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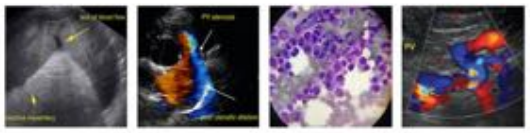


SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Lily Abamonte

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2011

WEIGHT

7.3 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebekah Jakum, CVT, ARDMS/RVT

HOSPITAL NAME

Blue Ridge VC

REFERRING VET

Filchner

INVOICE

12371

DATE

3.9.23

PRESENTING CLINICAL SIGNS

History: Elevated liver values, lethargy

Lab-work: ALT 639. AST 319. ALP 183. tBili 3.5. Cat received Batril. Liver values same. Cat feels bad but weight is holding. Mild eosinophilia. T4 2.1

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 1-2 cm, are normal.

The left kidney is normal in size (3.78 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (3.73 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 in size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.38 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent in size (1.09 cm in width at the level of the hilus) with normal curvilinear peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

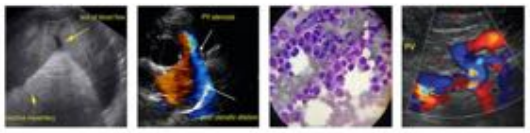
Liver

The liver is subjectively enlarged with swollen/irregular peripheral contours. The parenchyma is hypoechoic relative to the spleen and diffusely mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder is minimally to mildly distended. The wall is thickened (up to 0.17 cm) and hyperechoic. Luminal contents are mostly anechoic. The cystic and common bile ducts visible/tortuous. The walls are thickened (up to 0.21 cm) and can be followed to the duodenal papilla. There is no obvious evidence of an intraluminal obstruction. The duodenal papilla is normal in size (0.43 cm in width).

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



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intestinal wall is normal to mildly thickened (up to 0.29 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely hypoechoic 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 obvious evidence of free fluid. The left medial iliac lymph node is visible (1.01 cm in length). The node is normal in shape and echogenicity. A 0.60 cm gastric lymph node is also seen. A few prominent mesenteric lymph nodes are also seen (the largest measuring 1.10 cm in length). The mesentery surrounding all nodes is slightly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Nonspecific diffuse hepatopathy. Differentials include inflammatory disease (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis), infiltrative neoplasia (i.e., lymphoma), emerging hepatic lipidosis, other hepatopathy.
- The gall bladder and cystic/common bile duct wall changes are most consistent with cholecystitis and cholangitis, respectively.
- The pancreatic changes are suggestive of chronic pancreatitis with age-related remodeling.
- Bowel pattern suggestive of inflammatory bowel disease. However, correlation with the patient's clinical history is recommended.

Secondary Findings

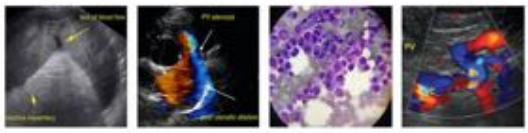
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

  *Given the sonographic changes, "triaditis" is a consideration in the patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fine-needle aspirate of the liver should be considered (if clotting status is appropriate). A 25-gauge needle should be used. If the cytology results are inconclusive, biopsies may be necessary to get a definitive diagnosis. If biopsies are pursued, aerobic and anaerobic bile cultures and should be obtained, as well as GI biopsies. Other considerations include the following:

