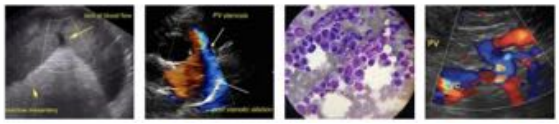

PATIENT

Petunia Pudas-Sherry

SPECIES

Feline

BREED

Domestic shorthair

SEX

Female, spayed

AGE

5/26/2009

WEIGHT

4.6

INTERPRETED BY

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

IMAGING PERFORMED BY

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

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PRESENTING CLINICAL SIGNS

Hyperthyroidism Elevated ALT, ALP Dental disease

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

*The gas within the bowel obscures portions of the abdomen and may mask some pathology.

Urinary System

The urinary bladder wall is 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 (3.36 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 hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.44 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 hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.47 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

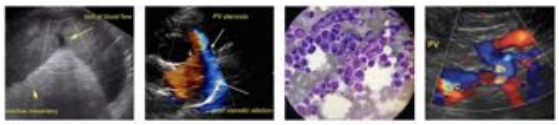
The spleen is normal in size (0.69 cm in width at the level of the hilus) with a normal capsular contour. Using a high frequency probe, the parenchyma appears subtly mottled. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is slightly mottled in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is diffusely thickened (up to 0.27 cm) and is hyperechoic. Luminal contents are anechoic. The cystic and common bile ducts are normal.

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



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not identified. The colonic wall is normal. The colonic lumen is gas distended. No obstructive disease is noted.

Pancreas

The pancreas is diffusely prominent to enlarged, particularly the left limb with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

Trace free fluid is observed between the liver lobes. The mesentery in the cranial abdomen, adjacent to the liver is mildly hyperechoic. The abdominal lymph nodes are normal/not visible.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Non-specific diffuse hepatopathy. Differentials include bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, other inflammatory disease, infiltrative neoplasia (i.e., lymphoma), other hepatopathy.
- Gallbladder wall changes could be consistent with cholecystitis and/or benign age-related hyperplasia.
- Pancreatic changes are consistent with chronic pancreatitis.
- Mild cranial peritonitis, likely secondary to hepatic and/or pancreatic pathology.

Secondary Findings:

- Minor age-related renal changes.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If an aggressive approach is desired, consider hepatic tissue sampling (i.e., fine needle aspirate or surgical biopsy). Hepatic cytology is best for diagnosing round cell neoplasia and hepatic lipidosis but may be less useful in assessing for other hepatopathies. Surgical biopsies are more likely to yield a definitive diagnosis. If pursued, aerobic and anaerobic bile cultures are also recommended.
- If hepatic tissue sampling is not pursued, consider empirical treatment for bacterial cholangiohepatitis with amoxicillin-clavulanic acid +/- metronidazole; Denamarin). If liver values improve with therapy, a 4-6 week course of treatment is recommended.

