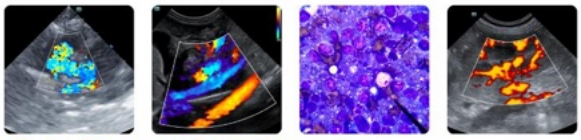


DATE

12/30/25

PATIENT

Forrest Brazil

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

7/16/2012

WEIGHT

8.1 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Homeward Bound VS

REFERRING VET

Dr. Dorn

INVOICE

13362

PRESENTING CLINICAL SIGNS

Patient History: P presented on 12/26 for losing weight despite a good appetite, physical exam WNL except for muscle wasting along spine and in hind end, bloodwork revealed normal kidney values, glucose, and thyroid levels but all liver and gallbladder values are mild to moderately elevated so want to investigate that further.

Current Medications: N/A.
Labwork Results: Labwork not attached, reported as: ALT 247 27 - 158 U/L HIGH, AST105 16 - 67 U/L HIGH ALP 185 12 - 59 U/L HIGH, GGT 13 0 - 6 U/L HIGH, TOTAL BILIRUBIN 2.5 0.0 - 0.3 mg/dL HIGH, BILIRUBIN UNCONJUGATED 1.0 0.0 - 0.2 mg/dL HIGH, BILIRUBIN CONJUGATED 1.5 0.0 - 0.2 mg/dL HIGH, CHOLESTEROL 420 91 - 305 mg/dL HIGH
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Alfax/Midaz.
Stat Report: Requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small to moderate amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.67 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is hyperechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild 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 (4.30 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is hyperechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild 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 (0.47 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent in size (0.93 cm in width at the level of the hilus) with smooth peripheral contours. There is appropriate echogenicity and echotexture. A light micronodular pattern, bordering on a “moth-eaten” appearance is observed throughout the organ. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. A 0.99 x 0.47 cm irregular septated cystic

structure is observed on the left to mid-liver at the caudal aspect. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1. See also *Other.*

The gall bladder lumen is moderately distended. The wall is mildly thickened (up to 0.22 cm and hyperechoic). A moderate amount of echogenic debris is observed within the lumen. The cystic and common bile duct walls are subjectively thickened. The ducts are tortuous and dilated. Echogenic debris is observed within the lumen. See also *Other.*

Gastrointestinal

The gastric lumen is not 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 is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileum is normal. The wall of the ascending colon at the level of the ileocecocolic junction is thickened (up to 0.49 cm. The remaining colonic wall is normal. There is no obvious evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and heterogeneous in appearance with numerous varying sized hypoechoic to anechoic nodules throughout the organ. The pancreatic duct is dilated (up to 0.41 cm in width). See also *Other.*

Lymph nodes

At least 2 prominent mesenteric lymph nodes are visualized, one of the nodes measuring 1.48 x 0.68 cm. At least one prominent gastric lymph node is also seen measuring 0.54 cm in its longest dimension.

Free Abdomen

Trace free fluid is observed.

Other

In the visualized portion of the thorax, a moderate amount of pleural effusion is present. There is no obvious evidence of pericardial effusion.

In the right cranial quadrant, a 3.6 x 2.3 cm irregular structure/lesion with 2 fluid pockets is observed. The tissue surrounding the fluid pockets is heterogeneous in appearance. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The origin of the fluid-filled structure in the right cranial quadrant is unclear. It may be arising from pancreas, common bile duct, duodenum, liver, mesentery, other. Differentials include a benign process (i.e., abscess, cyst) or neoplasia (i.e., abscessed or necrotic tumor, cystic tumor).
- The diffuse hepatic parenchymal changes could be consistent with hepatic lipidosis, an inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, feline infectious peritonitis), infiltrative neoplasia (i.e., lymphoma) and/or other hepatopathy.
- The gallbladder and cystic/common bile duct wall changes are most consistent with cholecystitis and cholangitis, respectively.
- The pancreatic changes are most consistent with chronic pancreatitis with benign nodular hyperplasia with a lower possibility of infiltrative neoplasia.

