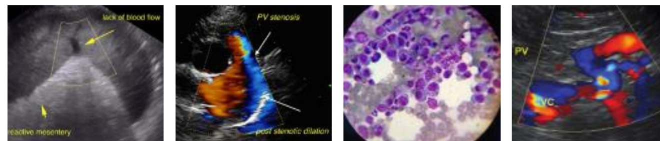


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Tempest Van Eijnsbergen

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

12 Years

WEIGHT

2.5 kg

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

La Paw AH

REFERRING VET

Dr. Deb La Paugh, DVM

INVOICE

13724

DATE

PRESENTING CLINICAL SIGNS

History: Weight loss and elevated liver and Bilirubin Primary Problem: Patient has lost ~ 2.2 kg over the last 2 years with acute weight loss of 2.2 kg in last month (17% body weight) Pertinent Medical History: 10/08/20: Abd US by Dr. Gray: findings consistent with cholangitis and enteritis and mild pancreatitis did well past year, eating very well but weight loss Current Medication: Urinary S/O food, Cosequin Gabapentin 25 mg PO last night and this morning to facilitate imaging

Abnormal PE/Chem/CBC/UA Results: Physical exam: Very lean, BCS ~3/9. Iris atrophy OU, mild dental tartar. No palpable abdominal masses. Slightly doughy abdomen with palpable thickened intestines. Diagnostic Tests Performed/Results: Uncertain date, but reportedly recent: AST 241 ALT 552 Alkp 238 Total BR 1.1 Platelets 512, EOS 2014

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is mildly distended. A scant amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (3.54 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.01 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is slightly small in size (0.21 cm); with normal curvilinear peripheral contours and homogeneous parenchyma. Surrounding vasculature appears normal.

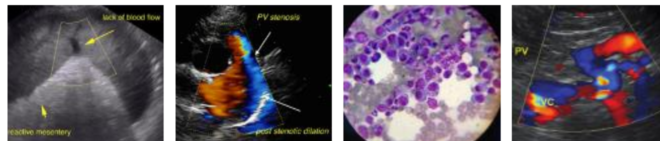
The right adrenal gland is slightly small in size (0.20 cm width); with normal curvilinear peripheral contours and homogeneous parenchyma. Surrounding vasculature appears normal.

Spleen

The spleen is normal in size (0.84 cm in width at the level of the hilus) with a normal capsular contour. Using the high frequency probe, a light micronodular pattern is observed throughout the parenchyma. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall



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bladder is moderately distended. The wall is thickened up to 0.17 cm and hyperechoic. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal to mildly thickened (up to 0.38 cm) with a normal layering pattern and appropriate mural detail. There is slight disruption in the normal 1:3 muscularis to mucosa ratio. In most segments discreet masses are not identified. The ileocecal junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The left limb of the pancreas is prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is. The hypoechoic relative to surrounding omental fat. No discreet focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

Trace free fluid is observed. A few prominent lymph nodes are observed adjacent to the ileocecalcolic junction.

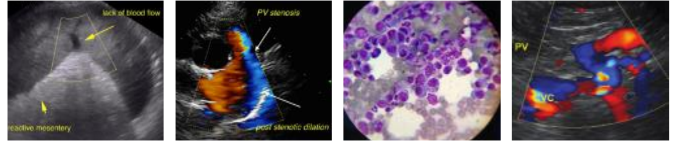
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The gallbladder wall changes are consistent with cholecystitis +/- benign age-related hyperplasia.
- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- The trace ascites is likely secondary to bowel +/- pancreatic and hepatobiliary pathology.

Secondary Findings

- Minor age-related renal pathology
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).



