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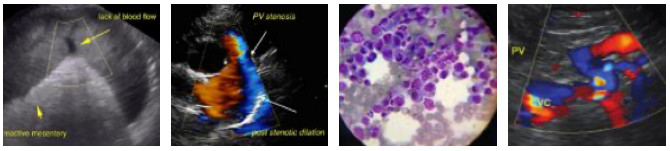

SonoPath.com
1-800-838-4268 info@sonopath.com

**PATIENT**
Jinx Adamson

**SPECIES**
Feline

**BREED**
Domestic shorthair

**SEX**
Male, neutered

**AGE**
2017

**WEIGHT**
18.7 lbs.

**INTERPRETED BY**
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

**IMAGING PERFORMED BY**
Amanda Crook

**HOSPITAL NAME**
Rivers Edge Pet Medical Center

**REFERRING VET**
Dr. David Gray

**INVOICE**
12746

**DATE**
12/21/21

## PRESENTING CLINICAL SIGNS

History: One week ADR not eating, icteric, dehydrated Currently on: IV fluids, vitamin K, mirtazapine, cerenia
Abnormal PE/Chem/CBC/UA Results: See attached lab results - CBC: HEmo 17.4, MCHC 39.6, RDW 29.4, Neu 0.19, Mono 1.06, Eos 0.00, CHEM: Gluc 240, Creat 2.6, Sod 149, Pot 3.2, Chl 108, ALT 182, ALP 274, Tbili 9.6. Coags PT normal, APTT abnormal See attached radiographs - poor detail,
The cat presented febrile with 105 fever, went up to 106, and now down to 104.5

## 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 moderately distended. A moderate amount of aggregated echogenic suspended 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 size (4.69 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 size (4.65 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 mildly enlarged (1.20 cm length; 0.60 cm width) with normal curvilinear peripheral contours. The parenchyma is of appropriate echogenicity and there was normal glandular detail. Surrounding vasculature is normal.

The right adrenal gland is mildly enlarged (1.12 cm length; 0.66 cm width) with normal curvilinear peripheral contours. The parenchyma is of appropriate echogenicity and there was normal glandular detail. Surrounding vasculature is normal.

### *Spleen*

The spleen is subjectively prominent in size with slightly irregular peripheral contours and swelling at the cranial aspect. The parenchyma is mottled in appearance. No distinct focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

### *Liver*

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic 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 gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

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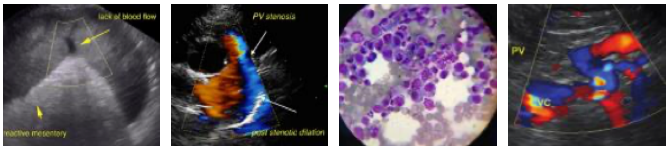

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### *Gastrointestinal*

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is minimally fluid distended. 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 with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

### *Pancreas*

The pancreas is diffusely prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is mildly hyperechoic.

### *Free Abdomen*

Trace free fluid is observed. 1-2 prominent lymph nodes are observed in the right cranial quadrant, the largest measuring 0.91 cm in length).

### *Other*

A brief echocardiogram reveals no evidence of pericardial effusion.

## ULTRASONOGRAPHIC FINDINGS

**Primary Findings:**

- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- The pancreatic changes are consistent with mild to moderate acute pancreatitis.
- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The splenic parenchymal changes could be secondary to benign pathology (i.e., lymphoid hyperplasia or extramedullary hematopoiesis). Alternatively, emerging neoplasia (i.e., round cell tumor) may be present.
- The trace ascites is likely secondary to hepatic, pancreatic and/or bowel pathology.

**Secondary Findings:**

- The bilateral adrenomegaly may be a normal variant for this patient or may be secondary to stress or hyperplastic change.
- Urinary bladder debris.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

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

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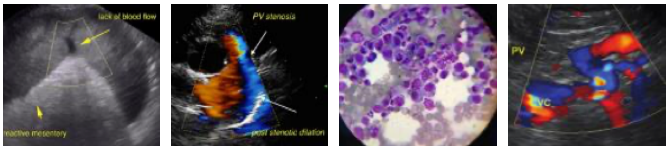

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess cardiopulmonary status.
- A fine needle aspirate of the liver can be considered, although the APTT is borderline elevated. If pursued, a 25-gauge needle should be used. The patient should be monitored sonographically for at least 5-10 min post aspiration. The client should also be warned of the possibility of iatrogenic hemorrhage associated with aspiration.
- Supportive care for hepatopathy and pancreatitis is recommended including fluid therapy, gastric protectants, antiemetics and broad-spectrum antibiotic therapy (i.e., as empirical treatment for cholangiohepatitis) +/- pain medication, if needed. Nutritional support (i.e., via esophagostomy tube) is also recommended to help prevent/treat hepatic lipidosis.
- A malabsorption panel including serum cobalamin, folate, TLI and PLI should also be considered.
- Ultimately, if the patient does not respond to supportive care, an abdominal exploratory with hepatic and GI biopsies may be warranted.




