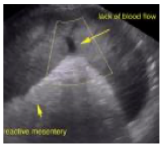
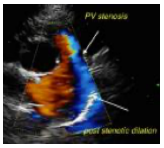
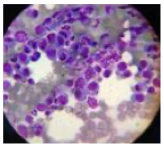
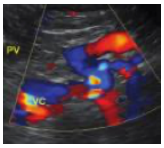





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Kip Solocinski

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
13 years

WEIGHT
8.9 lbs

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

IMAGING PERFORMED BY
Dr. Sheldon

HOSPITAL NAME
Advanced PC Oakland

REFERRING VET
Dr. Sheldon

INVOICE
11579

DATE
9.1.22

PRESENTING CLINICAL SIGNS

History: History of urinating outside of box, diarrhea outside of box started a month ago bloodwork and urine were normal other than elevated T4. Started methimazole. Last week started vomiting, and diarrhea has gotten worse these past few days. Lethargic and decreased appetite. Just started to scratch at face and irritate skin, new issue.

Abnormal PE/Chem/CBC/UA Results: Bloodwork was normal today, prior to methimazole therapy his T4 was 5.7. UA within normal limits

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is 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 1 cm, are normal.

The **left kidney** is normal size (3.99 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. The cortex is hyperechoic. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (3.92 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. The cortex is hyperechoic. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (0.87 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. A 1.47 x 1.13 cm irregular, multiseptated cystic nodule is observed deep on the left side. The remaining parenchyma is homogenous. 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** 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 visible/tortuous, but not overtly dilated.

Gastrointestinal

The **stomach and intestine** are free of stasis and exhibit normal peristaltic activity. 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 segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The **pancreas** is diffusely visible/prominent with minimal deviation from the normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and subtly mottled in appearance. The pancreatic duct is visible but not overtly dilated (0.21 cm in diameter).

Free Abdomen

There is no evidence of free fluid. A few prominent mesenteric **lymph nodes** are visualized, the largest measuring 1.66 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern consistent with inflammatory bowel disease with some potential for emerging lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The cystic hepatic lesion is most consistent with a biliary cystadenoma with a lower possibility of biliary cystadenocarcinoma.

  *An obvious cause for the patient's urinations outside the box is not identified in this study. Considerations include occult urinary tract infection, underlying neurologic disease, behavioral issue, other.

  *The defecations outside the box may be secondary to urgency (due to diarrhea), neurologic disease or a behavioral issue.

  *The recent GI signs and facial pruritis may be secondary to methimazole therapy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

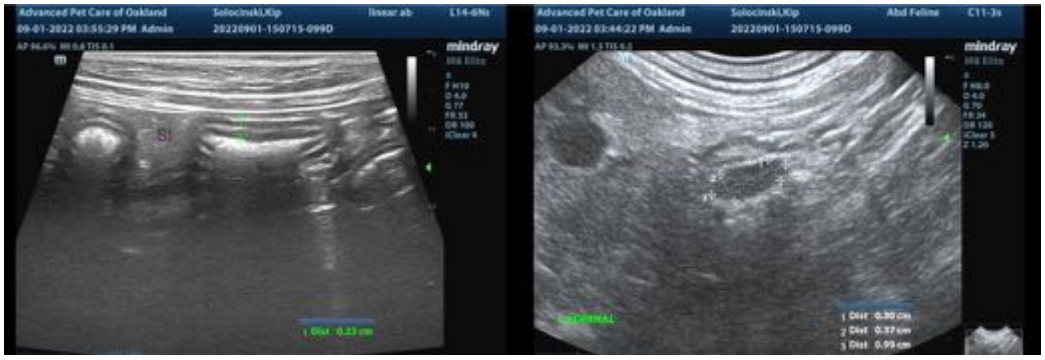
Regarding the dysuria, a urine culture and sensitivity is recommended to assess for an occult urinary tract infection.

