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Clinical Sonography & Telecytology
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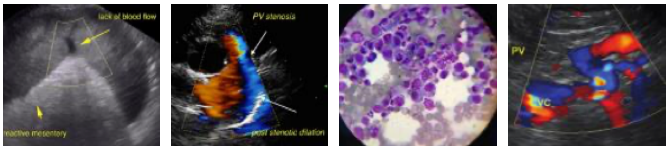


PATIENT
Rory Hutchins

SPECIES
Feline

BREED
Domestic shorthair

SEX
Male, neutered

AGE
2 Yrs.

WEIGHT
7.8 lbs.

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

IMAGING PERFORMED BY
Dr. Reyes

HOSPITAL NAME
Mobile Vet Ultrasound

REFERRING VET
Dr. Fine

INVOICE
13339

DATE
5/10/22

PRESENTING CLINICAL SIGNS

History: Pet presented beginning of march for lethargy and jaundice. Was initially treated with Doxycycline and SQ fluids, but returned next day for IV fluids. Pet has been on Denamarin, Convenia twice (03/25 and 04/13) since responded well. Pet also received a Praziquantel injection on 03/15 for possible liver fluke. Metronidazole (7 days) and Prednisolone was also given. owner stated that pet is feeling better, jaundice is improving but liver values remain elevated.
Abnormal PE/Chem/CBC/UA Results: 03/08 03/15 04/12. 05/06 ALT: 760 ALT: 920 ALT: 1120. ALT: 890 ALKP: 145 ALKP: 164 ALKP: 274 ALKP: 420 CBC: NSF Glob: 5.4 WBC: 21.4. Glob: 5.8 UA: trace of cocci

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. The region of the trigone is normal.

The left kidney is subjectively normal size with a normal shape and architecture with 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. Renal vasculature is normal.

The right kidney is normal size (4.09 cm in length); normal shape and architecture with 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.

Adrenal Glands

The left adrenal gland is normal in size (0.33 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

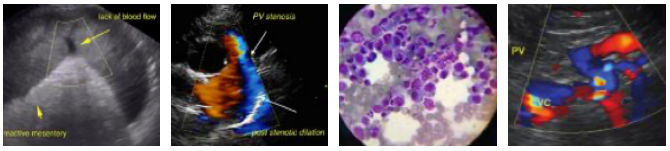
The right adrenal gland is normal in size (0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.64 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 diffusely mottled in appearance with a subtle increase in portal markings. Hepatic vasculature is of normal volume with no evidence of congestion. The portal vein; caudal vena cava ratio is approximately 1:1. The gall bladder lumen is mildly distended. The wall is diffusely thickened (up to 0.27 cm) and hyperechoic. Luminal contents are mostly anechoic. The cystic and common bile ducts are visible but not overtly dilated (0.23 cm in diameter). The wall is diffusely thickened. The common bile duct can be followed to the level of the duodenal papilla, which is also normal in size (0.47 cm in diameter). There is no obvious evidence of an intraluminal common bile duct obstruction.



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Gastrointestinal

The gastric lumen is mildly to moderately 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 not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The left limb of the pancreas is visible/prominent with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gallbladder and cystic/common bile duct changes are most consistent with cholecystitis/cholangitis respectively. It should be noted, however, that the gallbladder wall thickening may be somewhat artifactual due to lack of full repletion.
- Hepatic changes are non-specific and could be consistent with inflammatory/infectious disease, hepatic lipidosis, infiltrative neoplasia, or other hepatopathy.

