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Clinical Sonography & Telecytology
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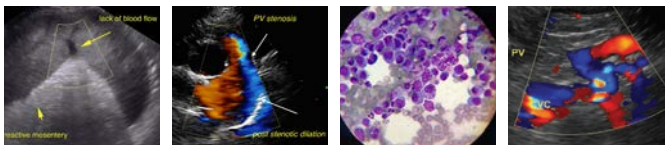

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1-800-838-4268 info@sonopath.com

PATIENT

Stardust Ferguson

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

12 Years

WEIGHT

3.37 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Brian Barnes

HOSPITAL NAME

Westview Vet Hospital

REFERRING VET

Dr. Brian Barnes

INVOICE

42432

DATE

11/1/22

PRESENTING CLINICAL SIGNS

Anorexia, Vomiting, for a few days. Some vomiting intermittently before became sick Has lost some weight

Abnormal PE/Chem/CBC/UA Results: CBC bands, Chem; ALT 243 (N 12-130), GGT 27 (N 0-4), TBil 142 (N 0-15) , ALP Normal. Snap fPl Abnormal. DDX: 1 Cholangitis, 2) Pancreatitis, 3) IBD, 4) Triaditis, 5) EHBDO

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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of mineral or infarcts observed. The left kidney measures 4.4 cm. The right kidney measures 4.2 cm. Mild pyelectasia is noted bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.49 cm at the cranial pole and 0.43 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.50 cm at the cranial pole and 0.43 cm at the caudal pole), 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) without disruption of architecture. 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 and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is subjectively overdistended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. The cystic and common bile duct are diffusely dilated, measuring 0.43 cm dilated and followed to the level of the duodenal papillae without evidence of mineral, nodules, etc. resulting in the obstruction visible in these images. There is no evidence of effusion or inflammation.

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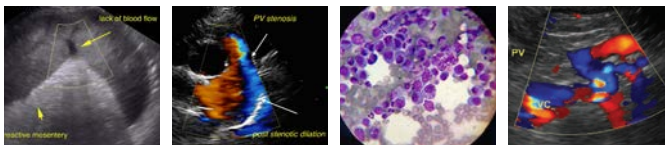

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Gastrointestinal

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

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. Some enhanced hyperechoic mesenteric fat is noted, suggesting an acute on chronic process.

Free Abdomen

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

There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Chronic active pancreatitis with suspected acute on chronic flare up
- Concurrent cholangitis/Triaditis or post-hepatic cholestasis/biliary obstruction secondary to the chronic pancreatitis.
- **Hyperechoic hepatomegaly** – This appearance is most consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

SECONDARY FINDINGS

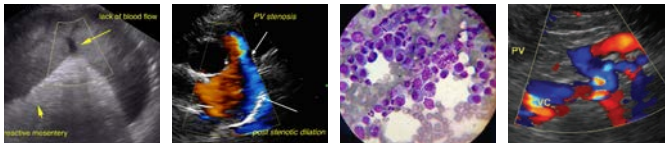
- Urinary bladder debris
- Age related kidney changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's chronic vomiting, 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.

If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

In the meantime, treatment recommendations include fluid therapy, antiemetics, gastroprotectants, hepatic nutraceuticals such as Ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional



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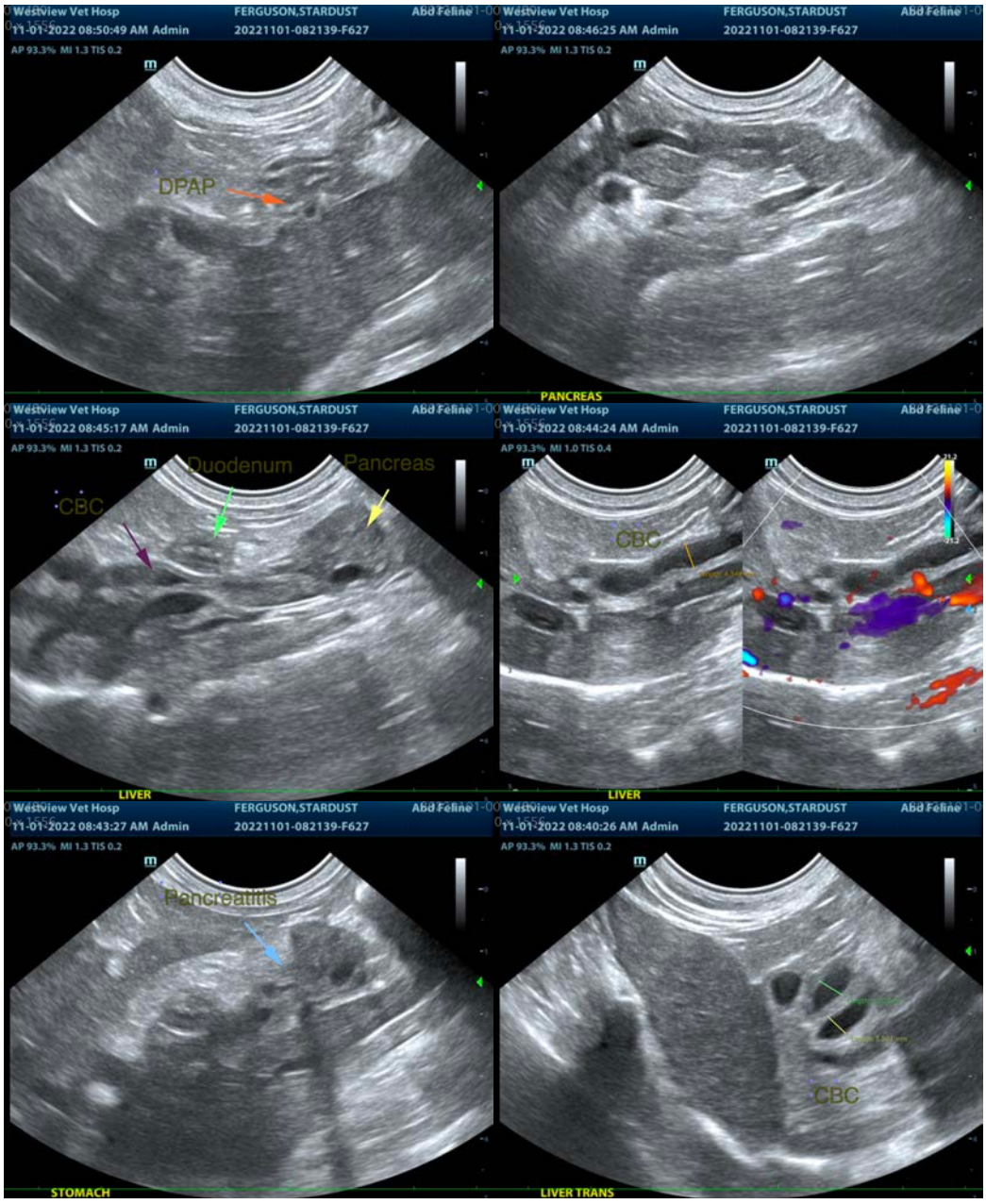
support is critical to prevent/manage concurrent hepatic lipidosis, so appetite and/or, if necessary, feeding tube placement is also recommended.

If clinical signs and/or liver enzymes don't improve with medical management, a fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate, and/or recheck imaging to assess improvement versus progression of post-hepatic biliary obstruction.



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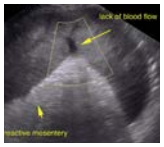
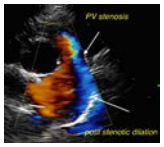
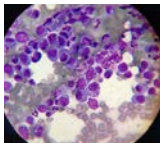
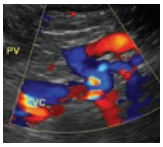