  1. Malabsorption panel, including serum cobalamin and folate, TLI and PLI
  2. Toxoplasmosis testing (IgM, IgG)



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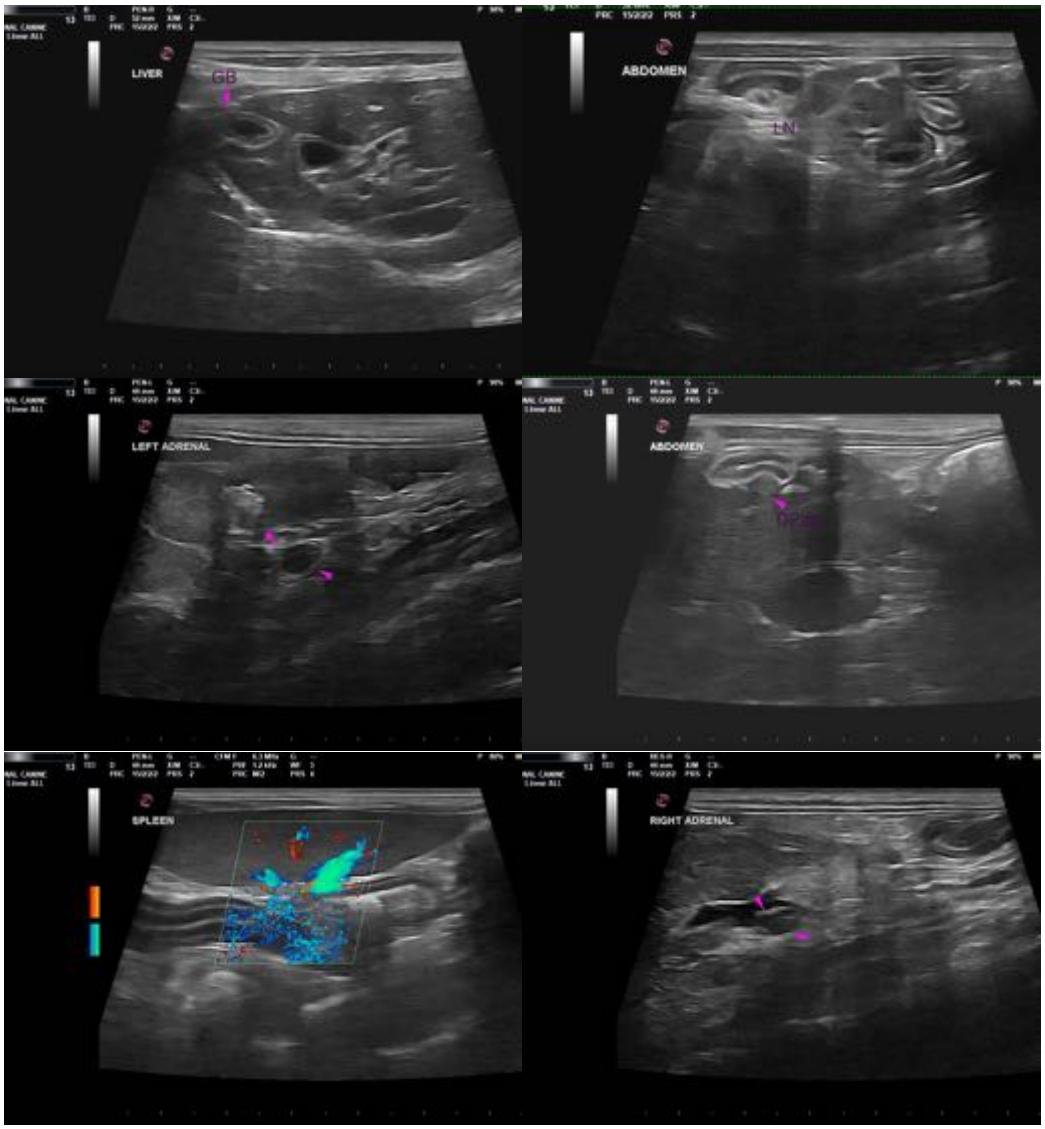
3. Thoracic radiographs to assess cardiopulmonary status
4. Nutritional support (i.e., via temporary feeding tube)
5. Aspiration of the black-pigmented subcutaneous mass



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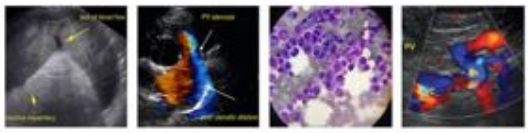