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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If an aggressive approach is desired, consider hepatic tissue sampling (i.e., fine needle aspirate or biopsy). Surgical biopsies are preferred in that they are more likely to be representative of global organ pathology. If pursued, aerobic and anaerobic bile cultures are also recommended.
- If medical management is to be pursued at this time, empirical treatment for bacterial cholangiohepatitis (i.e., Amoxicillin Clavulanic acid +/- Metronidazole, Denamarin +/- Ursodiol) is recommended along with supportive care. If no improvement in the liver values is seen within 5-7 days of initiating therapy, hepatic tissue sampling should be revisited.
- Also consider Toxoplasmosis testing (i.e., IgM, IgG).
- Other diagnostic considerations include clotting times (PT/PTT) and thoracic radiographs, particularly if the patient is to undergo anesthesia/hepatic tissue sampling.
- Given the possible presence of bacteria in the urine, consider a urine culture and sensitivity, preferably on a pre-antibiotic sample.

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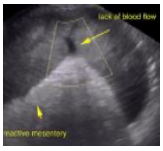
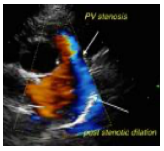
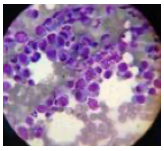
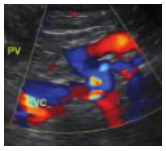

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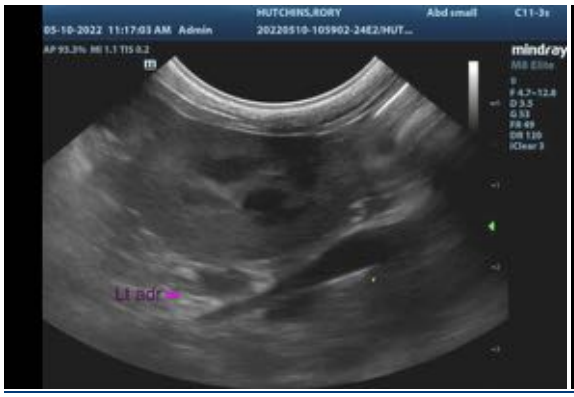
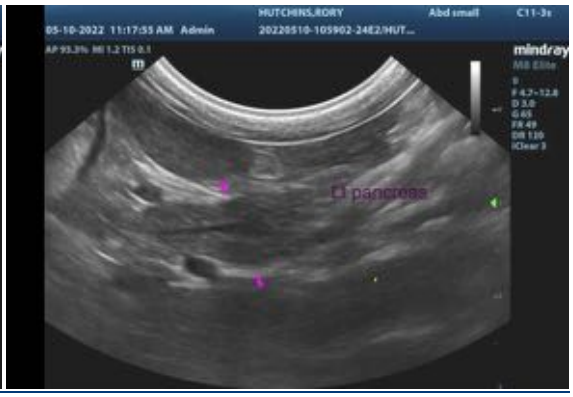
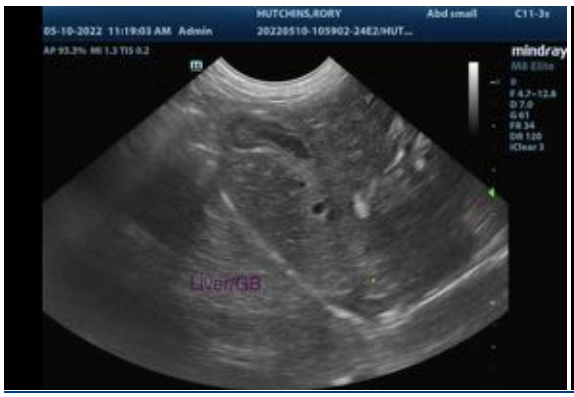
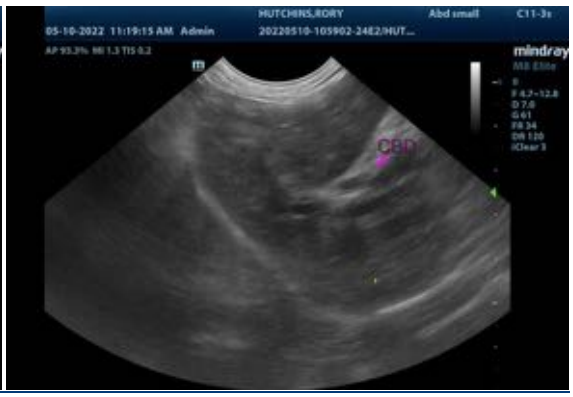
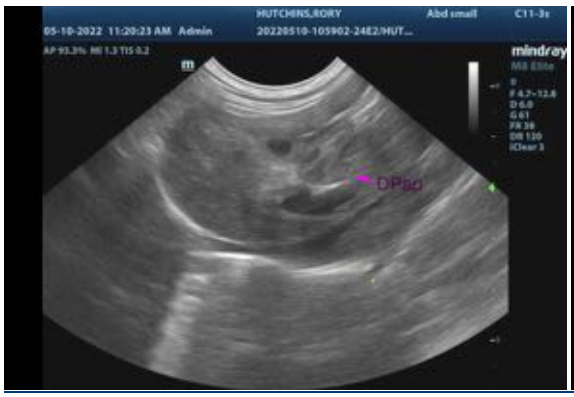
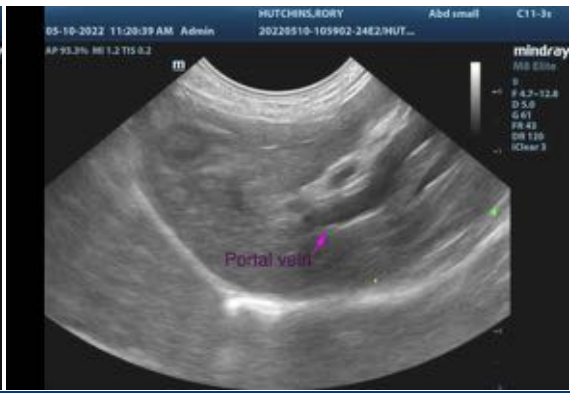


