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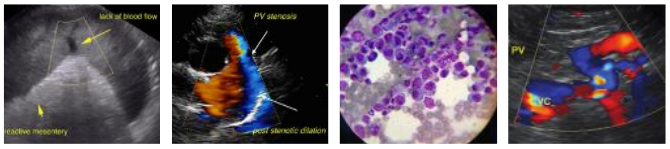


PATIENT

Dexter Berger

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 years

WEIGHT

8.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Morris Hills VC

REFERRING VET

Dr. Hirshenson

INVOICE

11033

DATE

6/6/22

PRESENTING CLINICAL SIGNS

History: Hepatomegaly on rads, severe jaundice. Current meds: Flagyl 50mg bid, Mirataz (appetite stim.)

Abnormal PE/Chem/CBC/UA Results: RBC 5.39 (6.54 L), HCT 23.6 (30.3 L), HGB 8.2 (9.8 L). WBC 20.38, NEU 15.25, MONO 1.44, PLT 137, CREA 10, BUN 128, PHOS >16.1,ALT 321, ALKP 923, GGT 14, TBIL 11.7, CHOL 370, K 3.2

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 moderately distended. A small amount of suspended, echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is small in size (2.33 cm in length); with a slightly irregular shape. The cortex is variably thickened and hyperechoic to heterogenous in appearance. A small focus of mineralization is visualized. Mild pyelectasia is present (0.23 cm in the longitudinal plane). There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is small in size (3.77 cm in length); with an irregular shape. The cortex is thickened and irregular, and mildly heterogenous in appearance. There is poor corticomedullary distinction. Hyperechoic to mineralized foci are visualized. Trace pyelectasia is present. There is no evidence of hydroureter. There is a questionable infarct at the craniomedial aspect. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (0.59 cm width) with rounded peripheral contours. Glandular echogenicity and detail are normal. Surrounding vasculature appears normal.

The right adrenal gland is normal size (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

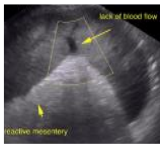
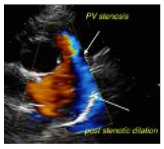
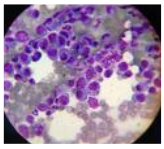
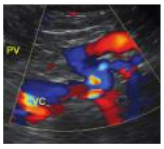
Spleen

The spleen is prominent in size with normal curvilinear peripheral contours. The parenchyma is mottled in appearance. No distinct focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is enlarged with smooth peripheral contours. The parenchyma is isoechoic relative to the spleen. On the left side, a 0.81 x 0.79 cm, ill-defined, multi-septated cystic nodule is visualized. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is mildly distended. The wall is diffusely thickened, up to 0.20 cm, and hyperechoic. A small amount of partially dependent, aggregated, echogenic debris/sludge is observed within the lumen. The common bile duct walls are thickened. The lumen is dilated (up to 0.73 cm) at the distal

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aspect. Within the duodenal lumen, at the level of the duodenal papilla, there is focal hyperechoic shadowing material.

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 segmentally gas distended. 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 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 visible but not overtly dilated (0.17 cm in diameter).

Free Abdomen

Trace free fluid is observed between the liver lobes. A 0.99 x 0.95 cm gastric lymph node is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The hepatic parenchymal changes are nonspecific and may be secondary to hepatic lipidosis, inflammatory disease (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, infiltrative neoplasia, lymphoma), other. The cystic nodule could be consistent with a biliary cystadenoma, cystadenocarcinoma, benign cystic area, other.
- The gall bladder and common bile duct wall changes are consistent with cholecystitis and cholangitis, respectively. The hyperechoic shadowing area at the level of the duodenal papilla may represent a small stone lodged within the common bile duct at this level or shadowing chyme within the duodenal lumen.
- The bilateral renal changes are consistent with chronic interstitial nephrosis/nephritis with dystrophic mineralization and pyelectasia.
- Trace ascites, likely secondary to hepatobiliary pathology

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.
- The prominent gastric lymph node is likely reactive.