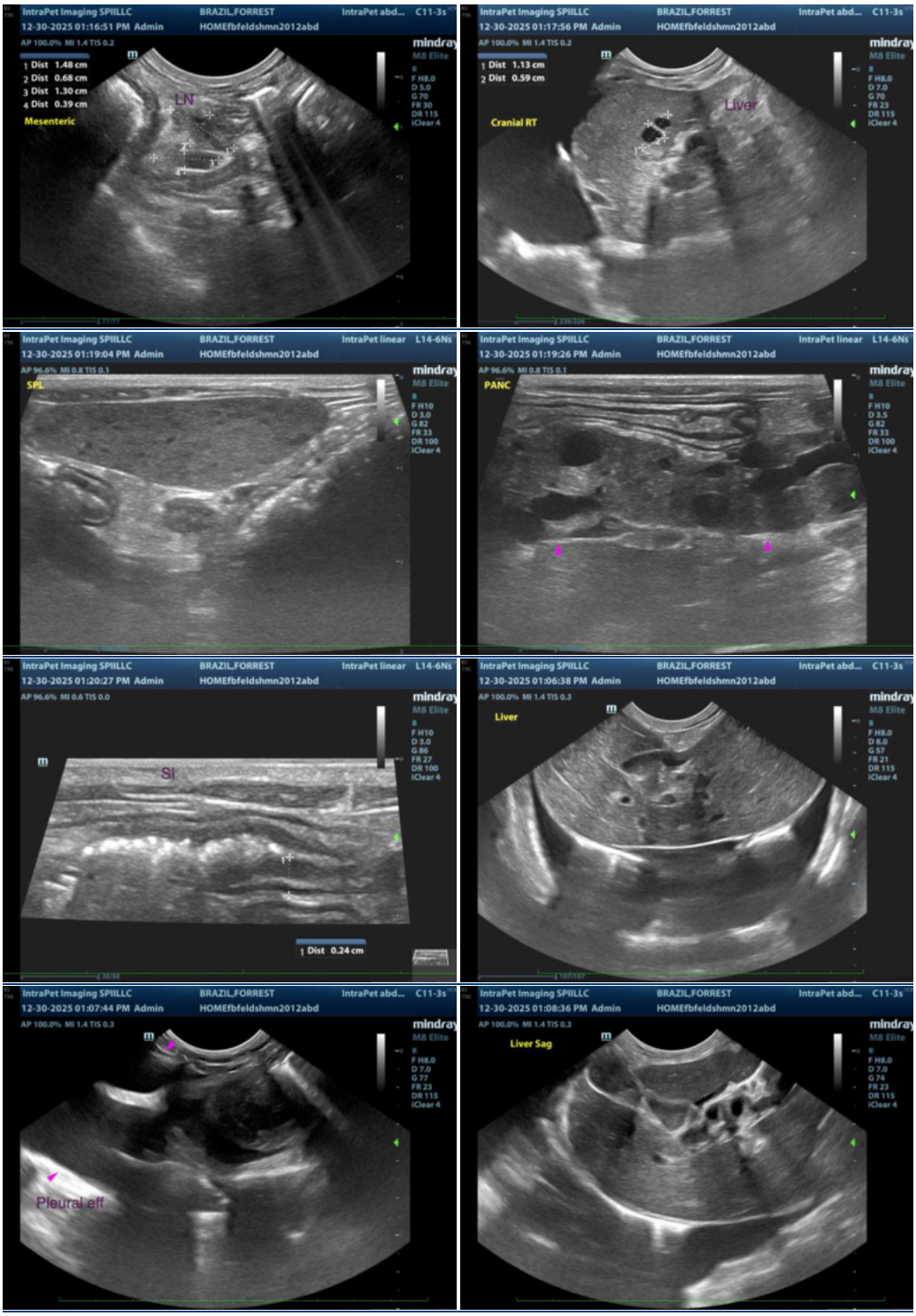
- The splenic parenchymal changes could be consistent with emerging neoplasia (i.e., round cell tumor), lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation, other.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The focal thickening of the ascending colon at the level of the ileocecocolic junction could be consistent with inflammation, emerging neoplasia, hypertrophy, other.
- Trace ascites
- Pleural effusion, the cause of which is unclear. Considerations include occult neoplasia, increased hydrostatic pressure, low oncotic pressure, increased vascular permeability, other.