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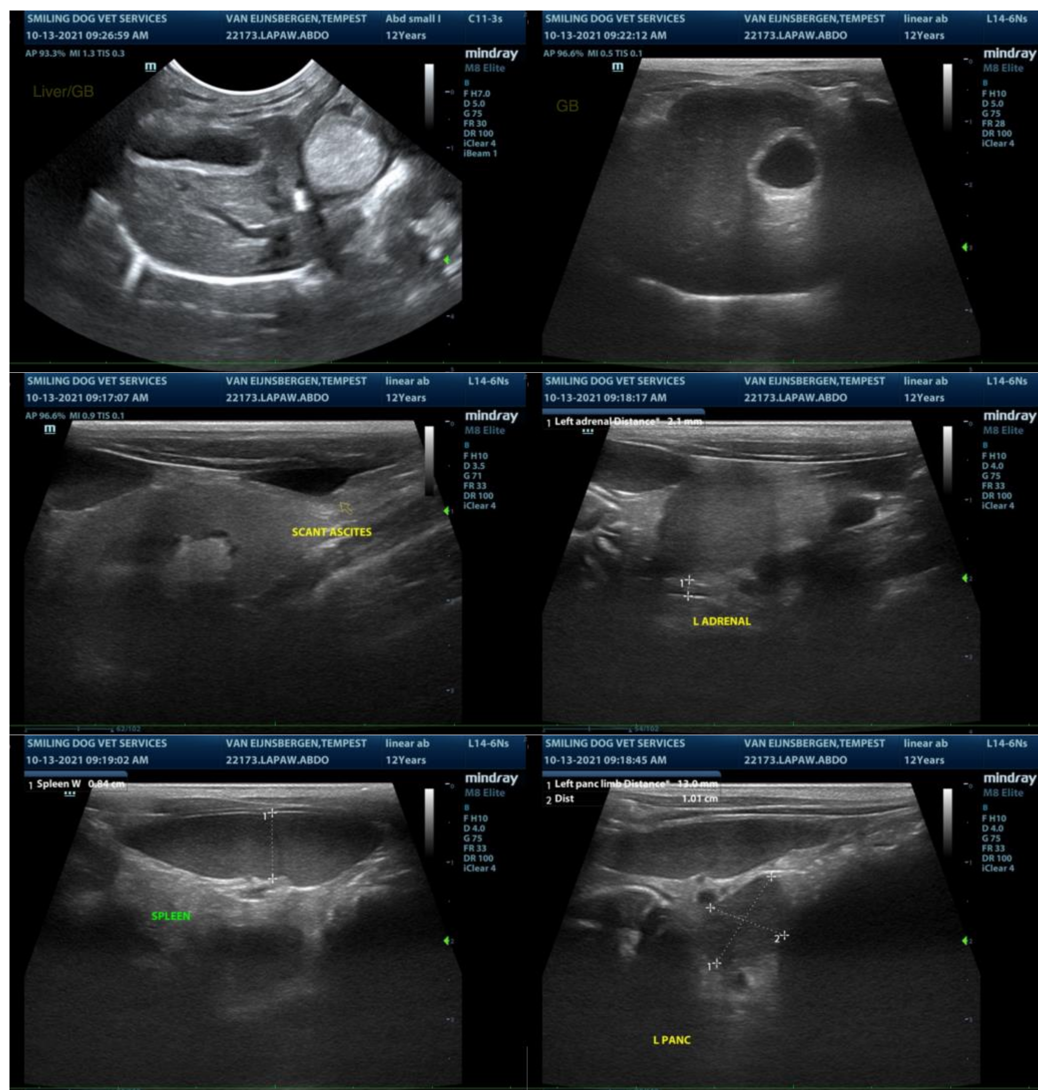
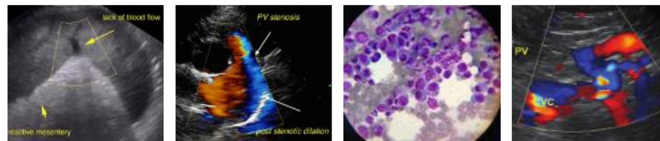
*Given the sonographic changes, “triaditis” is a consideration in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- 3-view thoracic radiographs are recommended to assess cardiopulmonary status.
- Fine need aspirates of the liver, pancreas, and abdominal lymph nodes (if accessible) can be considered if clotting status is appropriate. A 25-gauge needle should be used. If a more aggressive approach is desired, consider and abdominal exploratory with biopsies of these organs along with gastrointestinal biopsies.
- A malabsorption panel including serum cobalamin, folate, TLI and PLI is also recommended.