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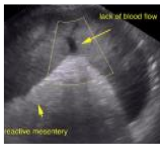
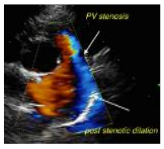
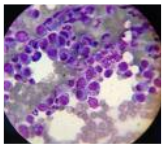
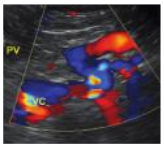

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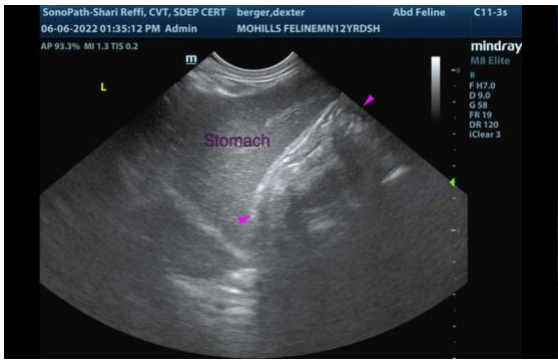
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation, with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The prominent right adrenal gland may be secondary to stress, hyperplasia, or an emerging tumor

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider fine-needle aspirates of the liver +/- spleen, if clotting status is appropriate. Twenty-five gauge-needles should be used. Cytology can be helpful in assessing for lymphoma and hepatic lipidosis but is less useful in diagnosing inflammatory hepatopathies. Therefore, if results are inconclusive, a surgical liver biopsy with aerobic and anaerobic bile cultures may be necessary to get a definitive diagnosis. If surgery is pursued, assessment of bile duct patency should be performed.
- While awaiting test results, empirical treatment for hepatic lipidosis/bacterial cholangiohepatitis is recommended, including nutritional support, broad-spectrum antibiotics, fluid therapy and symptomatic treatment.
- Thoracic radiographs are recommended to assess cardiopulmonary status.
- Also consider a GI panel including serum cobalamin and folate, TLI and PLI to evaluate for concurrent pancreatic and gastrointestinal disease.
- Serial monitoring of the patient's liver values, particularly the total bilirubin, is recommended. If total bilirubin continues to increase, an abdominal exploratory should be performed to assess bile duct patency.



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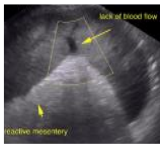
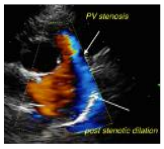
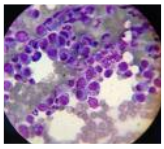
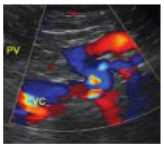

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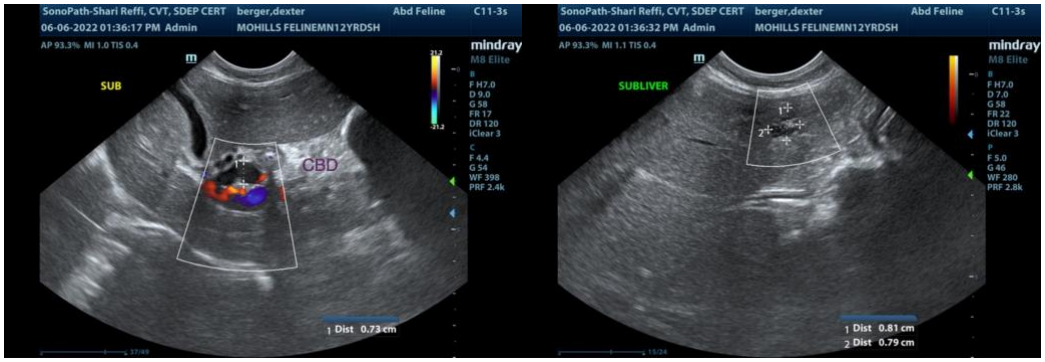

