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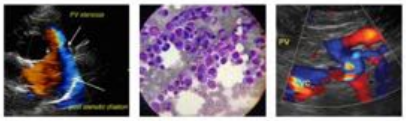


SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Oliver Collard

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

8 years

WEIGHT

11.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew LVT

HOSPITAL NAME

SVS Imaging Michigan

REFERRING VET

Dr. Thomas Watson

INVOICE

12280

DATE

2.24.23

PRESENTING CLINICAL SIGNS

History: Presented to our office for weight loss and lethargy, jaundice.
Abnormal PE/Chem/CBC/UA Results: We did some bloodwork on 2/15/23 and 2/20/23. BUN 12. Albumen 2.1. ALT 132. ALP 760. tBili 6.7.

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 mostly anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.31 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.

The right kidney is normal in size (4.80 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.

Adrenal Glands

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

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

Spleen

The spleen is normal in size (0.70 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 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.

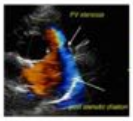
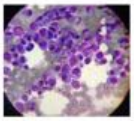
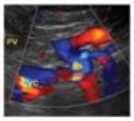
The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are visible but not overtly dilated. The walls are slightly thickened. The common bile duct measures 0.33 cm in diameter). There is no obvious evidence intraluminal obstruction.

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. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The left limb is visible with normal curvilinear peripheral contours. The parenchyma is mildly

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hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen
A moderate amount of anechoic free fluid is present. The mesentery throughout the abdomen is hyperechoic and irregular, bordering on nodular in appearance.

Lymph nodes
(See "Other" category).

Other
A 0.47 cm hypoechoic nodule is observed in the right mid- to caudal abdomen.

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 cystic and common bile duct wall thickening is consistent with cholangitis, without obvious evidence of an intraluminal obstruction.
- The mesenteric changes could be consistent with reactive mesentery. However, carcinomatosis cannot be completely excluded.
- The significance of the hypoechoic nodule in the right mid- to caudal abdomen is unclear. It may represent a prominent lymph node, an inflammatory focus, granuloma, or emerging tumor within the mesentery, other.
- The ascites may be secondary to increased hydrostatic pressure (i.e., due to portal hypertension), low oncotic pressure (less likely), or increased vascular permeability (i.e., vasculitis).

Secondary Findings

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- Mild bilateral renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If the abdominal fluid diagnostics is inconclusive, consider a fine-needle aspirate or biopsies (i.e., laparoscopic or surgical) of the liver, if clotting status is appropriate. Twenty-five gauge-needles should be used.
- Thoracic radiographs are also recommended to assess for occult neoplasia in the chest.
- While awaiting test results empirical treatment for bacterial cholangiohepatitis/cholangitis, hepatic lipidosis is recommended, including broad-spectrum antibiotics, hepatic antioxidants and symptomatic measures. Nutritional support is also strongly recommended to help

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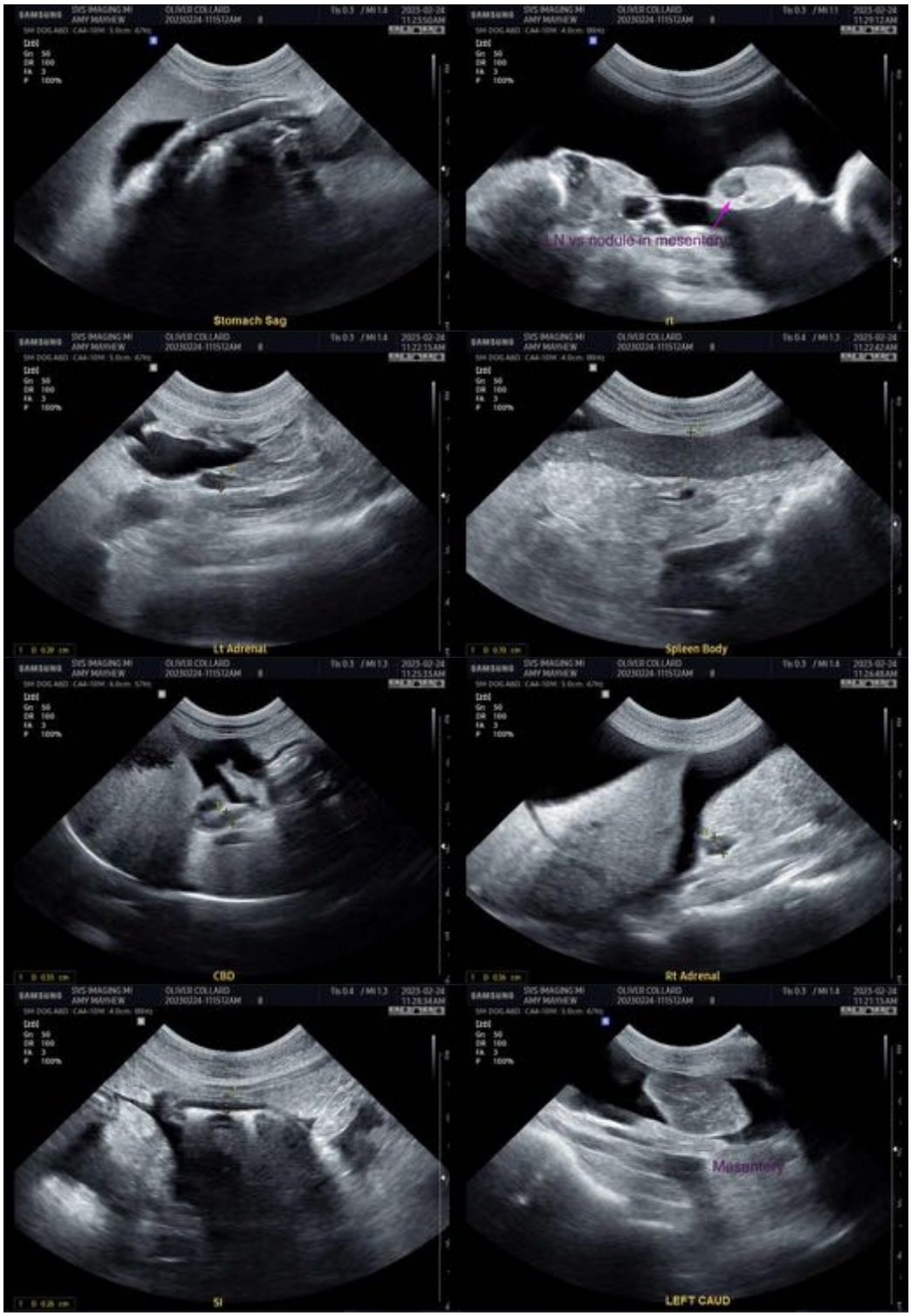
prevent/treat hepatic lipidosis. A temporary feeding tube (i.e., esophagostomy) may be warranted.

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



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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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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