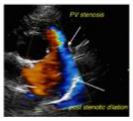
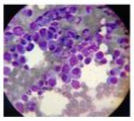
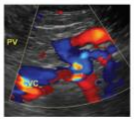




PATIENT

Callie Pearce

SPECIES

Feline

BREED

DSJ

SEX

Spayed Female

AGE

18 years

WEIGHT

-

INTERPRETED BY

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

IMAGING PERFORMED BY

Kim Liedberg

HOSPITAL NAME

SVS Imaging WI

REFERRING VET

WVRC - Dr. Sevde

INVOICE

11025

DATE

6/3/22

PRESENTING CLINICAL SIGNS

History: Patient History (required): 3/4/22 - Presented to rDVM for bloated abdomen - PE - heart murmur, soft non painful abdomen but does feel somewhat distended - POCUS - liver mottled; between liver and stomach there is an irregular bright echogenicity that is not shadowing with possible very scant free fluid - Recommended recheck in 1 month 4/1/22 - Presented to rDVM for recheck ultrasound, increased vomiting, sneezing/coughing - Ultrasound - liver still mottled in appearance, cannot find area between liver and stomach that was noted last time, no free fluid - Recommended starting miralax and chlorpheniramine daily 5/27/22 - Presented to rDVM for increased vomiting and distended abdomen. - POCUS - no free fluid; bladder mid-size with non-shadowing material that appears to be stemming from the bladder wall and protruding into the bladder - Recommended increasing Miralax to twice daily, Rx Clavamox 6/1/22 - Presented for recheck with rDVM - abdomen still distended and hard, vomiting - POCUS - fair amount of gas in stomach create shadowing and makes imaging hard; no free fluid, GB normal, bright coalescing nodules in the liver, irregular bright material or mass in urinary bladder (similar in size to previously noted) Callie has been hyporexic for the past few days and she vomited yesterday. The owner's daughter saw Callie urinate and noted that it was a large amount. Relevant

Exam/labs/imaging results/treatments: Distended and taught abdomen, grade 3/6 parasternal heart murmur

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 is distended. A small amount of aggregated debris is observed within the lumen. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1-2 cm, are normal. The hyperechoic shadowing within the bladder lumen is artifactual due to excessive bladder distention.

The left kidney is normal in size (3.21 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. The cortex is hyperechoic. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The right kidney is normal size (3.62 cm in length); with a slightly irregular shape. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. The cortex is hyperechoic. Trace pyelectasia is present. There is no evidence of nephroliths or hydroureter.

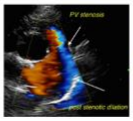
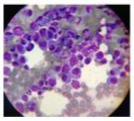
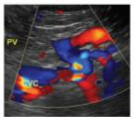
Adrenal Glands

The left adrenal gland is normal size (0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.67 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.

PATIENT

Callie Pearce

SPECIES

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WEIGHT

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Liver

The liver is subjectively normal in size with slightly irregular peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely mottled in appearance. Numerous, small cystic areas are observed throughout the organ. In addition, a 2.70 cm cyst is observed at the caudal aspect. A 1.41 cm hypoechoic nodule is also seen at the caudal aspect. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithsare observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly to moderately distended with ingesta (small, hypoechoic bodies consistent with kibble). 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.

Pancreas

The left limb is prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. The mesentery effacing the serosal surface is hyperechoic. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Polycystic liver. The hypoechoic nodule may represent a benign process (i.e., area of lymphoid hyperplasia or similar). Alternatively, an emerging tumor is possible. The diffuse hepatic parenchymal changes are nonspecific and could be consistent with age-related remodeling, infiltrative neoplasia, inflammatory disease, other hepatopathy.
- The pancreatic changes are suggestive of chronic active pancreatitis.

Secondary Findings

- The bilateral renal changes are consistent with chronic interstitial nephrosis/nephritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