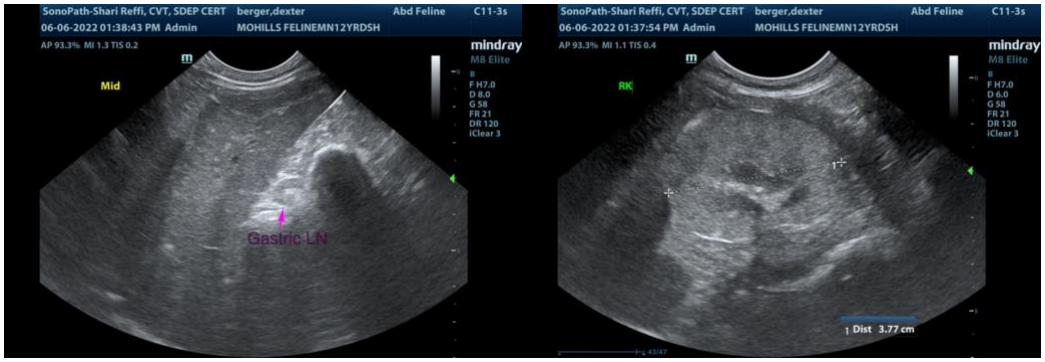

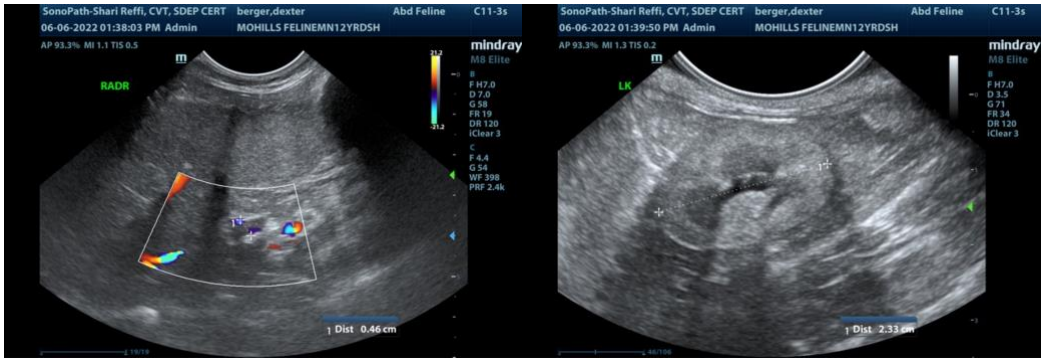

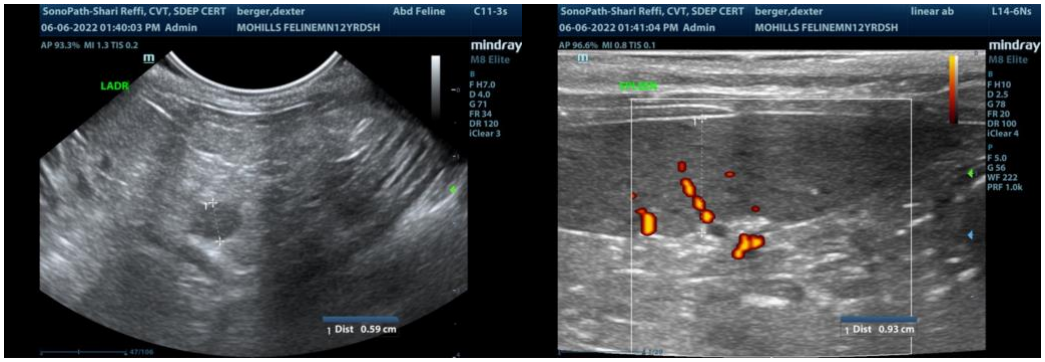

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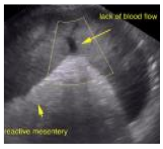
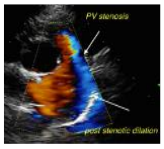
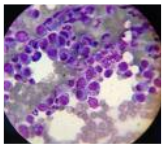
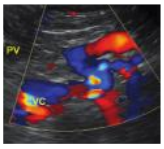

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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