Secondary Findings:

- Bilateral nonspecific, age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- To further evaluate the origin and extent of the structure in the right cranial quadrant, consider an abdominal CT scan and/or referral to a board-certified surgeon to discuss abdominal exploratory with excisional biopsy and cultures. If pursued, three-view thoracic radiographs and clotting times should be performed prior to anesthesia. Liver biopsies as well as aerobic and anaerobic bile cultures should also be obtained.
- If a conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis/cholecystitis (amoxicillin-clavulanic acid, Denamarin). If no improvement in the liver values is seen within 7-10 days of initiating therapy, antibiotics should be discontinued, and hepatic tissue sampling reconsidered. If liver values improve, continue therapy for at least 3-4 weeks and 1 week beyond normalization of the liver values.
- Also consider a GI panel including serum cobalamin, folate, TLI and PLI to assess for “triaditis”.
- Other considerations include the following:
  1. Submission of the pleural fluid for cytologic evaluation
  2. Thoracic radiographs (as stated above) to assess cardiopulmonary status
  3. +/- echocardiogram, if indicated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mindray
M8 Elite
1 Dist 1.48 cm
2 Dist 0.68 cm
3 Dist 1.30 cm
4 Dist 0.39 cm
Mesenteric
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Cranial RT
Liver
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Pleural eff
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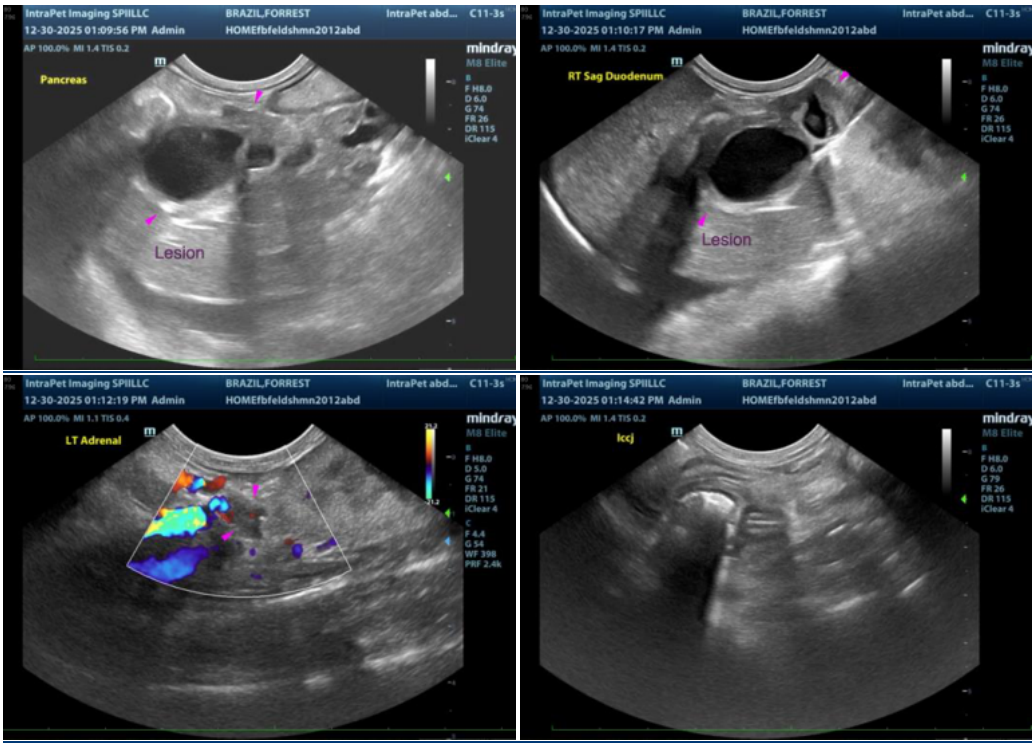
Liver Sag



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