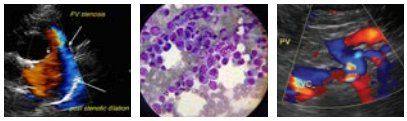
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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

DATE

1/26/23

PATIENT

Eddie Eichelberger

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11/9/11

WEIGHT

12.94 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Unger

INVOICE

44553

PRESENTING CLINICAL SIGNS

Presented on 12/22 for weight loss and nasal discharge. Pet has a history of chronic URI and as a kitten initially tested FIV positive but when rechecked a few months later was FIV neg. O notes occasionally when pet seems to have worse URI signs breathing will improve if she gives him a dose of her other pets flovent. On exam a 3 lb weight loss was noted. Other than increase in respiratory signs pet is acting normal. Eating and drinking well, no vomiting or diarrhea. Other than weight loss on exam and some congestion and nasal discharge, exam unremarkable. Elevated liver enzymes found on labs.

Current Medications: Clavamox 62.5 mg/ml 1.3 ml PO BID started 12/23, Metronidazole 100mg/ml 0.45 ml PO BID started 12/23
Imuquin supplement daily
Lab Results: ALT- 343 (27-158), AST- 134 (16-76), ALP- 215 (12-59)
Bili- 0.4 (0-0.3)
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (4.58 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (3.98 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.38 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.42 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in

echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of very ildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Soft stool noted.

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Pancreatic duct dilation is noted.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

PRIMARY FINDINGS

- Urinary bladder debris
- **Very mild inflammatory bowel disease (IBD) pattern –** Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- **Reactive mesenteric lymph nodes –** infiltrative neoplastic disease cannot be ruled out but is considered less likely.

