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IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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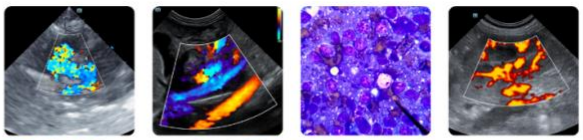

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Favor Gourdine

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

13

WEIGHT

Not Provided

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Central VH Summerville

REFERRING VET

Dr. Ott

INVOICE

22211

DATE

11-3-25

PRESENTING CLINICAL SIGNS

Liver values have been increased since at least August 2023. At that time ALT was 365. ALP 183. Normal T4. In July, patient was losing weight and polyphasic. Had a T4 of 4.5. ALT 544. ALP 269. Tbili 3.4. Started on methimazole and recheck bloodwork October 12: ALP 771. ALP 213. Globulin 5.8. T4 is now normal. CBC unremarkable. Patient sedated with butorphanol and sevoflurane gas for the study.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is distended. Luminal contents are anechoic. A small amount of suspended echogenic debris is observed within the lumen. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is mildly enlarged (4.59 cm in length) with smooth peripheral contours. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Trace pyelectasia is present (0.19 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.05 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate 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 normal size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.51 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.82 cm in width at the level of the hilus) with a normal capsular contour. Using a high-frequency probe, a light micronodular pattern is observed throughout the organ. focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent to enlarged with slightly irregular peripheral contours. The parenchyma is diffusely mottled and heterogenous in appearance. A 4.3 x 1.9 cm isoechoic to heterogenous, expansile swelling/mass is observed left- to mid-liver. In addition, a .50 cm thin-walled, fluid-filled structure is observed on the right side. Also, a few, ill-defined hyperechoic nodules are seen throughout the organ (one measuring 0.98 cm in its longest dimension). Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is moderately distended. The wall is mildly thickened (up to 0.17 cm) and hyperechoic. A small amount of aggregated, echogenic gravity-dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are visible/tortuous but not overtly dilated. There is no obvious evidence of an intraluminal obstruction. The duodenal papilla is normal-in-size (0.22 cm in width).

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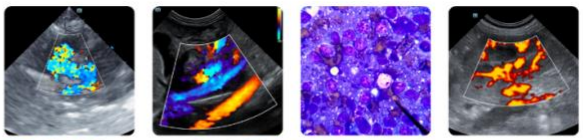

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Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is moderately distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal. There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas
The left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes
A few prominent mesenteric lymph nodes are visualized (one measuring 2.79 x 0.49 cm).

Free Abdomen
A small amount of free fluid is observed.

Other
In the visualized portion of the thorax, a few B-lines are suspected.

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Left- to mid-hepatic swelling/mass. Considerations include neoplasia (i.e., carcinoma, round cell tumor) vs a benign process (i.e., inflammatory focus, other). The diffuse hepatic parenchymal changes are nonspecific and could be secondary to and inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis), emerging hepatic lipidosis, or infiltrative neoplasia. The cystic hepatic structure on the right side likely represents a benign cyst.
- The gallbladder wall changes are most consistent with cholecystitis
- Trace ascites

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this patient. Correlation with the patient's long-term clinical history is recommended.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral, nonspecific, age-related renal changes

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- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

