



PATIENT

Gloria Brumm

SPECIES

Feline

BREED

Domestic shorthair

SEX

Female, spayed

AGE

2.5 Yrs.

WEIGHT

6.08 kg.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Dr. Patton

INVOICE

13878

DATE

8/24/22

PRESENTING CLINICAL SIGNS

History: Gloria was presented to MVS for IBD. starting February owners noticed her losing weight and found out it was IBS, they started her on prednisolone, noticed she gained weight then decided to drop the medication to 7.5mg and then the weight loss started again. Owners noticed her being lethargic, weak, wobbly and she has not groomed herself in the last week. She had no interest in food since yesterday, she urinated and defecated yesterday but owners were unknown if she has today. She is on Prednisolone 5mg SID. **MAJOR PROBLEM LIST** Cholangiohepatopathy (pcDVM) Elevated ALT, AST, ALP, TBili Glucosuria; ketonuria Hx moderate diffuse infiltrative SI disease - IBD (pcDVM) Hx diffuse infiltrative hepatic disease - DDx hepatic lipidosis vs hepatitis vs infiltrative neoplasia Ataxic Lethargy Inappetence

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 mostly 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 size (4.13 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly hyperechoic. 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 hydronephrosis.

The right kidney is small in size (2.73 cm in length) with a slightly irregular shape. The cortex is hyperechoic and variably thickened and there is mild to moderate loss of corticomedullary distinction. There is no evidence of nephroliths. Mild to moderate pyelectasia is present (0.25 cm in the transverse plane). The right ureter is dilated (up to 0.24 cm up until the mid to caudal abdomen after which it tapers and was no longer visible).

Adrenal Glands

The left adrenal gland is normal in size (0.36 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.32 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.59 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 enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.



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Gastrointestinal

The gastric lumen is 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 with retention of the normal with a normal layering pattern. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portion of the left limb, the pancreas is prominent to enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.14 cm in diameter).

Free Abdomen

A small to moderate amount of anechoic free fluid is present. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes are most consistent with mild to moderate acute or chronic active pancreatitis.
- Hepatic changes are non-specific and could be consistent with diabetic hepatopathy, hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Small intestinal wall changes are suggestive of inflammatory bowel disease. However, some bowel pathology may be masked by chronic corticosteroid use.
- The ascites may be secondary to increased hydrostatic pressure (i.e., fluid overload, portal hypertension), low oncotic pressure (if applicable) and/or increased vascular permeability. Correlation with the patient's clinical history is recommended.

Secondary Findings:

- The right degenerative renal changes with pyelectasia and hydroureter. The hydroureter is likely secondary to a stricture. However, a small distal ureterolith or tumor cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If the patient is hyperglycemic, supportive care for diabetic ketoacidosis is recommended including regular insulin, fluid therapy, and stabilization of electrolyte derangements. Empirical treatment for pancreatitis (i.e., gastric protectants, anti-emetics, pain medication +/- fresh frozen plasma) is also recommended.
- Regarding the hepatic changes, consider hepatic tissue sampling (i.e., fine needle aspirate or surgical biopsy) when the patient is stable (if clotting status is appropriate). A 25-gauge needle



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should be used. Nutritional support (i.e., via temporary feeding tube) should also be considered to help prevent/treat hepatic lipidosis.

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- While awaiting test results, consider initiation of broad-spectrum antibiotic therapy (i.e., amoxicillin clavulanic acid +/- low-dose metronidazole) along with hepatic antioxidants as empirical treatment for bacterial cholangiohepatitis.

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- Given the patient's clinical state, three-view thoracic radiographs are recommended to evaluate cardiopulmonary status.
- Given the clinical history and sonographic changes, also consider a malabsorption panel including serum cobalamin, folate, TLI and PLI.

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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)
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