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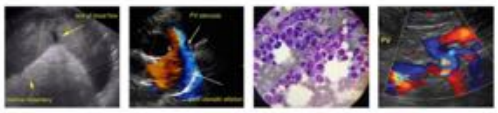

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Luna Griffin

SPECIES

Feline

BREED

Terrier Mix

SEX

Female Spayed

AGE

13 years

WEIGHT

27 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Norfolk County VS

REFERRING VET

Christina Poor, BVetMed

INVOICE

12386

DATE

3.10.23

PRESENTING CLINICAL SIGNS

History: Previous CBC: Hct 30% - Today 50%. ALT 145, Lipase 785. Radiography results normal. No significant clinical signs.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is 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 1-2 cm, are normal.

The left kidney is normal in size (5.64 cm in length) with a normal shape and smooth peripheral contours. The cortex is mildly thickened and heterogenous with numerous cortical cysts, some of which are septated. There is poor corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia or hydroureter.

The right kidney is normal in size (5.01 cm in length) with a normal shape and smooth peripheral contours. The cortex is mildly thickened and heterogenous with numerous cortical cysts, some of which are septated. There is poor corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.74 cm at cranial pole) (0.73 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.74 cm at cranial pole) (0.71 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.72 cm in width at the level of the hilus) with a normal capsular contour. A light micronodular pattern is observed throughout the organ. A few ill-defined myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely heterogenous in appearance. No distinct focal lesions are observed. Intrahepatic biliary stones are present. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is distended. The wall is normal in thickness. A large amount of aggregated hyperechoic suspended sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

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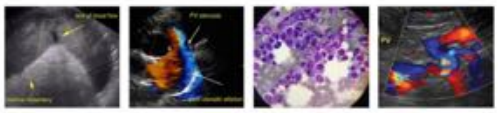

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Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gall bladder changes are consistent with a developing mucocele.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. Intrahepatic biliary stones – incidental.

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral degenerative renal changes with dystrophic mineralization and cortical cysts
- Mild bilateral adrenomegaly
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

*An obvious cause for the patient's anemia is not identified in this study. Considerations include chronic disease, blood loss, homolysis, bone marrow disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.
- Three-view thoracic radiographs are recommended to assess for occult disease in the chest.
- A T4/free T4 by equilibrium dialysis is recommended (if not already performed) as hypothyroidism can result in mild anemia.
- Serial monitoring of the patient's hematocrit is recommended to evaluate for recurrence of anemia. If anemia recurs, a reticulocyte count is recommended to assess for regeneration.

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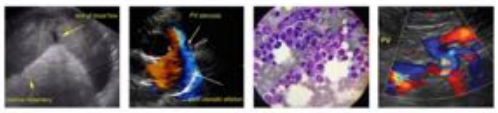

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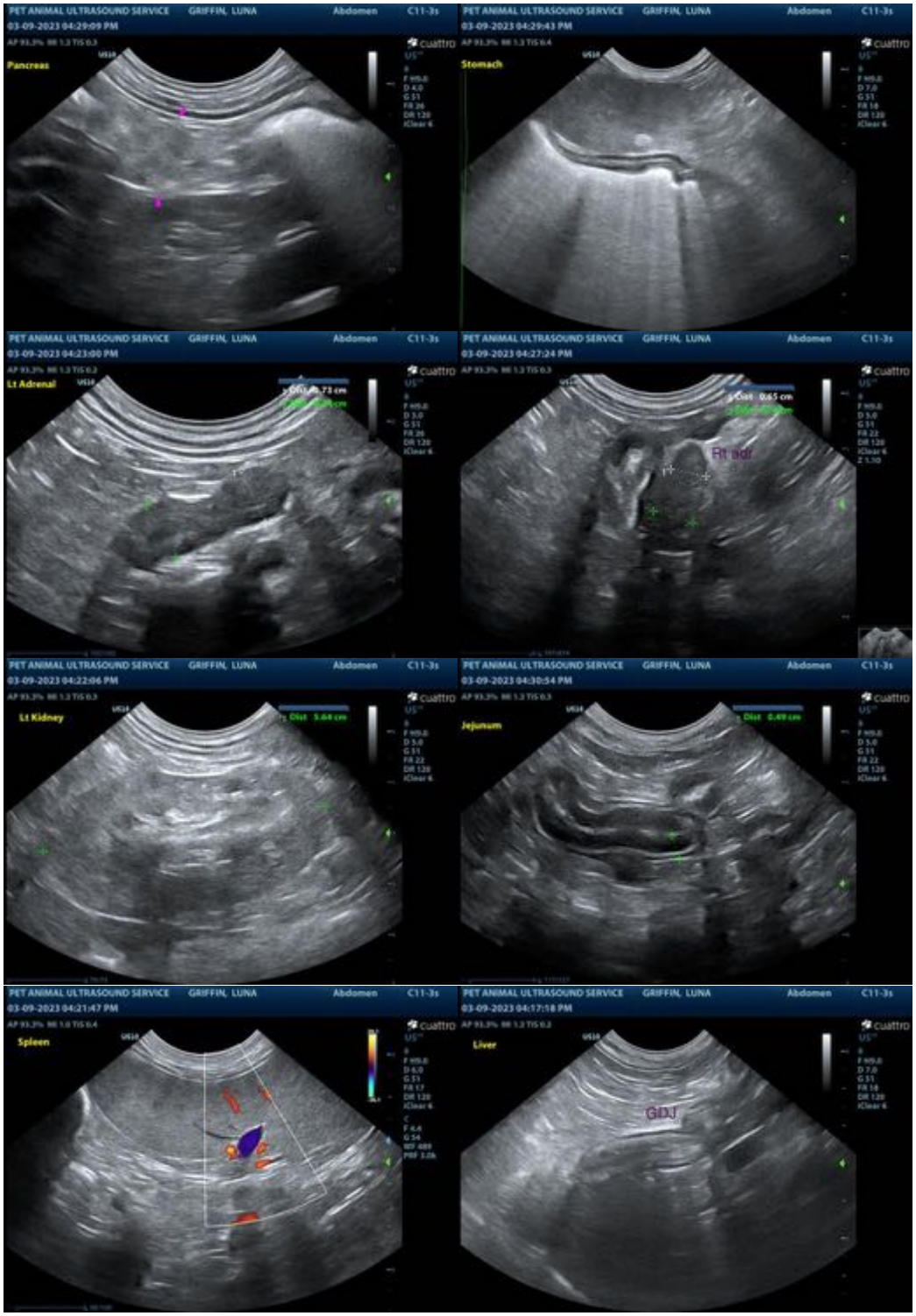

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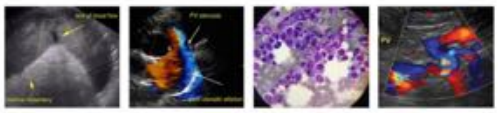

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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