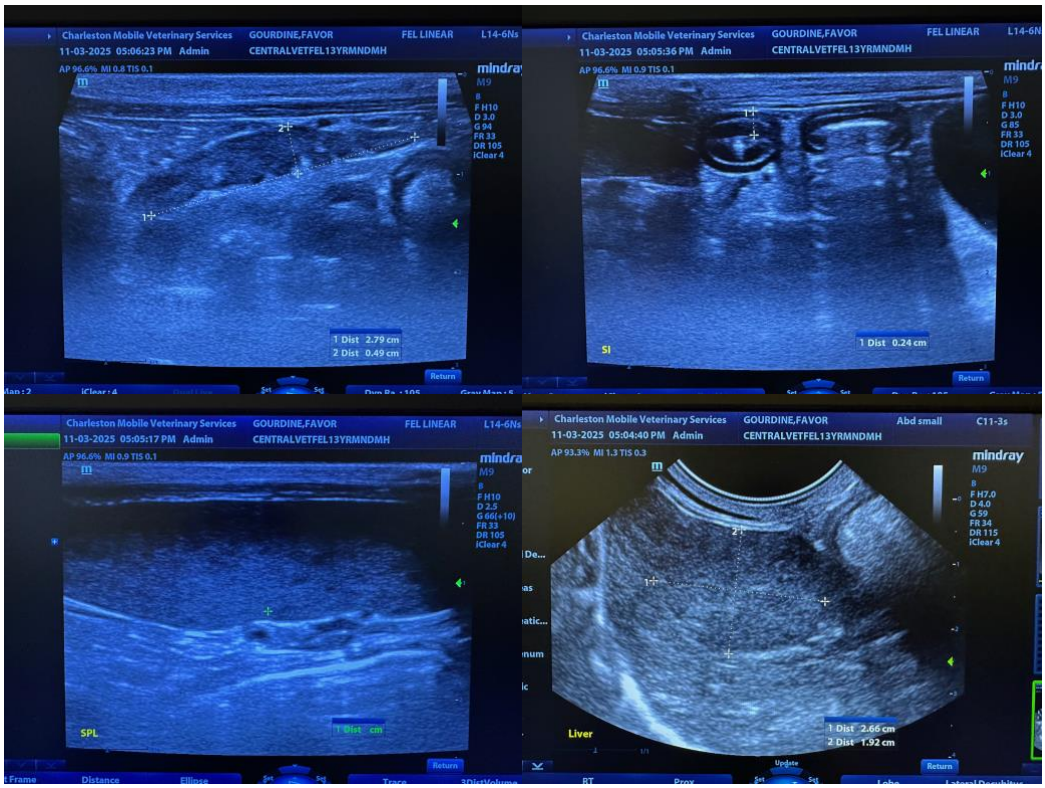
*Given the sonographic changes, "triaditis" is a consideration in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- In order to get a definitive diagnosis, hepatic tissue sampling (i.e., aspirates or biopsies) along with aerobic and anaerobic bile cultures would be necessary. Biopsies are preferred in that they are more likely to yield a definitive diagnosis. If tissue sampling is not pursued, consider empirical treatment for bacterial cholangiohepatitis. If liver values do not improve on antibiotics, hepatic tissue sampling should be revisited. Also consider hepatic antioxidant therapy (i.e., Denamarin, Ursodiol) as an ancillary treatment.

- Given the suspected B-lines in the patient's thorax, consider three-view thoracic radiographs to assess cardiopulmonary status.

- Also consider a GI panel including serum cobalamin and folate, TLI and PLI to assess for concurrent maldigestion/malabsorption and pancreatic disease.



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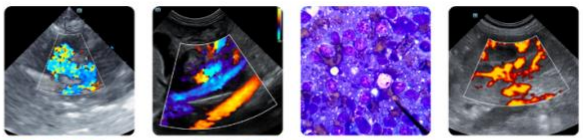

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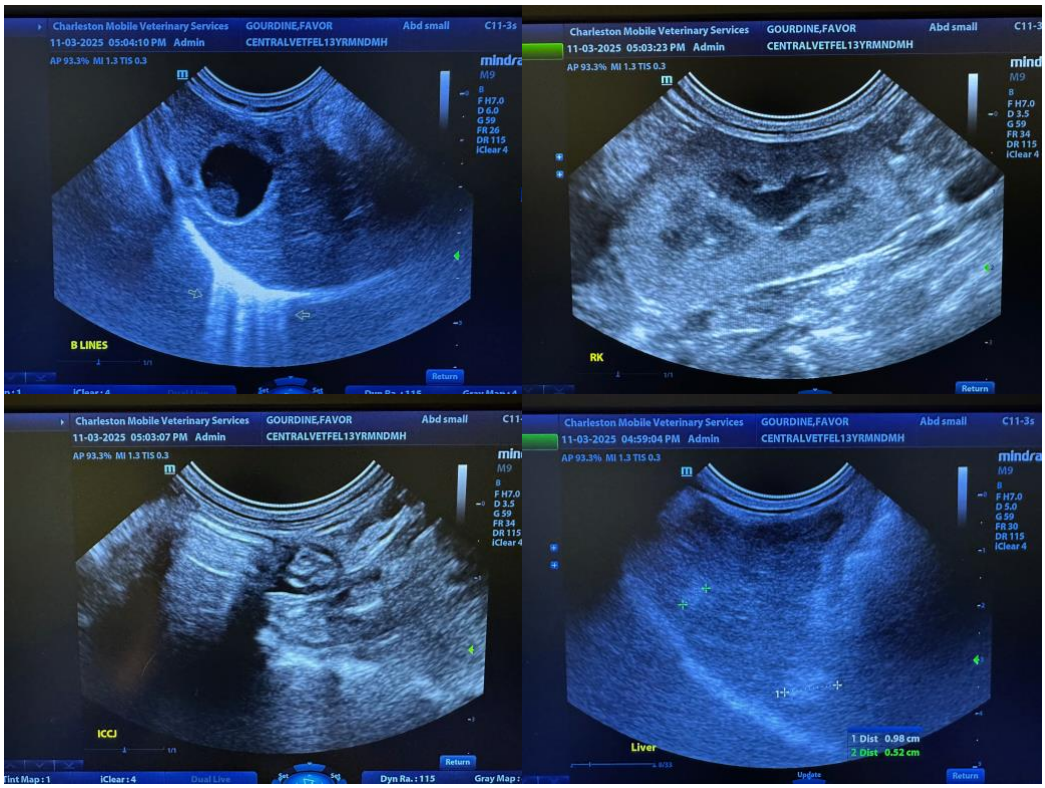

