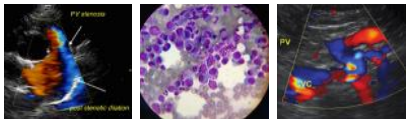
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

2/23/2022

PATIENT

Mrz. Z Halpern

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2/14/2003

WEIGHT

6.5lbs

INTERPRETED BY

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

HOSPITAL NAME

Paradise Animal Hospital

REFERRING VET

Dr. Halpern

INVOICE

10447

PRESENTING CLINICAL SIGNS

Ravenous appetite, stealing food off plates. Had single episode of unilateral epistaxis- found to have a BP of 230 mmHg. Renal values elevated with poor concentration, a big jump in BW from 3 months ago. Diagnosed hyperthyroid, inflammatory bowel disease (eosinophilic), FIV positive. Has arthritis and hx of FORLs. Also has significant hind end OA and front paw OA.

Current Medications: Prednisolone 2.5mg SID for 3 years, Methimazole 2.5mg BID (to be reduced to SID), Gabapentin 25mg BID.
Lab Results: SDMA 15, Crea 1.5 (wnl), BUN 43, USG 1.014, pH 5.5, WBC 0-2/hpf, Hyperkalemic 5.6 (3.7-5.2), Spec fPL 2.6 (wnl), TT$ 1.1, Ft4 <0.3 (low). Urine culture and sensitivity LCC pending.
Date of Previous IntraPet Ultrasound: 2/12/20. See attached.
Sedation: Patient sedated with Gabapentin.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

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 with anechoic urine. 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 (3.13 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A pinpoint hyperechoic focus is observed at within the cortex. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter.

The right kidney is normal size (3.68 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.36 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively normal in size (0.68 cm in width at the level of the hilus) with a a slightly undulating medial contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with mostly curvilinear peripheral. A 1.47 x 1.21 cm irregular multiseptated cystic nodule/mass is observed in the left lateral lobe. The remaining parenchyma is

hyperechoic relative to the spleen and homogenous in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

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 segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portion of the right limb, the parenchyma is largely isoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.18 cm in diameter).

Free Abdomen

There is no evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The presence of ingesta in the gastric lumen despite fasting is suggestive of delayed gastric emptying.

Secondary Findings

- The cystic hepatic nodule/mass is most consistent with biliary cystadenoma or cystadenocarcinoma. The diffuse hepatic parenchymal changes are most consistent with hepatic lipidosis. Other differentials include inflammatory disease or infiltrative neoplasia. This finding was seen on the previous sonograph (2020) and is likely clinically insignificant, particularly in light of the normal liver values.

- Age-relate pancreatic remodeling

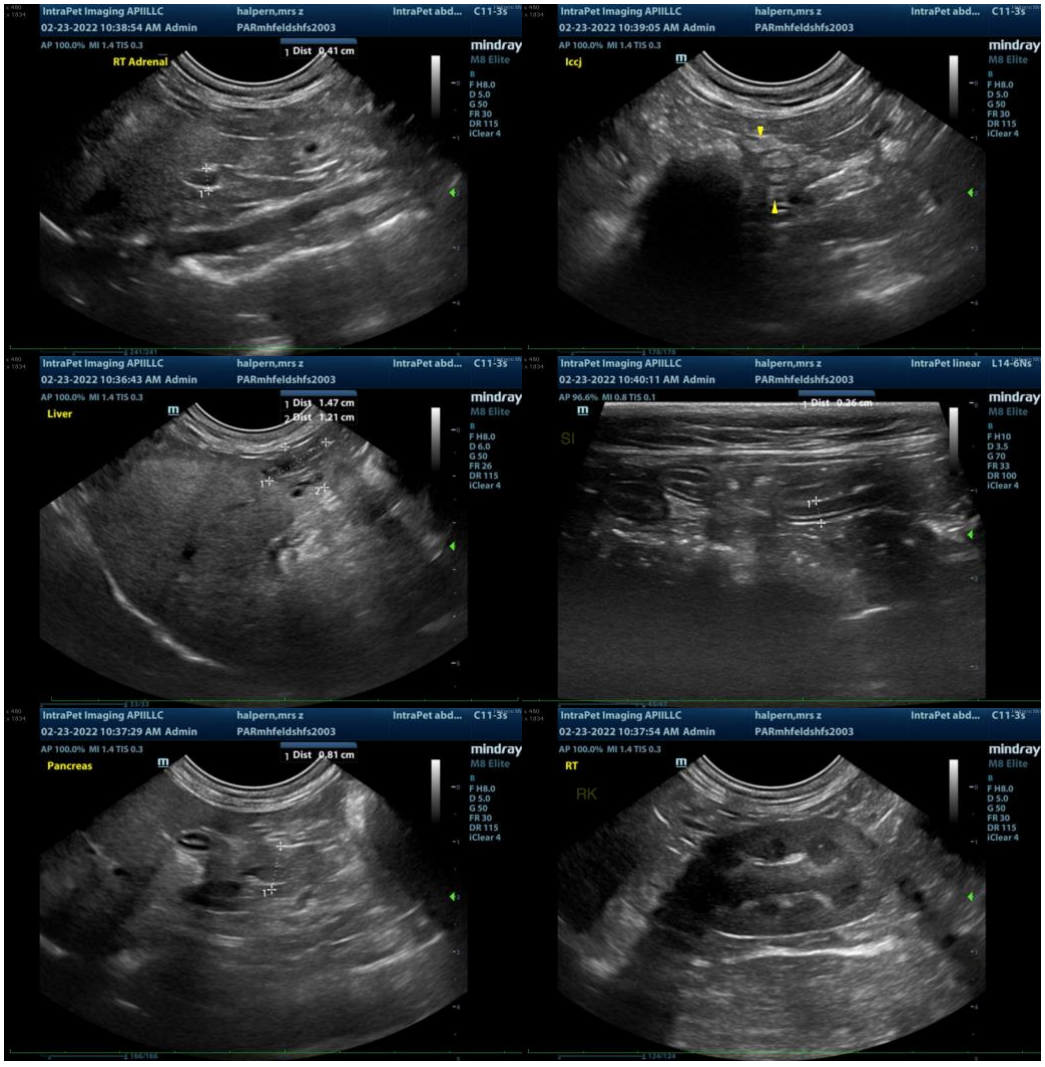
- Minor non-specific age-relate renal changes