ULTRASONOGRAPHIC FINDINGS

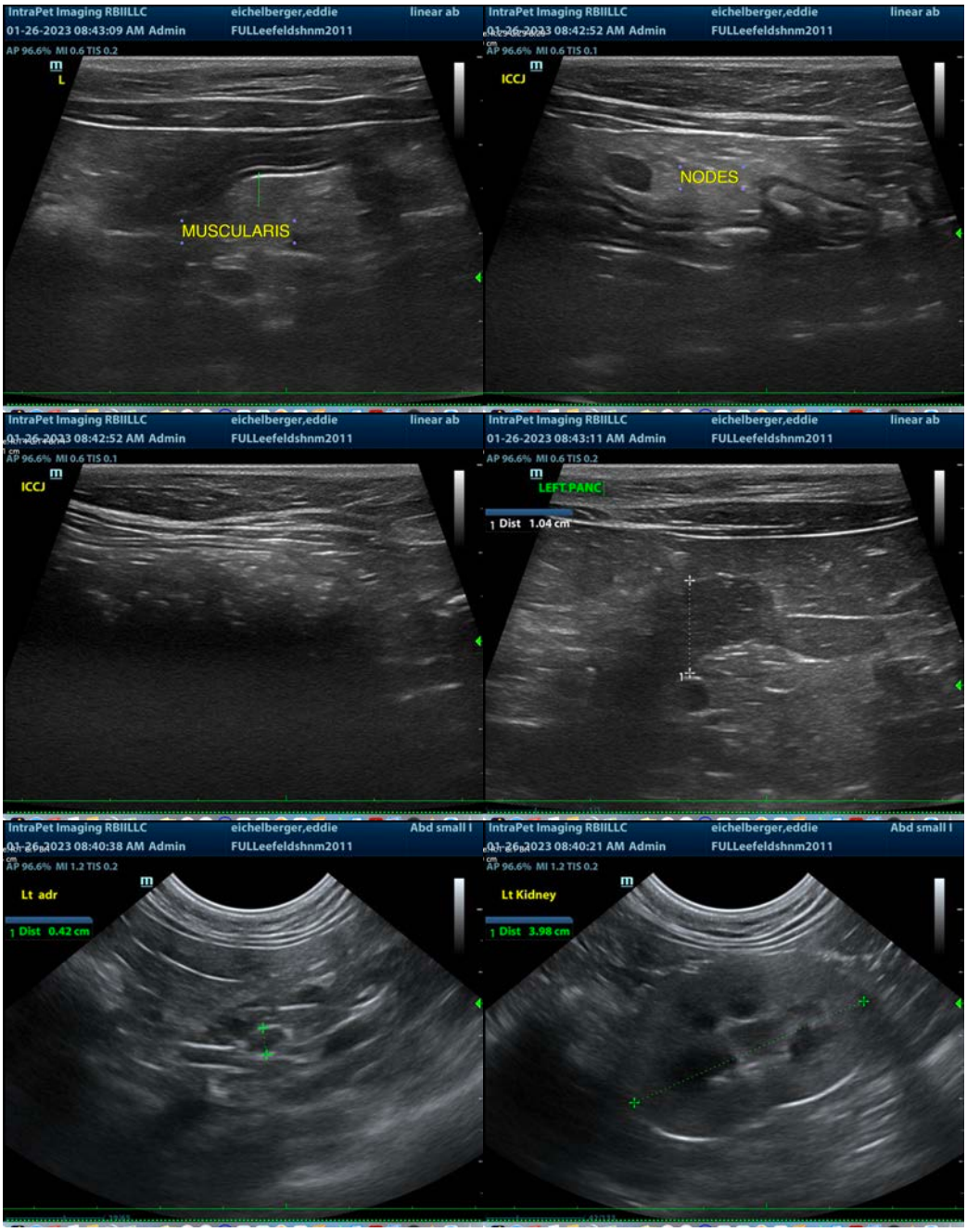
- Chronic active pancreatitis

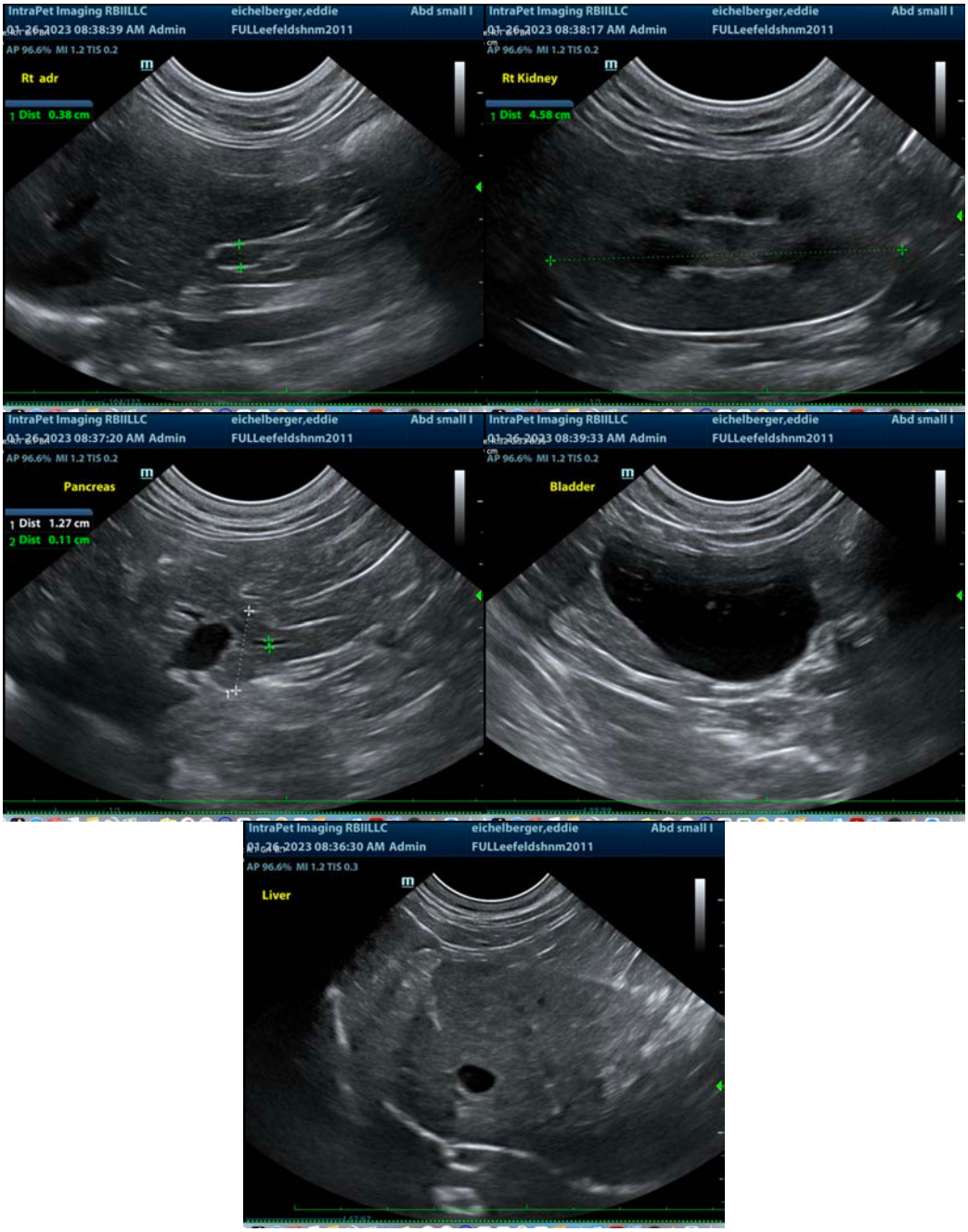
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient may have some underlying gastrointestinal or pancreatic disease resulting in the weight loss. Further evaluation is recommended with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory.

Having said that, given the concurrently increased liver enzymes and the mild changes described above in the bowel, a 2nd contributing factor if not the primary factor in this patient weight loss is suspected to be

decreased appetite secondary to the nasal disease and possibly some emerging hepatic lipidosis from the decreased appetite. A fine needle aspirate of the liver is recommended to help diagnose this, if patient's coagulation status is appropriate, followed by management of the upper respiratory congestion combined with potentially antiemetics and/or gastroprotectants to see if that helps improve appetite. Additionally, if tolerated, hepatic nutraceuticals could be administered.





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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com