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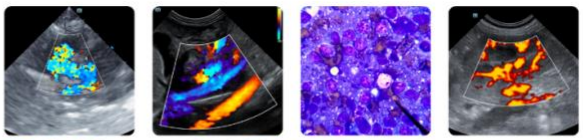

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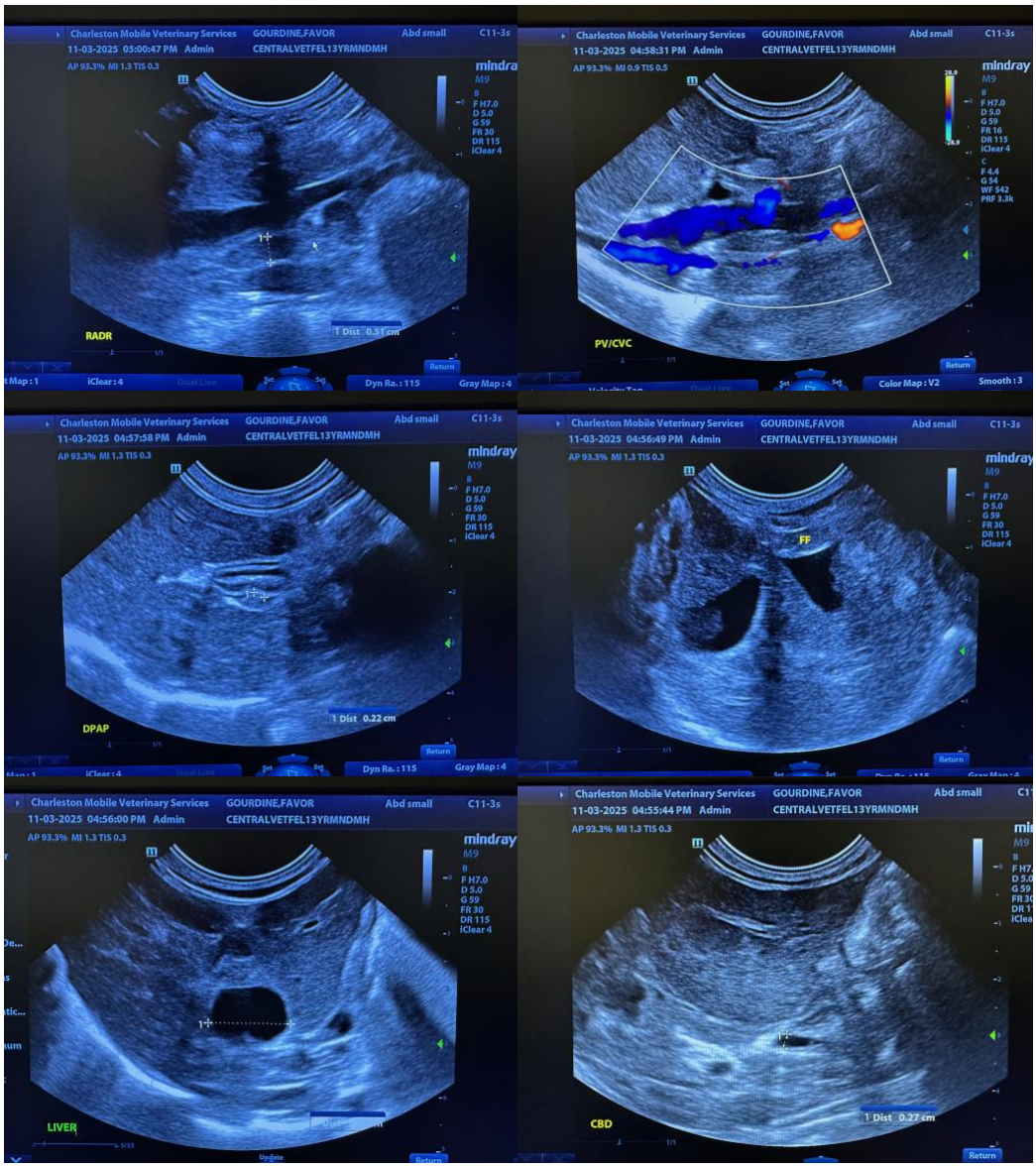

