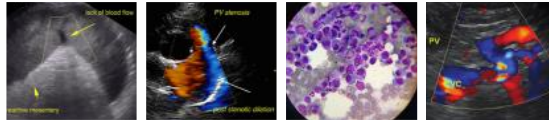
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com