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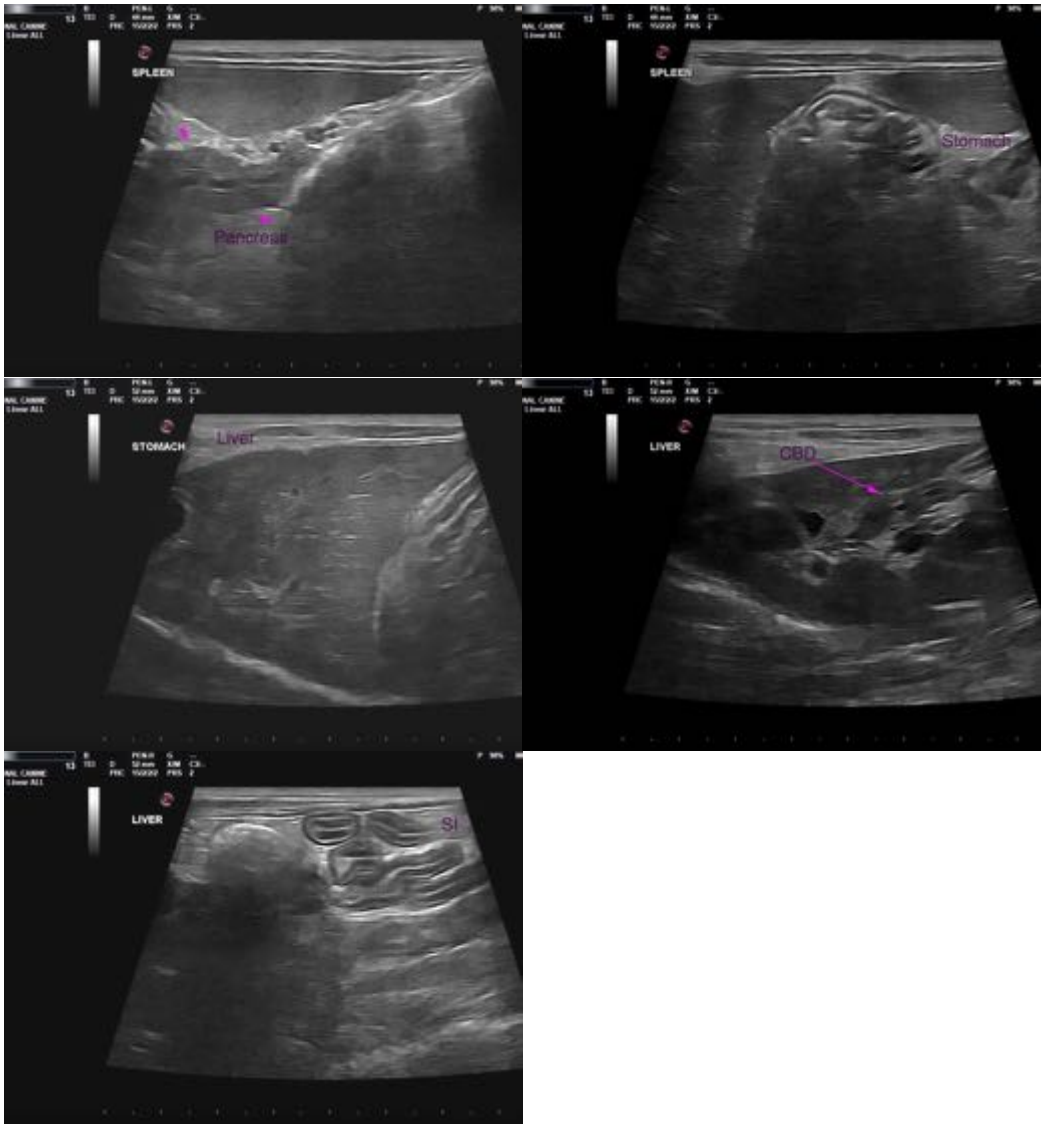

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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