



PATIENT

Spencer Slate

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years 9 Months

WEIGHT

14.33 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Cassel-Conways

HOSPITAL NAME

Central Broward

REFERRING VET

Dr. Oms

INVOICE

35192

DATE

1/28/22

PRESENTING CLINICAL SIGNS

Had sx explore- splenectomy done 2000, lymphoid nodular hyperplasia. Enteritis, lymphoplasmacytic, eosinophilic moderate with lymphocyte epitheliotropism. HAs been on budosenide 0.5 mg daily, presently also diabetic good regulation. Not on LID.

Abnormal PE/Chem/CBC/UA Results: cbc- hct 30 nl, plt cnt 559 h, nos 13904h, lymphocytes 948L, tg 487 H,

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is moderately distended. It has a normal uniform wall thickness (<0.2 cm). Contents include primarily anechoic fluid combined with suspended echogenic non-shadowing debris within the fluid. 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 (4.32 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 (4.4 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 (0.80 cm long x 0.27 thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.79 cm long x 0.28 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen has been previously removed surgically.

Liver

Liver is subjectively enlarged. Margins are smooth but round. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is mildly distended with anechoic bile and gravity dependent echogenic sediment. The wall is smooth without physical thickening. There is no evidence of common bile duct dilation. There is no evidence of effusion or inflammation.

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 intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions



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per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

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ULTRASONOGRAPHIC FINDINGS

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- Cholecystic debris of unknown clinical significance – This can be seen with biliary stasis from fasting or illness. However, it is often associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased Alk Phos and/or increased total bilirubin. In this patient, it could be secondary to steroids.

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- Hyperechoic hepatomegaly – consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- Urinary bladder sediment – Urine changes are most consistent with incidental suspended lipid in a cat, however, cellular debris or crystalluria cannot be ruled out and should be interpreted in combination with urinalysis results.
- The spleen has been previously removed.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Unfortunately, a normal appearing small bowel doesn't rule out infiltrative inflammatory disease, so it is difficult to say based on the ultrasound what the results of discontinuing the Budesonide would be. Recommendations include a gastrointestinal malabsorption panel including TLI, PLI, folate and cobalamin to Texas A&M Gi laboratory to make sure other supportive care such as cobalamin supplementation, etc. aren't necessary prior to discontinuing Budesonide. If the original clinical signs were diarrhea, a probiotic could potentially be added to help prevent a flare up when Budesonide is discontinued.

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Finally, if this patient is not already on a novel or hydrolyzed protein diet, that could be put in place all before discontinuing Budesonide. After discontinuation of Budesonide, the patient should be closely monitored for recurrence of clinical signs and/or weight loss, as the success of discontinuing it can only be determined based on trial and error. Having said that, there is no ultrasonographic reason why discontinuation couldn't be attempted.

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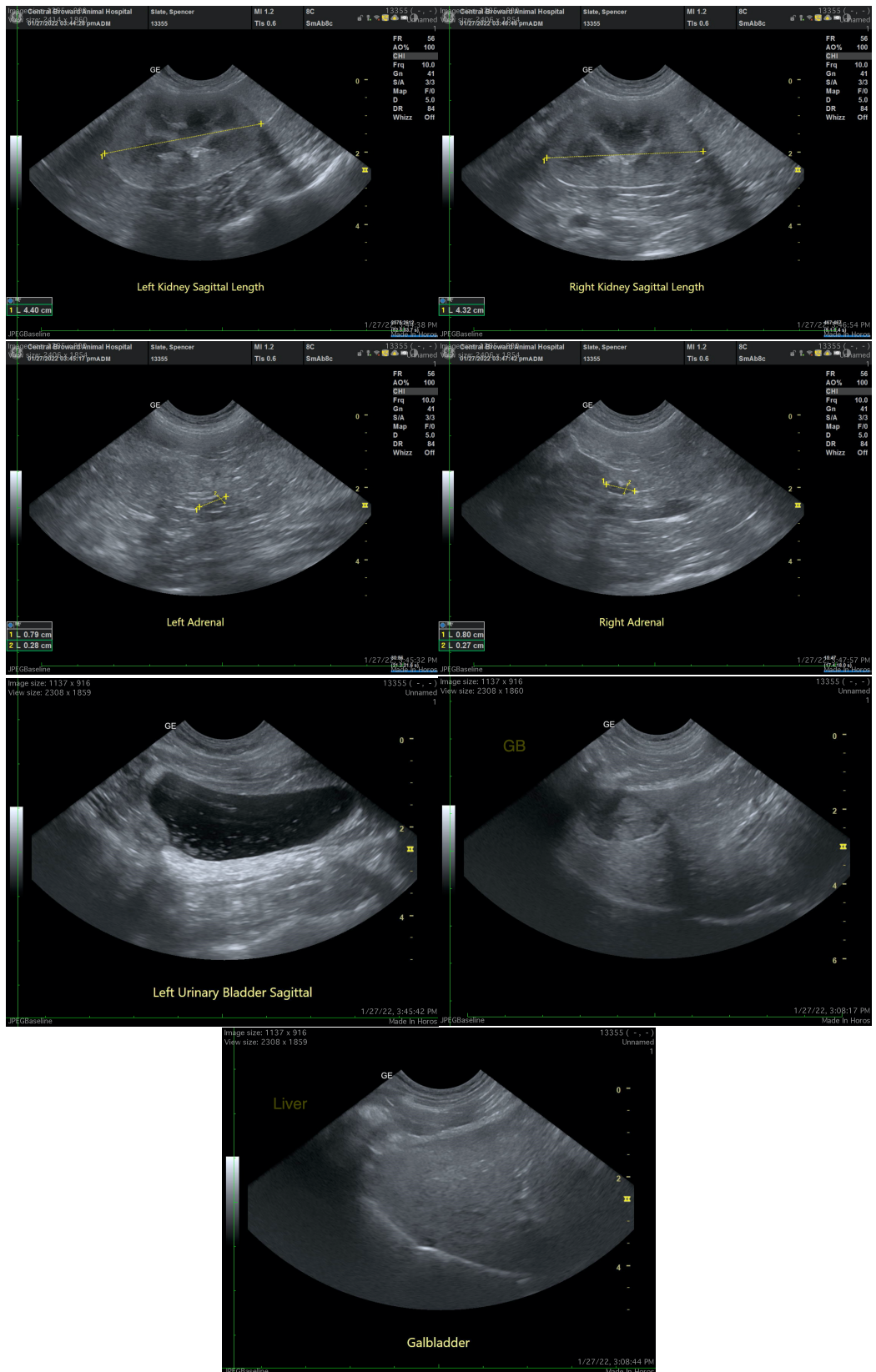
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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

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