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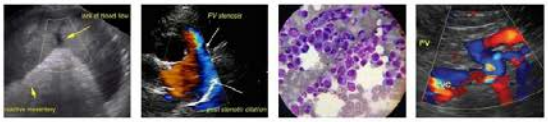

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Abbey Crockett

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8 Years

WEIGHT

7 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

FourPaws AC

REFERRING VET

Dr. Sue Lester

INVOICE

42218

DATE

10/20/22

PRESENTING CLINICAL SIGNS

10.5.22: Went to another clinic, P is anorexic and losing weight rapidly per o. Bloodwork was performed (see below for notes) P has continued to lose weight, will barely eat any food. O feels like she is “losing her.” No C/S/D Someone in the house did vomit some undigested cat food, but there are two cats in the house so unsure which one it was. O thinks that she is drinking water but can't tell since all animals share the same bowl. All stools in litter box are formed, with no issues. Previous lab work about a month ago showed mild neutropenia 1880 (2500-8500). T4 = 2.0 Tried Mirataz - not much change in appetite Has tried many many different kinds of cat foods. Tx with: cerenia, B-12, SQF (LRS), probiotics.

Abnormal PE/Chem/CBC/UA Results: Eyes: Abnormal: Large, pigmented area on R iris, slightly irregular. OS WNL. Abdomen: Abnormal: Scant formed feces in distal colon. Small intestine empty. Irregular 1cm mass in caudal left abdomen at previous exam but did not palpate it today. Abnormal CBC Values 9.29.22: Absolute Neutrophils 1880 (2500-8500) Abnormal Chemistry Values 9.29.22: Albumin 4 (2.5-3.9)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (3.95 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 (3.75 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 (0.39 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.46 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

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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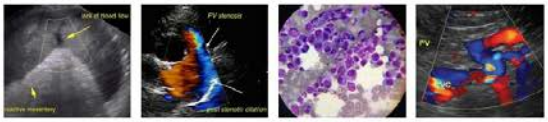

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The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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 intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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

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 a very scant amount of anechoic free fluid as well as a hypoechoic mesenteric lymphadenopathy and pancreaticoduodenal lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- **Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- Chronic active pancreatitis
- **Mucosal speckling –** Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- **Mesenteric lymphadenopathy –** Differentials for which include both reactive disease as well as infiltrative neoplasia and cannot be differentiated without tissue sampling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fine needle aspirate of the liver as well as lymph nodes (if they can safely be reached) is recommended for cytologic evaluation if the patient's coagulation status is appropriate.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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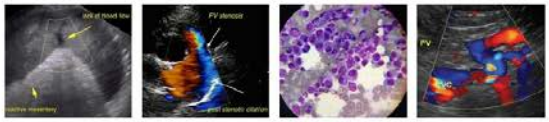

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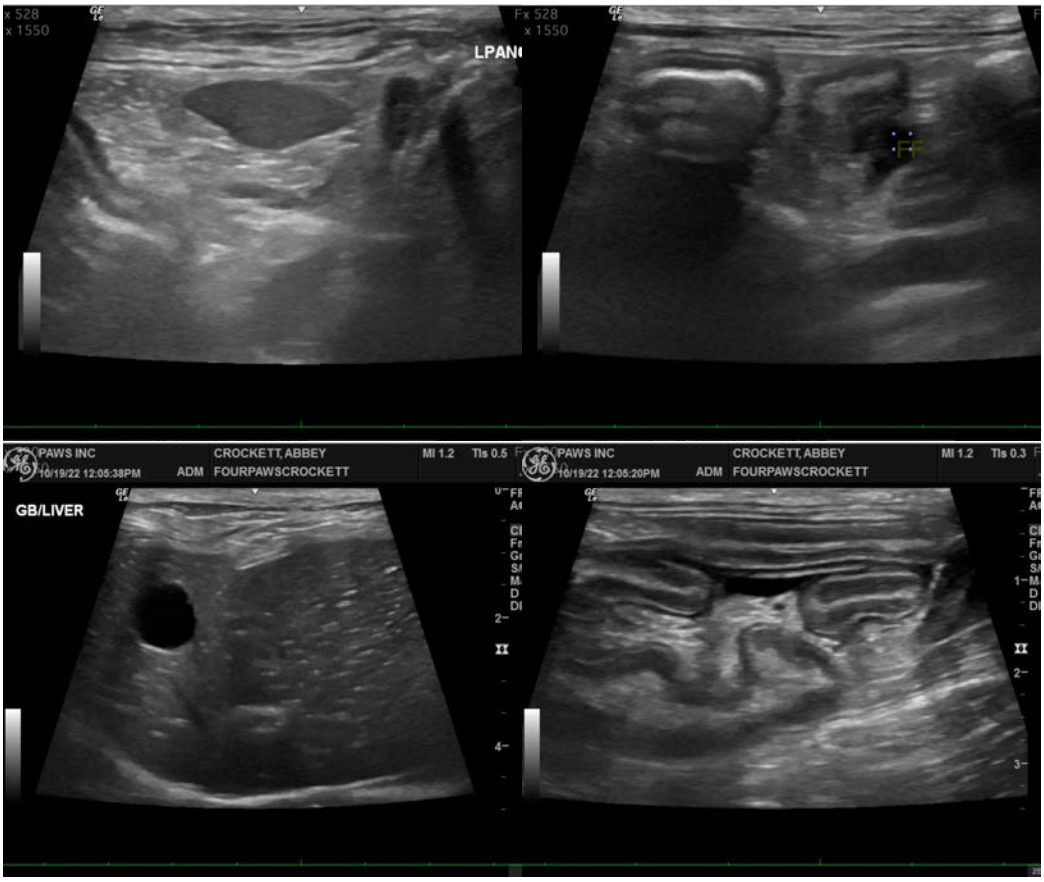
A recheck metabolic health screen in the form of a CBC/Chem panel, electrolytes, and urinalysis is recommended if not already rechecked, and if the leukopenia remains, the comprehensive infectious disease testing include viral testing is recommended, followed potentially by bone marrow cytology if a diagnosis is not obtained with liver aspirates, infectious disease testing, etc.