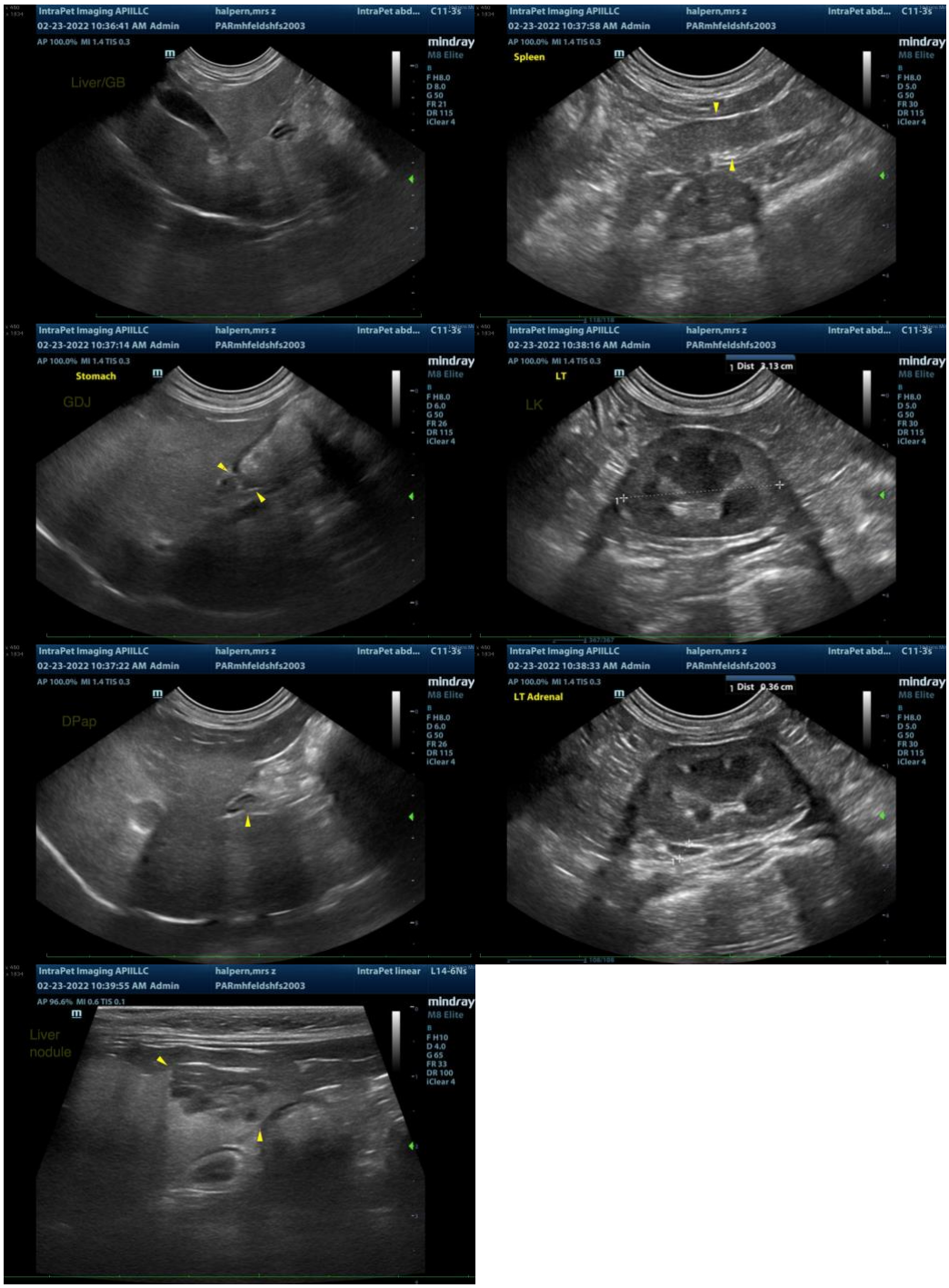
  **An obvious cause for the patient's polyphagia is not identified in this study. Considerations include microscopic progression of the inflammatory bowel disease, primary neurologic disease (i.e., brain tumor), other.

  **An obvious cause for the hypertension is also not identified in this study. Considerations include idiopathic/primary hypertension, secondary to primary neurologic disease, stress, cardiovascular disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess cardiopulmonary status. Depending on the results, an echocardiogram may be warranted.
- Given the hypertension, a UPC is also recommended to further evaluate for a protein-losing nephropathy.
- A thorough neurologic examination is recommended.
- Given the ravenous appetite, consider a GI panel including serum cobalamin, folate, TLI and PLI to assess for maldigestion/malabsorption.





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