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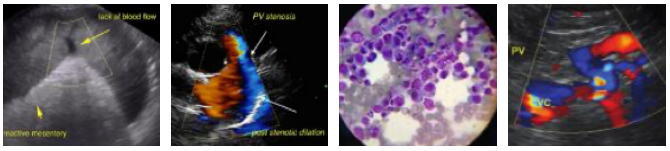

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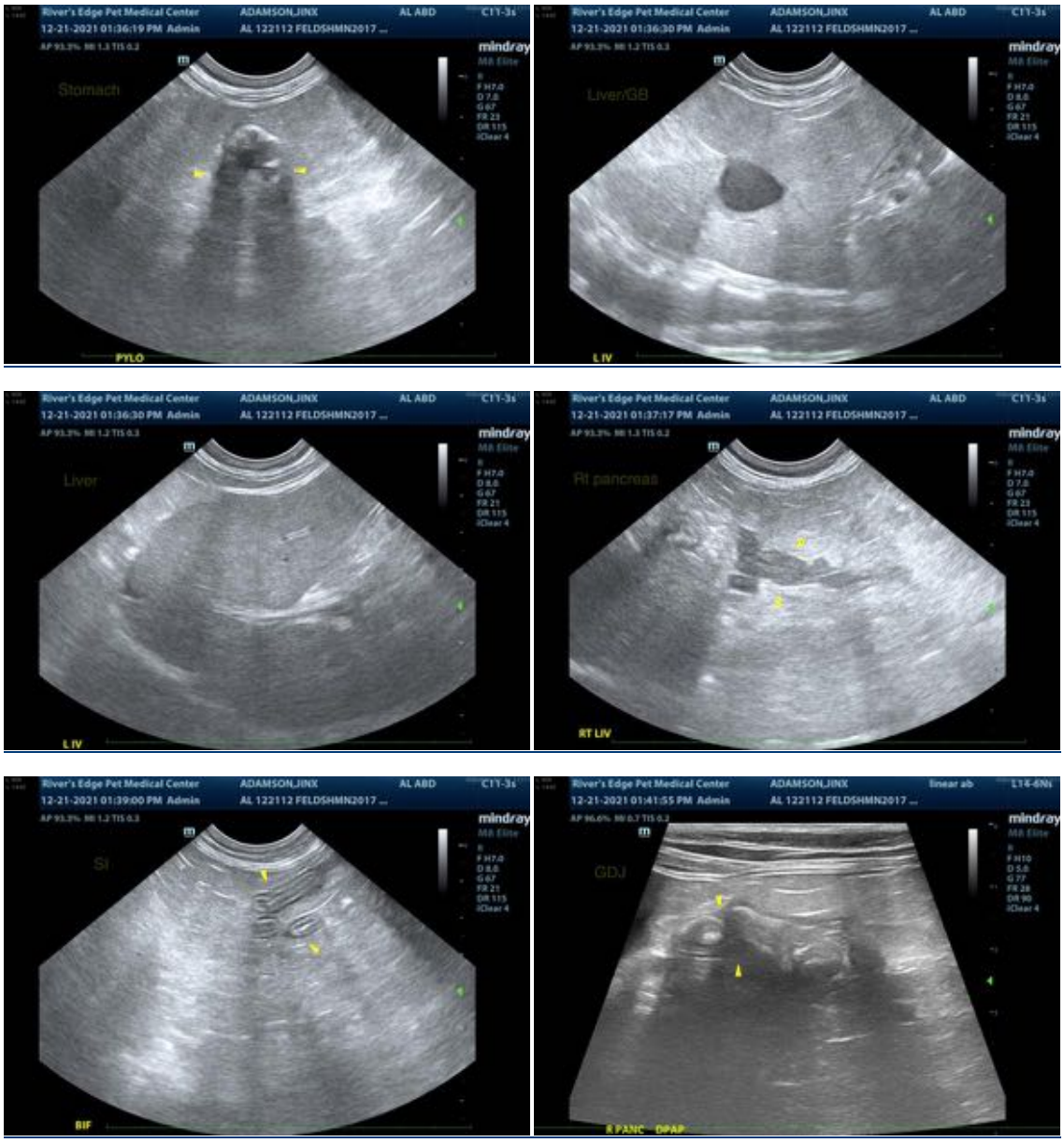


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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 ACVIM (*Small Animal Internal Medicine*)

Andrea.nicastro@sonopath.com