In the meantime, given this patient's severe prolonged hyporexia and lack of response to appetite stimulants, placement of a feeding tube, such as an esophageal feeding tube, may be necessary to offer patient stabilization while working up and obtaining a diagnosis.



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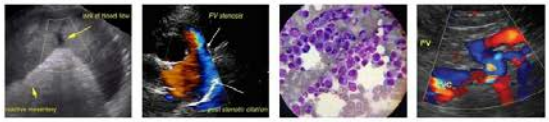

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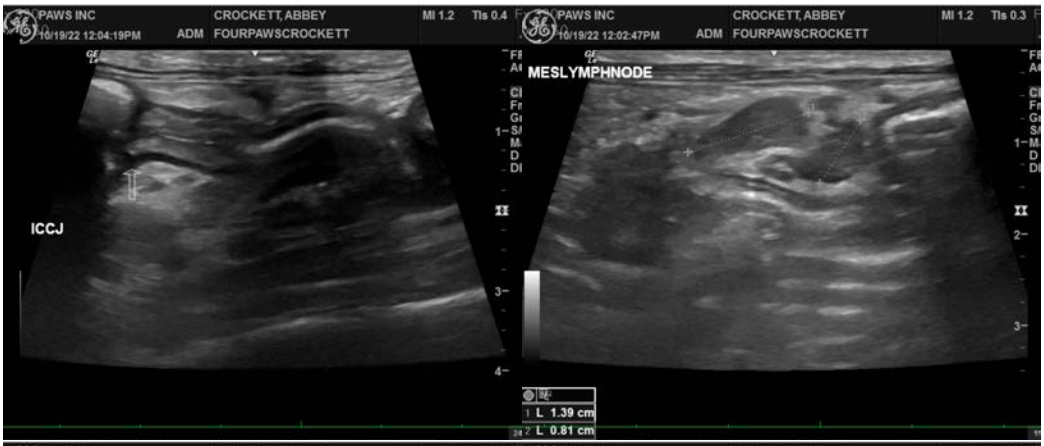