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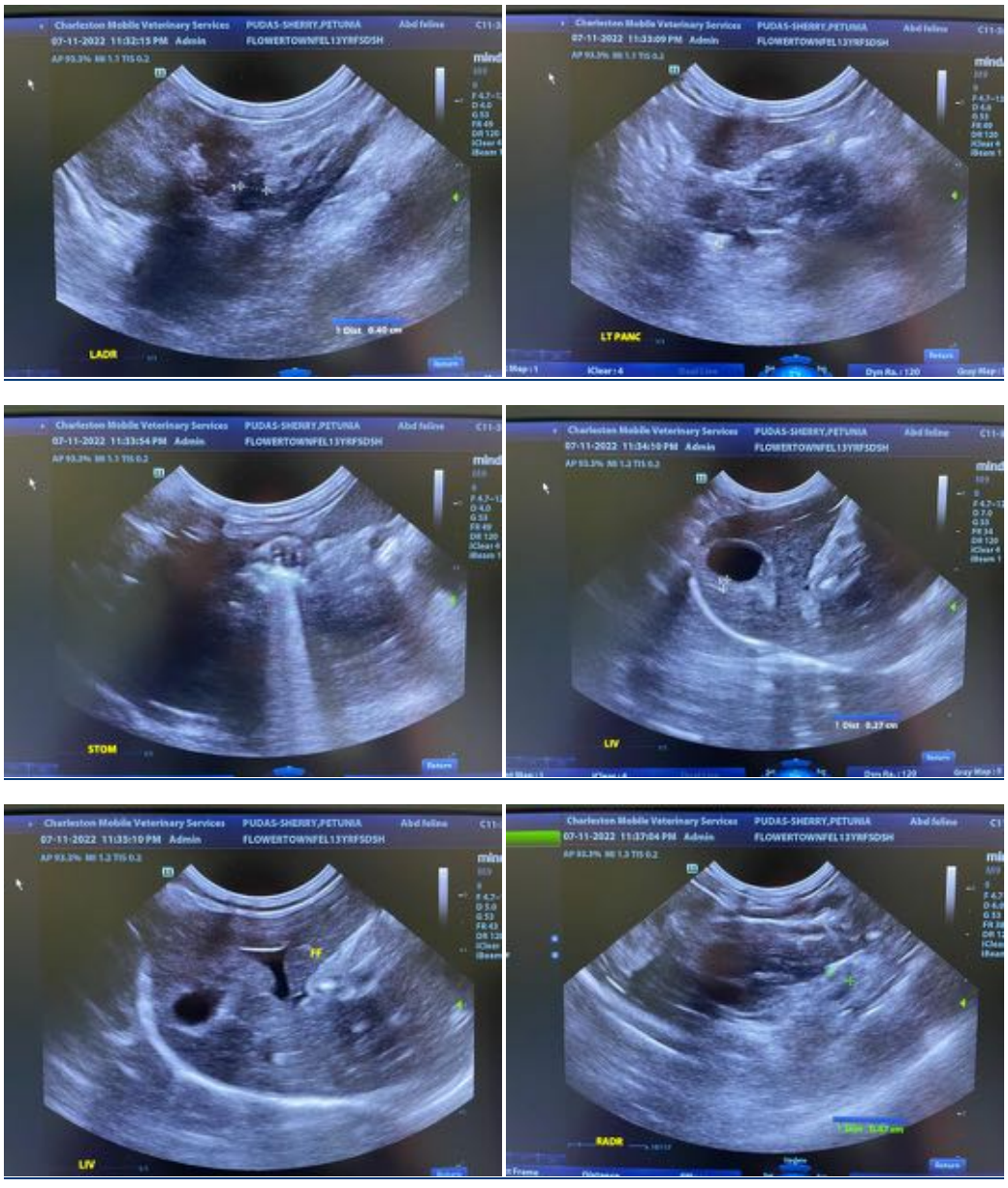
- Also consider a malabsorption panel including serum cobalamin, folate, TLI and PLI to further evaluate for concurrent pancreatic and gastrointestinal disease.
- Toxoplasmosis testing can also be considered, as this infection has been associated with pancreatitis in cats.
- Given the patient's age, thoracic radiographs (three-view) should also be considered to assess cardiopulmonary status, particularly if the patient is to undergo anesthesia at any point.



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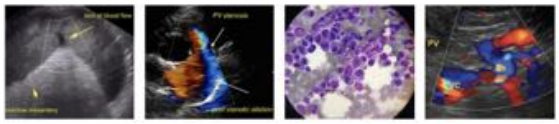

Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

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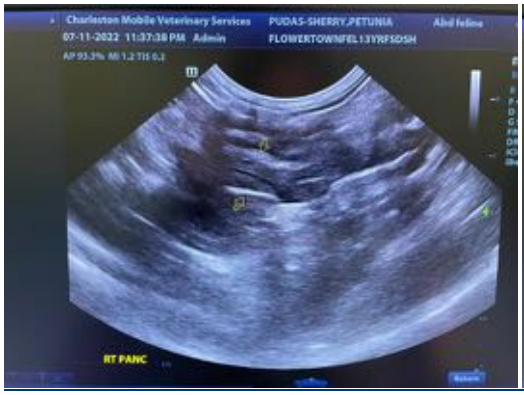

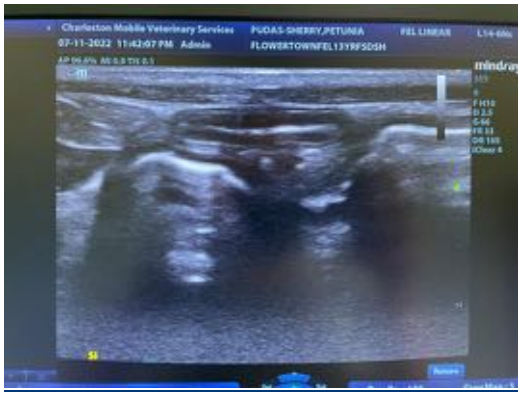

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

Andrea.Nicastro@CharlestonMobile.net