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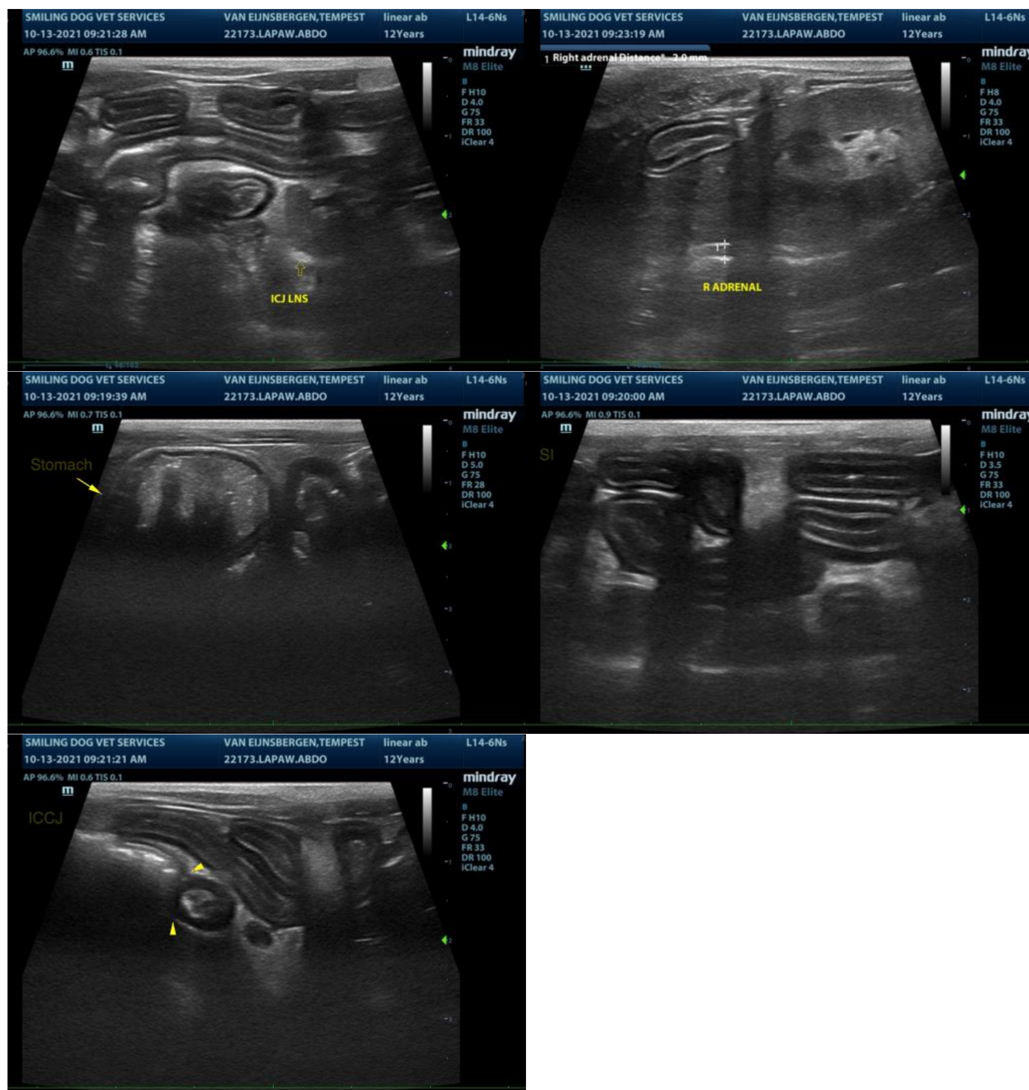

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com