

PATIENT

Miss Kitty Curiale

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Female Spayed

AGE

13.5 years

WEIGHT

7.2 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Heidi Putnam

HOSPITAL NAME

VCA Salem AH

REFERRING VET

Dr. Tremper

DATE

8/13/21

INVOICE

11637kk

PRESENTING CLINICAL SIGNS

History: Patient presented for weight loss of 2 lb over last year and was diagnosed with hyperthyroidism, concurrent significant elevation of ALT was noted in addition to reported picky appetite and chronic intermittent soft stools- patient just started on methimazole on 8/4. hyperthyroidism with secondary hepatopathy vs primary liver disease/pancreatitis/triaditis.

Abnormal PE/Chem/CBC/UA Results: TT4- 18 ug/dL (0.8-4), ALP- 220 IU/L, ALT-1420 IU/L (10-100)

Current meds: Methimazole 2.5 mg PO BID, Denamarin recommended.

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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (3.62 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (3.86 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.70 cm length; 0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

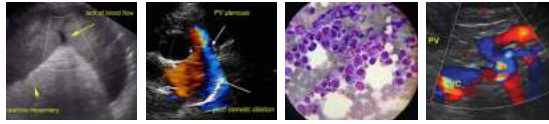
The right adrenal gland is normal size (0.73 cm length; 0.33 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.60 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 contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder is moderately distended. The wall is normal in thickness. Luminal contents are anechoic. The cystic and common bile ducts are visible/tortuous and mildly dilated (common bile duct measures up to 0.39 cm proximally and



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0.19 cm distally). The common bile duct can be followed to the level of the duodenal papilla. There is no obvious evidence of an intraluminal obstruction. The duodenal papilla is normal in thickness (0.39 cm in width).

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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 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.

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Pancreas

The left limb of the pancreas is visible/prominent with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. The pancreatic duct is borderline dilated (0.22 cm in diameter). There is no evidence of peripancreatic inflammation or effusion.

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Free Abdomen

There is no evidence of free fluid. A few prominent lymph nodes are observed adjacent to the ileocolic junction. One prominent node is also seen in the right cranial quadrant. Surrounding mesentery is hyperechoic.

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The uterine stump is visible (0.36 cm in width). No obvious pathology is observed.

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Bilateral, non-specific, age-related renal pathology.
- The pancreatic changes are suggestive of chronic, low-grade pancreatitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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Secondary Findings:

- Bilateral, non-specific, age-related renal pathology.
- Uterine stump – incidental.

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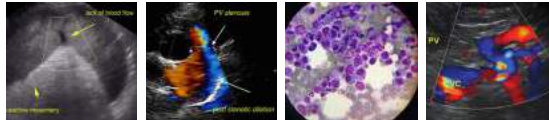
** An obvious cause for the elevated liver enzymes is not identified in the study. However, a microscopic hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, hepatic lipidosis, infiltrative neoplasia (less likely)) are possible differentials.

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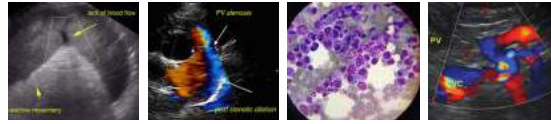
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. A fine needle aspirate of the liver is recommended if clotting status is appropriate. A 25-gauge needle should be used. If cytology results are inconclusive, consider a surgical liver biopsy with aerobic and anaerobic bile cultures. Empirical treatment for cholangiohepatitis (i.e., amoxicillin-clavulanic acid +/- metronidazole; Denamarin) should be considered while awaiting test results.
2. Three-view thoracic radiographs are recommended to assess for occult neoplasia.
3. Consider a malabsorption panel including serum cobalamin, folate, PLI and TLI to evaluate for concurrent gastrointestinal and pancreatic disease.





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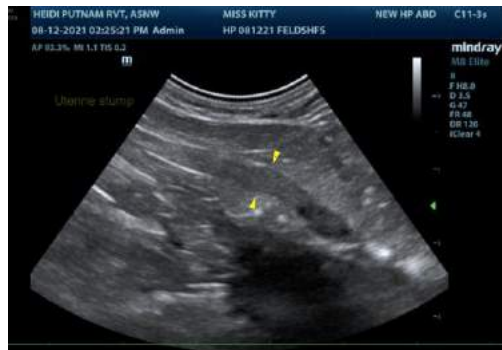
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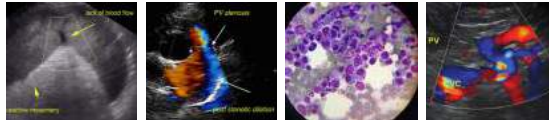
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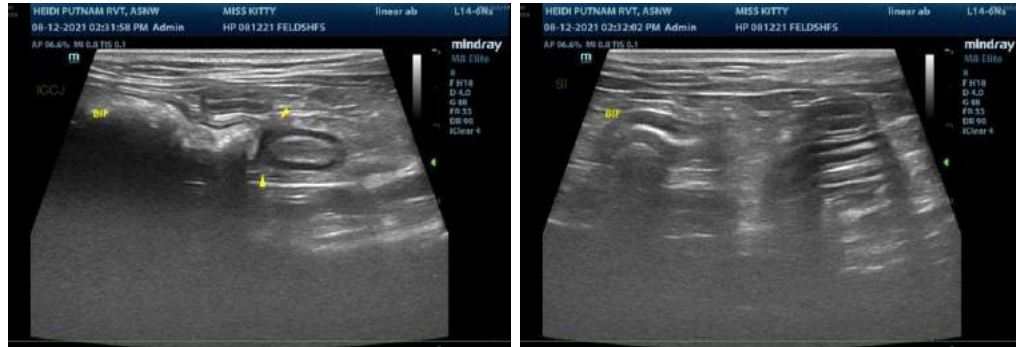
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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