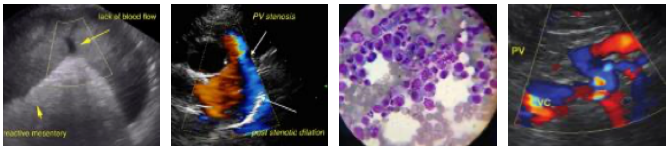
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Shadow Gartside

SPECIES
Feline

BREED
Domestic shorthair

SEX
Female, spayed

AGE
15 Yrs.

WEIGHT
6.6 lbs.

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

IMAGING PERFORMED BY
Dr. Mengine

HOSPITAL NAME
Stoney Creek VH

REFERRING VET
Dr. Mengine

INVOICE
13027

DATE
2/22/22

PRESENTING CLINICAL SIGNS

History: Treated empirically for infiltrative bowel disease, based on U/S finding, since 5/19 - initially with pred, and then with budesonide, as well as B-12 and cerenia, since early 2020. Also history of chronic UTIs. Has recently been losing weight and inappetant (down 1.5 pounds in 5 months) CBC unremarkable, Chem - stable azotemia (BUN 33, Creat 2.0), new liver enzyme elevations (ALT 492, AST 204, ALP 52, TBili 0.6, unconj Bili 0.3). T4 normal (1.8), U/A pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A few cystic calculi are visualized, the largest measuring 0.68 cm in diameter. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.39 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter.

The right kidney is normal size (3.63 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Mild pyelectasia is present (0.29 cm in the transverse plane). There is no evidence of infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.29 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

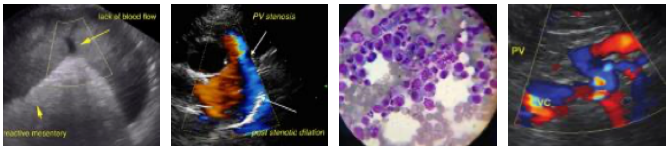
The spleen is normal in size (0.84 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogeneous in appearance. No distinct focal lesions are observed. Several intrahepatic biliary stones are visualized. Vascular is of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. 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 thickness is normal with a normal layering pattern and appropriate mural detail. In some segments,



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there is a thickening of the submucosal layer. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 0.52 cm in length. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

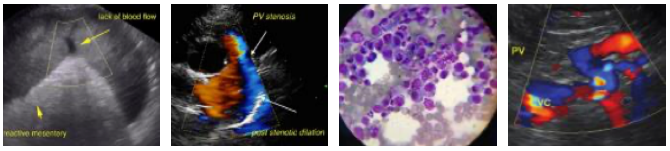
- An obvious cause for the elevated liver enzymes is not identified in the study. However, a microscopic hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, hepatic lipidosis, infiltrative neoplasia (less likely) should be considered. Intrahepatic biliary stones- incidental.
- Cystic calculi.

Secondary Findings:

- Degenerative renal changes with dystrophic mineralization.
- The thickening of the submucosal layer in the small intestine could be consistent with inflammatory bowel disease or less likely, emerging neoplasia.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a fine needle aspirate of the liver if clotting status is appropriate. This can be helpful in assessing for hepatic lipidosis and infiltrative neoplasia (i.e., lymphoma) but may not be useful in diagnosing other hepatopathies. Alternatively, a surgical liver biopsy with aerobic and anaerobic bile cultures can be considered.
- If a more conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis/hepatic lipidosis using broad spectrum antibiotics, hepatic antioxidants, and nutritional support. If liver values do not improve within 5-7 days of initiating therapy, hepatic tissue sampling should be re-visited.
- Three-view thoracic radiographs should be performed prior to anesthesia.
- Also consider a GI panel including serum cobalamin, folate, TLI and PLI to assess for concurrent small intestinal and pancreatic disease.