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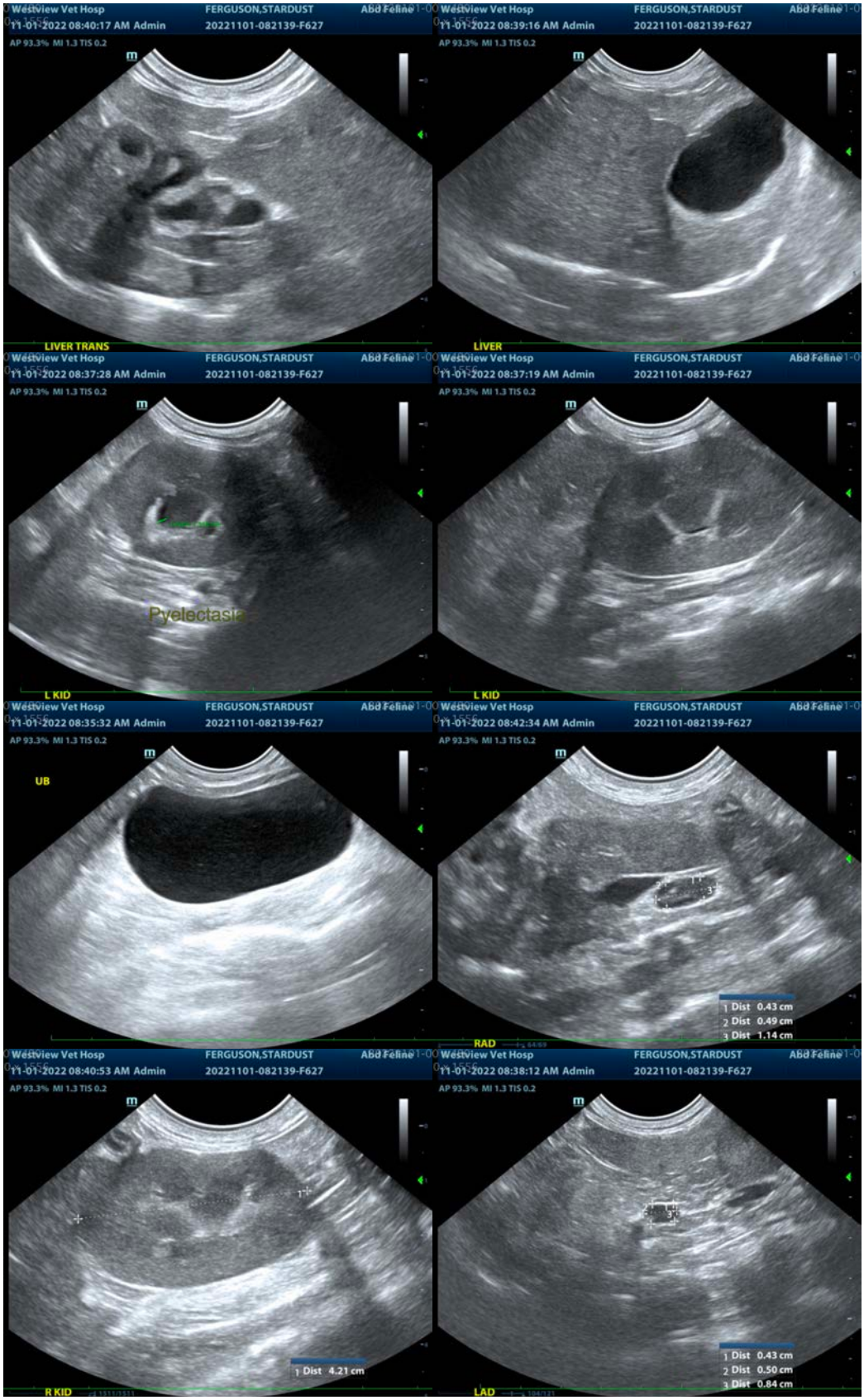

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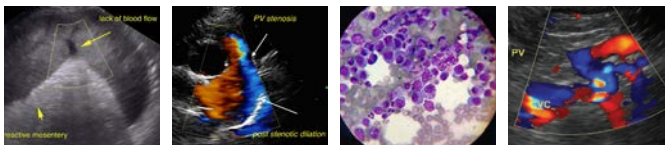

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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