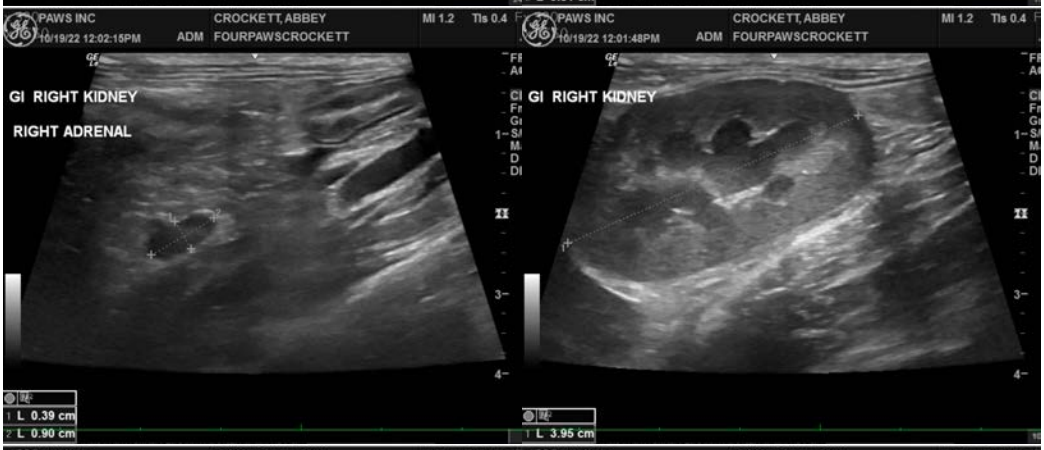

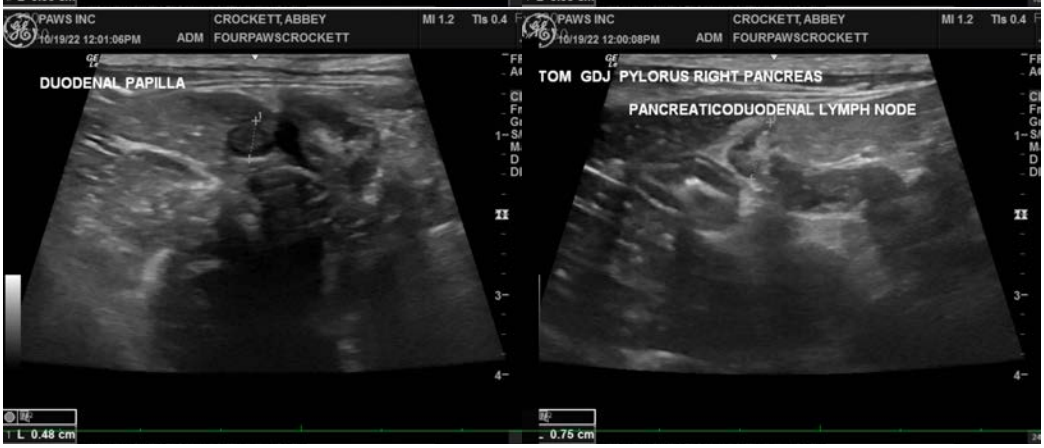

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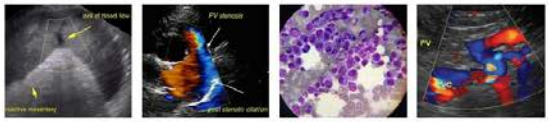

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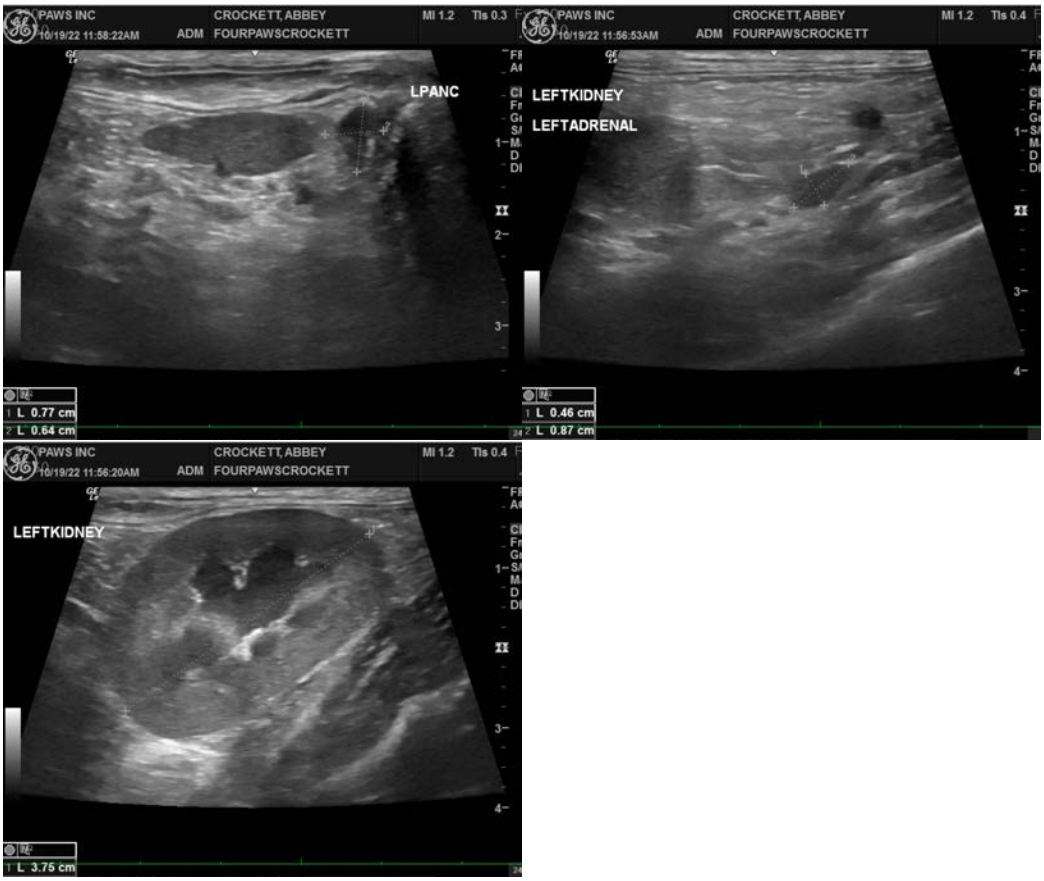

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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