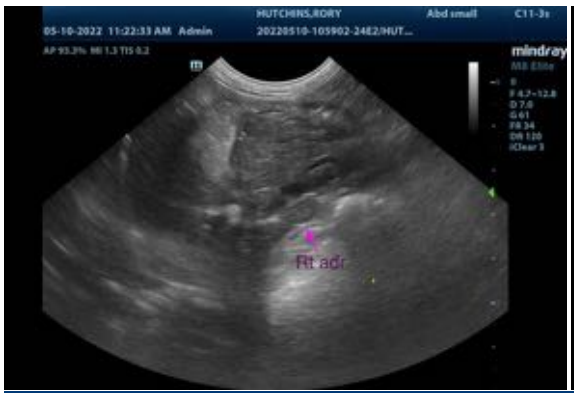


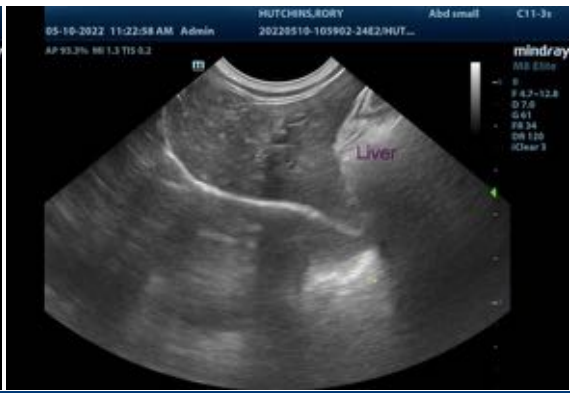




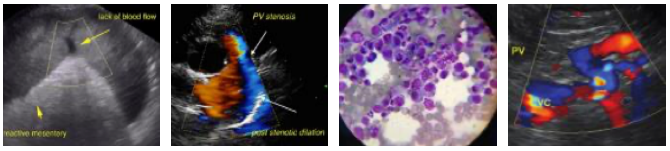








The information and recommendations provided are based on the images presented by the referring



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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.

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

Andrea.nicastro@sonopath.com