PATIENT

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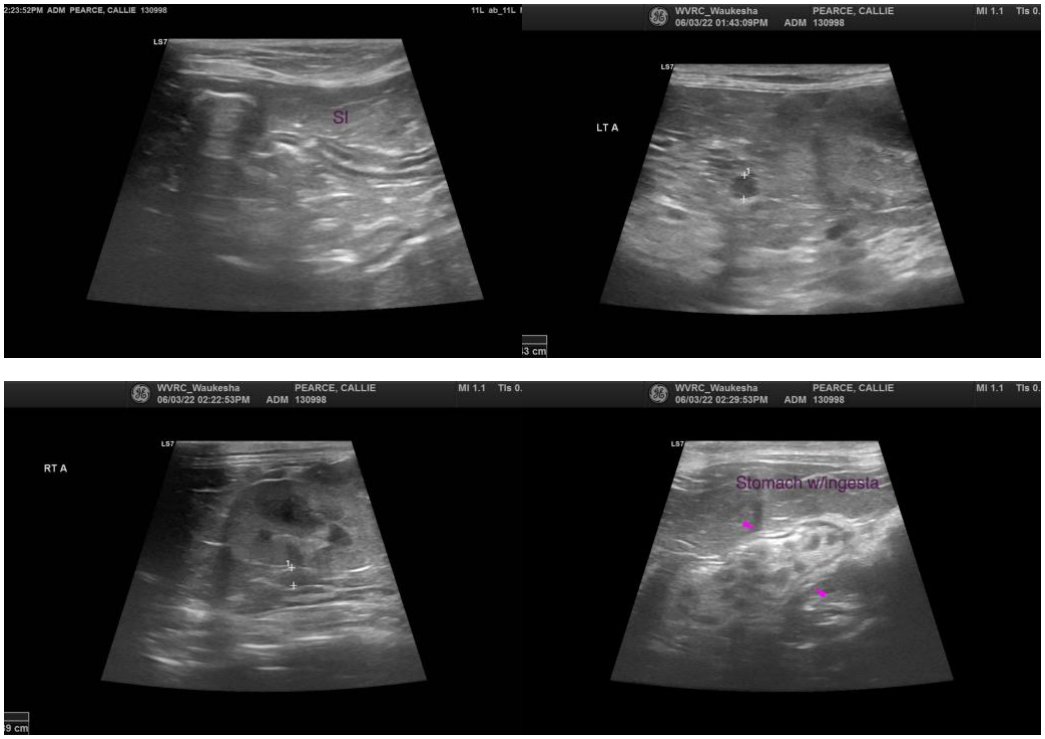
- A CBC, chemistry panel, urinalysis and T4 are recommended to assess overall metabolic function, if not already performed
- To further evaluate the GI signs, consider the following:

1 Malabsorption panel, including serum cobalamin and folate, TLI and PLI
2 Fecal evaluation for ova and Giardia
3 Thoracic radiographs to assess for occult esophageal disease
4 Heartworm testing (i.e., antigen and antibody) as this disease can cause chronic vomiting in cats.
5 Also consider a hypoallergenic diet trial if the patient will tolerate it.

- Given the hepatic changes, consider pre-and postprandial serum bile acids to assess hepatic function.
- Ultimately, gastrointestinal, hepatic, +/- pancreatic biopsy may be necessary to get a definitive diagnosis. Given the patient's age, the risk of anesthesia must be weight against the benefits of biopsies.



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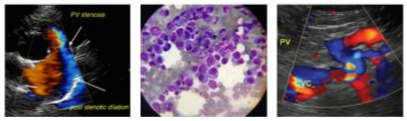

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Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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PATIENT

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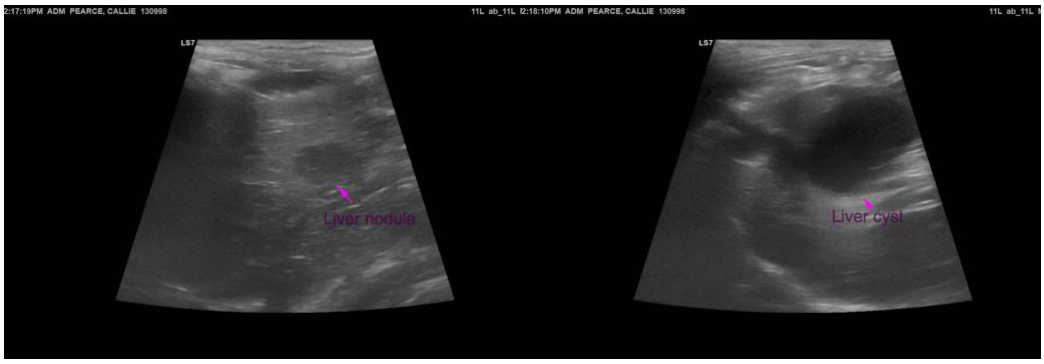

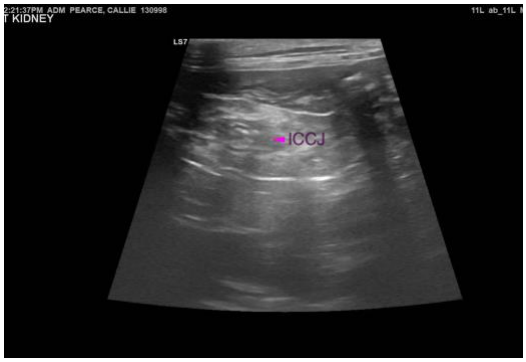

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com