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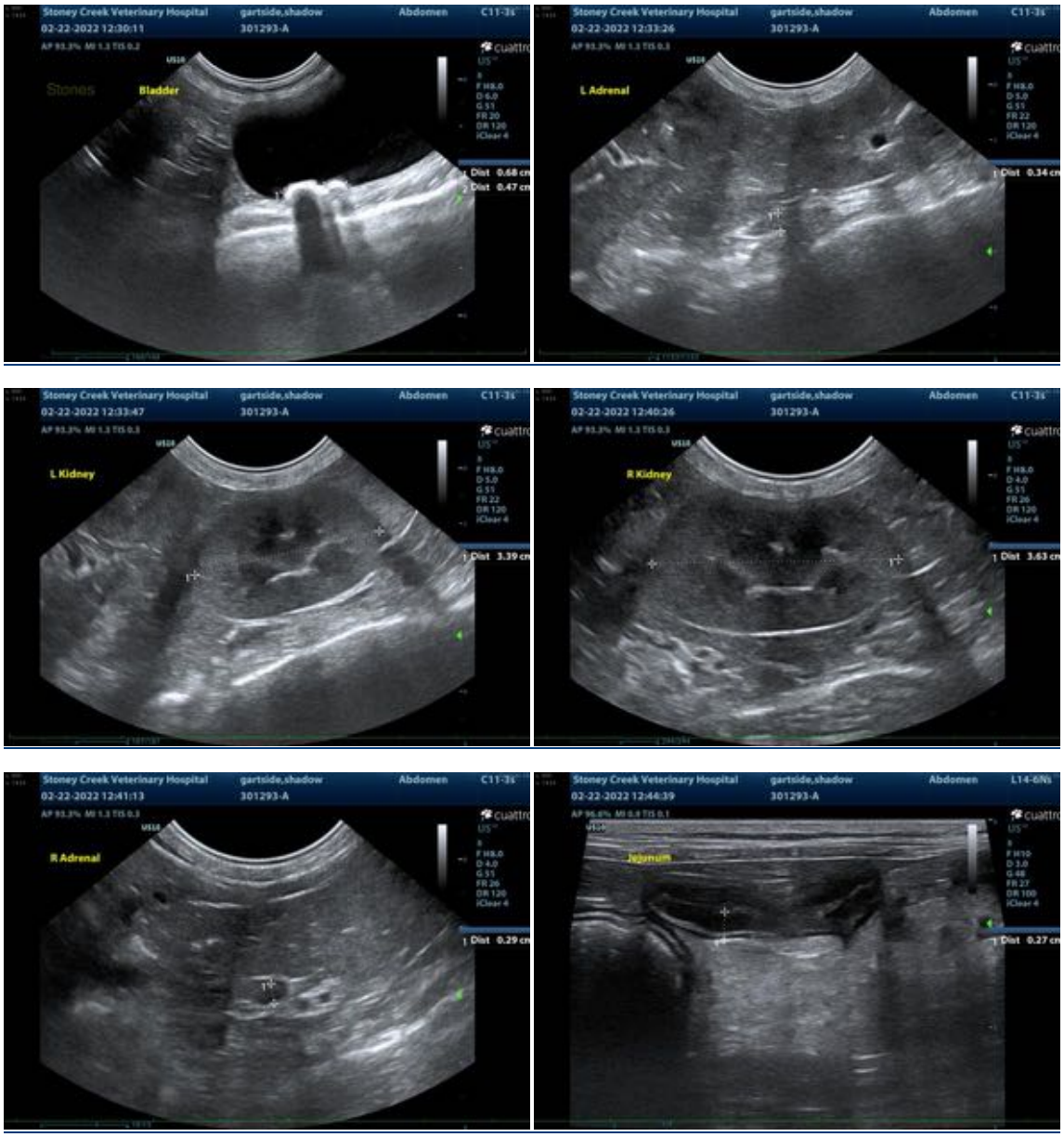
- Regarding the bladder stones, consider a cystotomy with stone removal, analysis and culture when the patient is stabilized with regard to the liver issue. Or, if a surgical liver biopsy is pursued, a cystotomy can be performed at that time. An attempt at medical dissolution of the stones can also be considered.