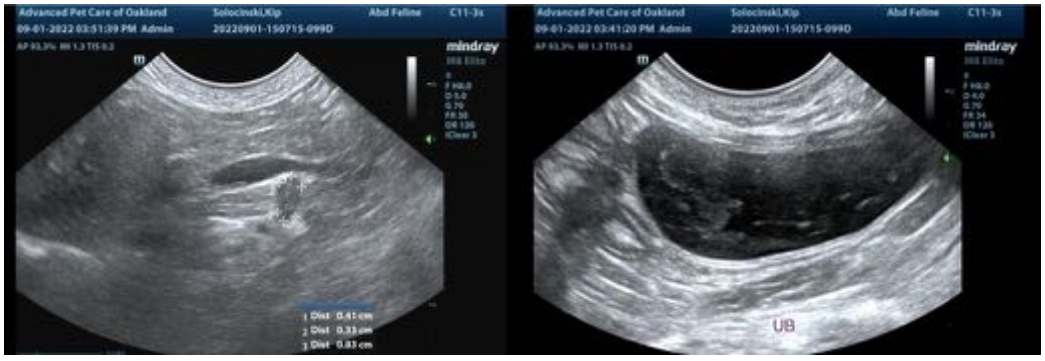
A neurologic examination is also recommended to assess for deficits that may be causing urinations/defecations outside of the litter box.

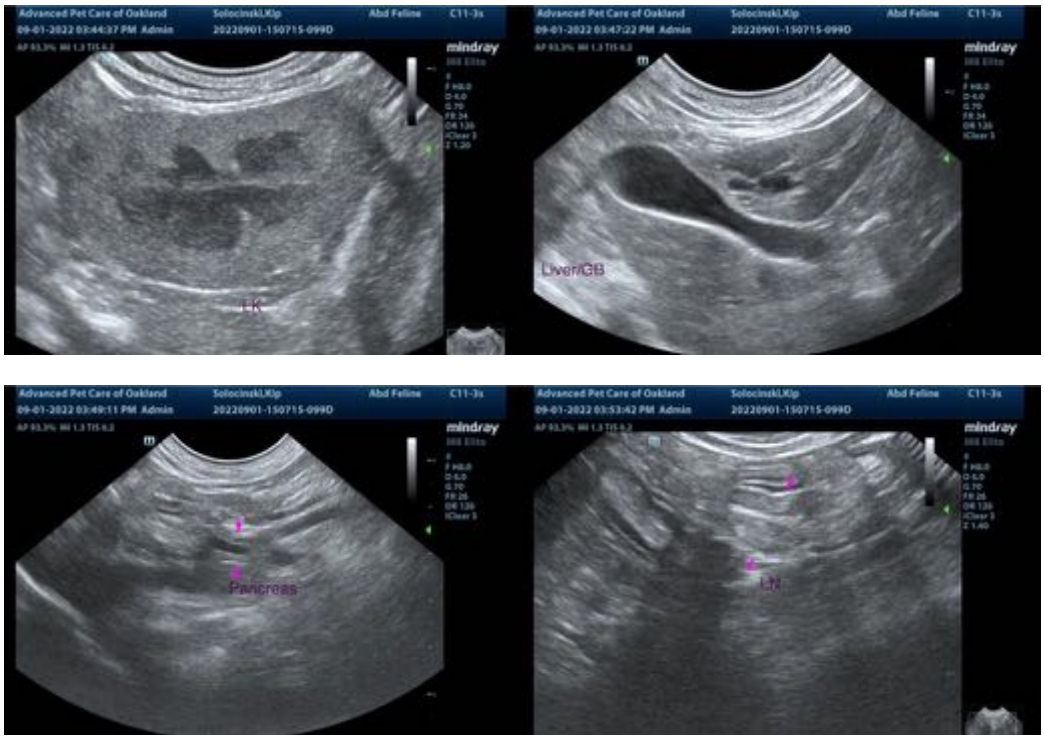
Regarding the history of diarrhea and bowel changes, consider the following:

1. A fecal evaluation for ova and Giardia
2. Prophylactic deworming with Fenbendazole
3. Malabsorption panel including serum cobalamin and folate, TLI and PLI (send to Texas A&M)
4. Hydrolyzed or novel protein diet trial
5. Supplementation with a probiotic with a high colony count (i.e., Proviable Forte)

6. Consider empirical treatment for small intestinal bacterial overgrowth with a 2–4-week course of Tylosin.
7. Fiber supplementation (i.e., Metamucil or Konsyl) can also be considered.
8. Ultimately, GI biopsies (endoscopic or surgical) may be necessary to get a definitive diagnosis.
9. Three-view thoracic should be performed prior to any anesthetic event.







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)
info@SonoPath.com