



**PATIENT PRESENTING CLINICAL SIGNS**

**PATIENT** Shady Schlosser Presented 11/30/21 for vomiting and meowing in what was interpreted as pain. Constipation part of clinical picture but does not explain marked weight loss in previous 9 months, so ultrasound scheduled at owner's earliest convenience. Constipation currently well managed with Fiber response food and lactulose. Shady has maintained his weight since 11/30/21.

**SPECIES**

Feline

Abnormal PE/Chem/CBC/UA Results: Weight loss of 1.2 kg between Feb 2021 and Nov 2021. BCS 4/9, MCS 4/5. Constipation: transverse and descending colon full. Enema produced small, firm fecal balls and then firm, slightly larger pieces. GLUCOSE 197 mg/dL 72 - 175; AST 69 U/L 16 - 67; Lipase 55 U/L 0 - 45; fPL 23.3 ug/L 0.0 - 3.5;

**BREED**

DSH

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

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.

**SEX**

Neutered Male

Right kidney is normal in size (3.8 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.

**AGE**

12 Years 10 Months

Left kidney is normal in size (4.0 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.

**WEIGHT**

5.7 kg

**Adrenal Glands**

Right adrenal gland is normal in size (0.34 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Left adrenal gland is normal in size (0.33 cm thick) shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**Spleen**

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). There is a hyperechoic nodule mid body that does not disrupt the capsule and measures 0.5 cm in diameter. Splenic vasculature appears normal.

**HOSPITAL NAME**

Sherwood Family PC

**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.

**REFERRING VET**

Dr. Woodside

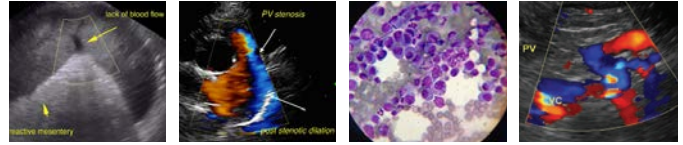
Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

**INVOICE NUMBER**

33429

**DATE**

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**PATIENT** *Gastrointestinal*

Shady Schlosser 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.

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Feline

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.

**BREED**

DSH

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

**Pancreas**

**SEX**

Neutered Male

Pancreas is prominent in size and mildly irregular in shape with a diffusely coarse echotexture and heterogenous to hypoechoic echogenicity.

**Free Abdomen**

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

**AGE**

12 Years 10 Months

**ULTRASONOGRAPHIC FINDINGS**

**WEIGHT**

5.7 kg

- Hyperechoic splenic nodule - most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are less likely.
- 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.
- Prominent heterogenous pancreas – This finding is most consistent with chronic pancreatitis.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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Given the history of weight loss, recommendations include a gastrointestinal malabsorption panel to Texas A&M GI laboratory to include TLI, PLI, folate and cobalamin as well as thyroid testing with a T4 and free T4. A fine needle aspirate of the liver +/- spleen is also recommended if the patient's coagulation status is appropriate, and pre-medication with diphenhydramine is recommended since mast cell tumor is on the list of differentials.

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Pending diagnostic results, therapeutic recommendations include continued management of the constipation with close monitoring of the weight since the weight has recently reportedly stabilized since managing the constipation. If weight loss persists, further intervention such as gastrointestinal +/- pancreatic biopsies may be indicated in the future.

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Shady Schlosser

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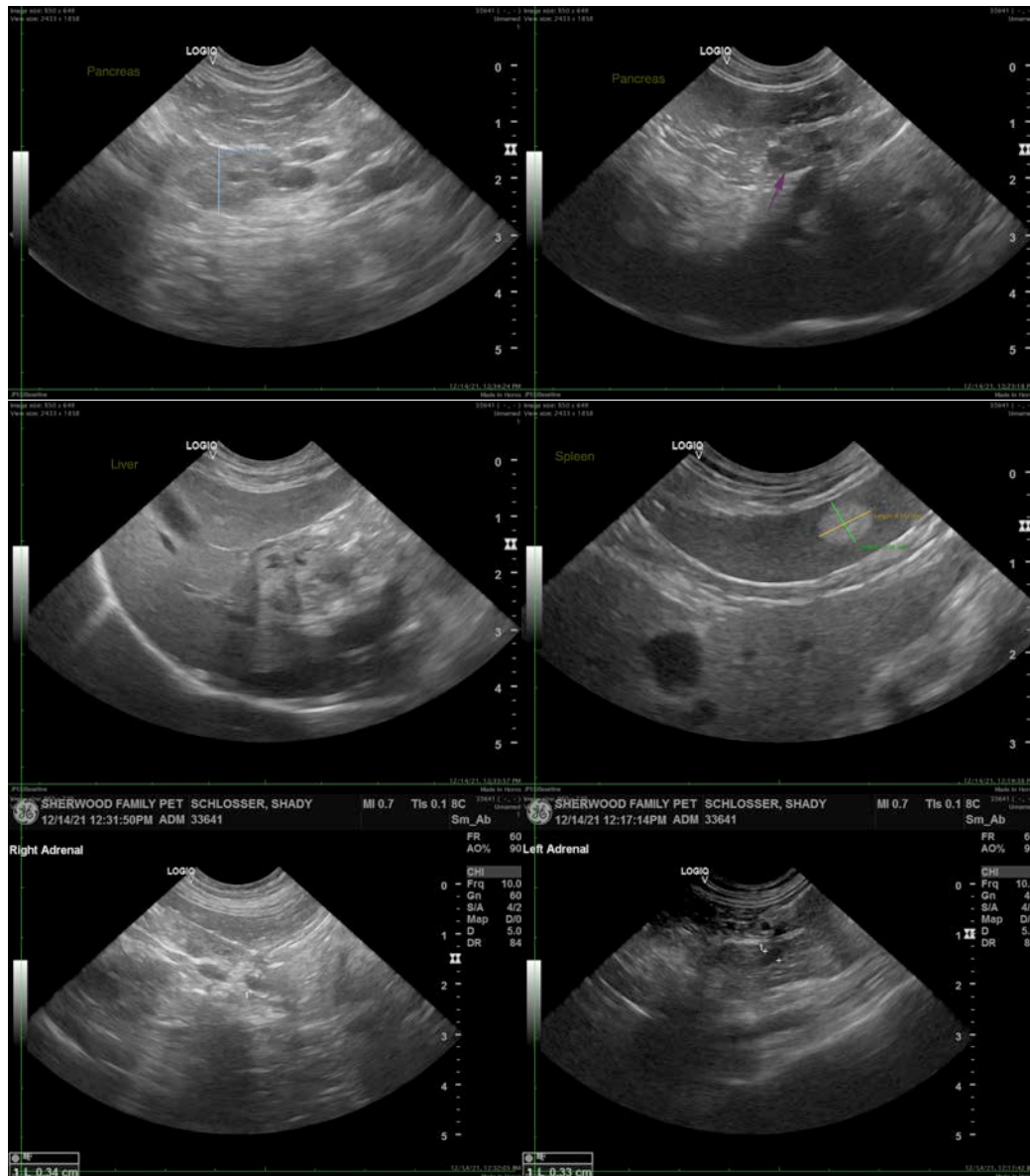
Dr. Woodside

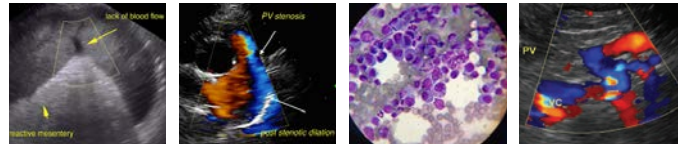
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**  
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