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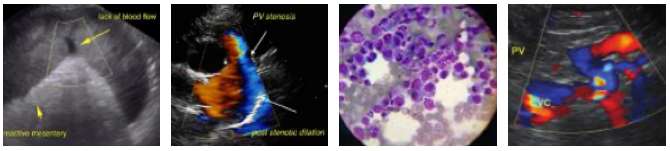

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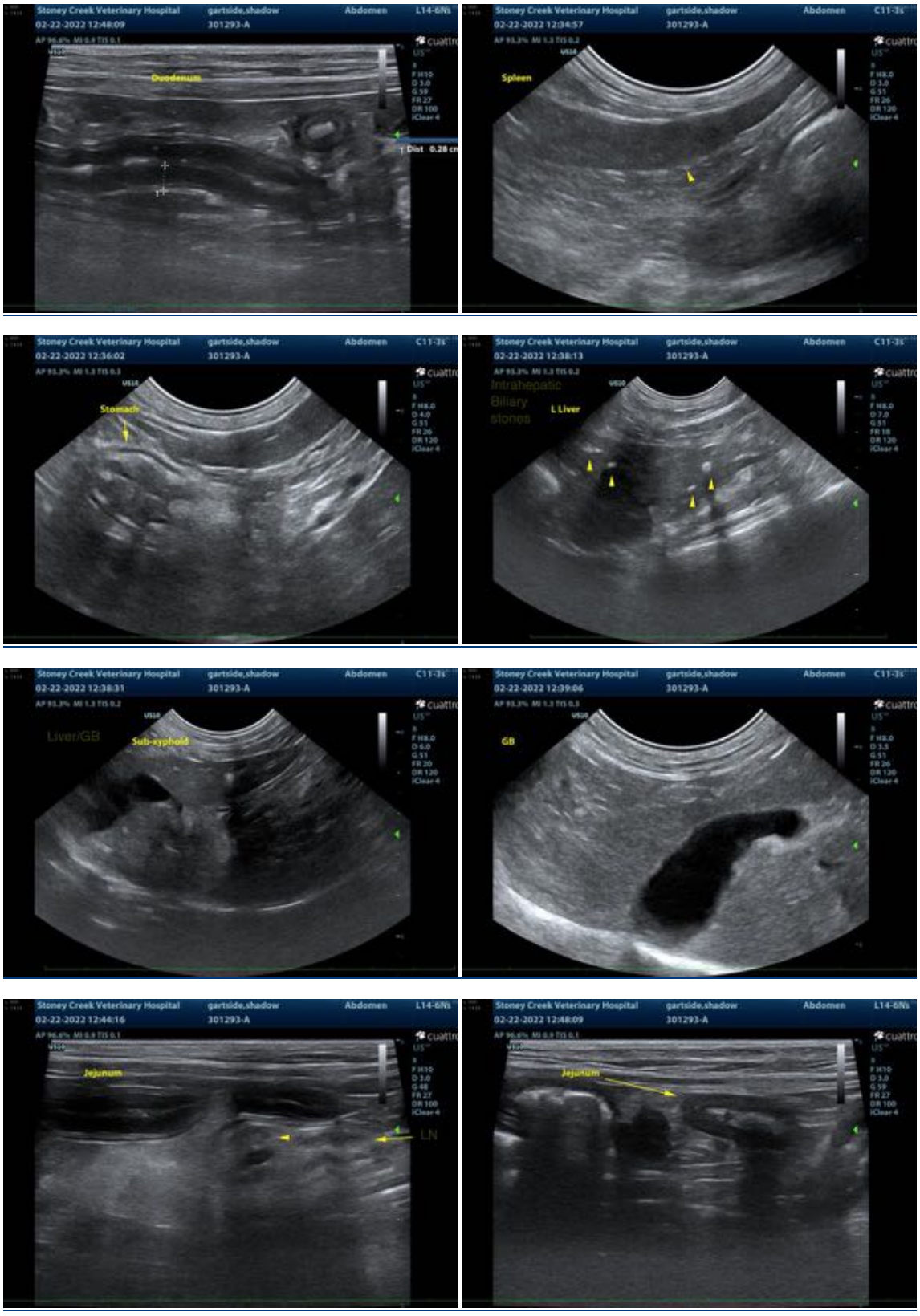
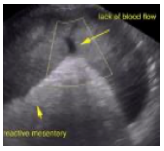
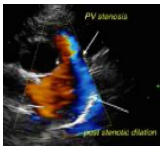
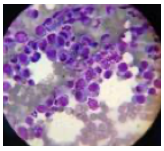
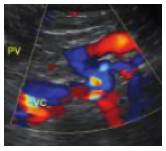


The information and recommendations provided are based on the images presented by the referring

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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.

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