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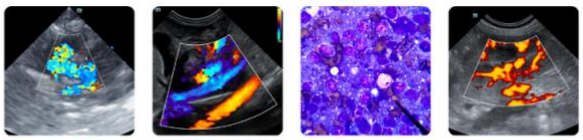

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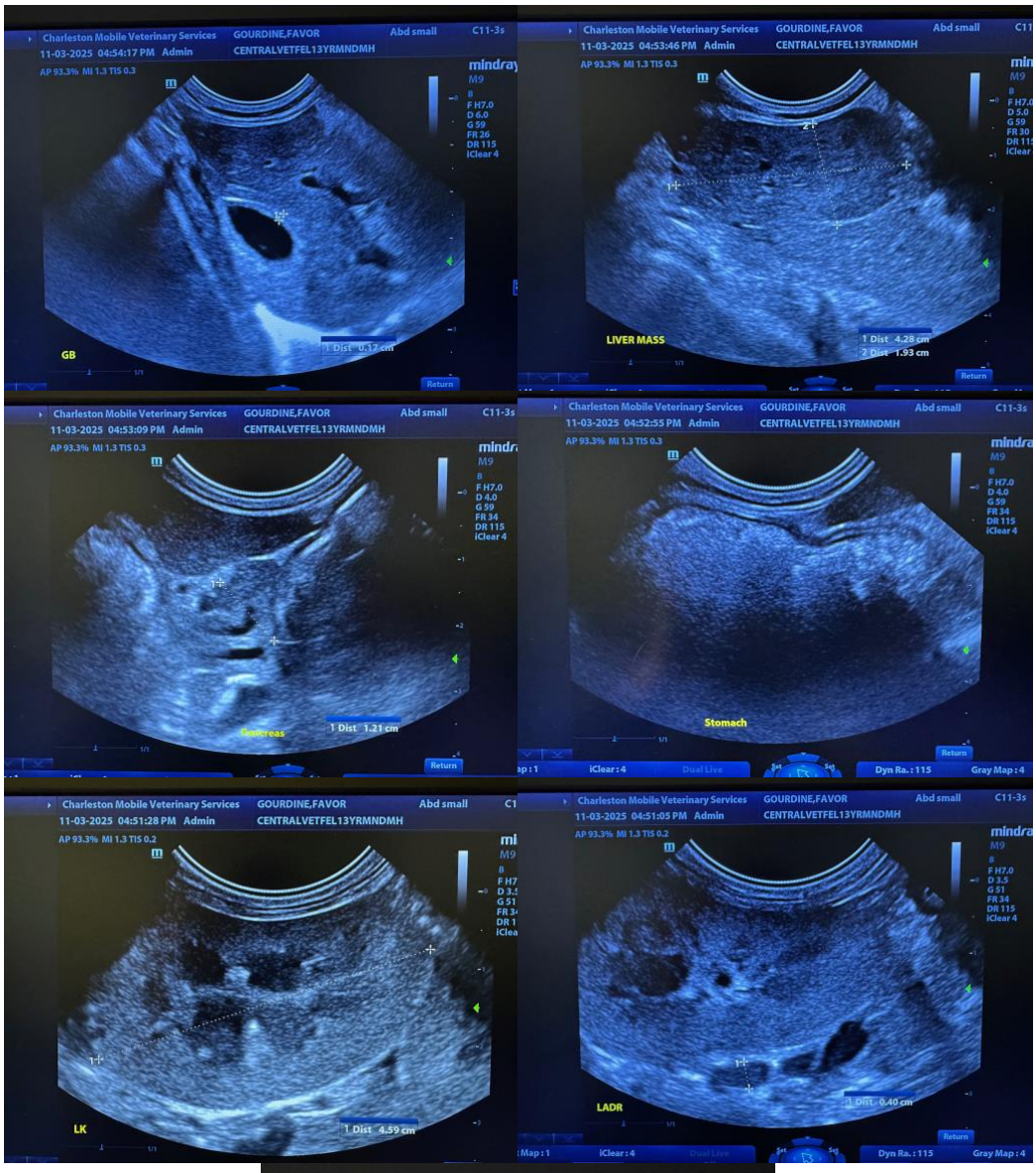

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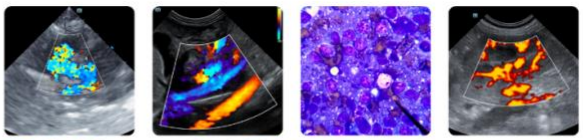

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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