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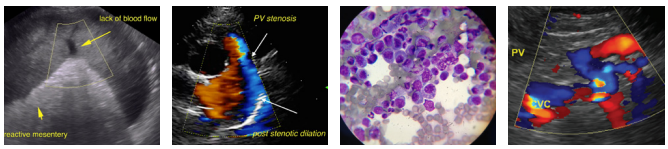

PATIENT

Paw Paw Dilbeck

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

11.1 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Tam Mengine

INVOICE

35655

DATE

2/15/22

PRESENTING CLINICAL SIGNS

Surrendered to shelter in 8/21 for FLUTD symptoms. Small CBC / Chem performed at that time was normal (Creat 1.5, ALT 120). Adopted by new owner in 10/21. Seen for vomiting 1/22 - ALT was 275,ALP 93 (normal), Creat 2.0, Globs 5.4, else normal CBC/ Chem. Rechcek labwork 2 weeks later - ALT 271, ALP 127, Creat 2.5, Globs 5.6. U/A pending

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 (4.04 cm) 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (3.56 cm) 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.30 cm at the cranial pole and 0.40 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 (0.41 cm at the cranial pole and 0.39 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. 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 moderately distended with anechoic bile and a small amount of gravity dependent, echogenic sediment combined with several mineral foci that contain acoustic shadowing, consistent with choleliths. The wall is smooth without visible thickening. There is no evidence of common bile duct dilation. There is no evidence of effusion or inflammation.

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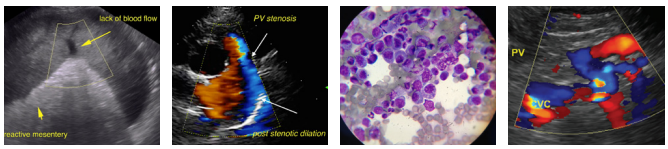

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Gastrointestinal

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. Normal layering is maintained except for a diffusely disproportionately thick muscularis layer relative to mucosa. 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

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.

Free Abdomen

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

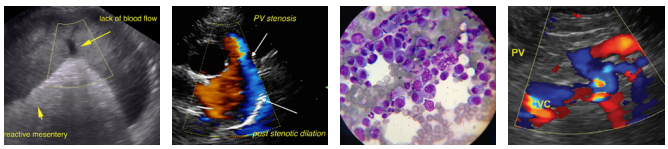
ULTRASONOGRAPHIC FINDINGS

- Thick muscularis – This finding has been reported in cats with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma.
- 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.
- Choleliths and cholecystic debris of unknown clinical significance – This can be an incidental subclinical finding, or 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.
- Age related kidney change – This finding is expected/consistent with age-related mild degenerative disease and should be interpreted clinically in combination with laboratory changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the hyperechoic, enlarged liver and the thick muscularis, recommendations include a gastrointestinal malabsorption panel to include TLI, PLI, folate and cobalamin to Texas A&M GI laboratory to further assess the GI tract as well as the pancreas, and a fine needle aspirate of the liver if patient's coagulation status is appropriate. If a diagnosis is not obtained cytologically, biopsies of the gastrointestinal tract (being sure to include the jejunum if possible) may be necessary to definitively diagnosis the underlying infiltrative small bowel disease.

If biopsies are elected, surgical biopsies versus endoscopic biopsies are recommended so that the gallbladder/choleliths can be addressed/removed at the same time. In the meantime, empirical therapy with broad-spectrum antibiotics is recommended to address any possible bacterial cholangitis. If gastrointestinal signs are the prominent clinical sign, a transition to a novel or hydrolyzed protein diet may be helpful. However, given the history of feline lower urinary tract disease as well as the emerging



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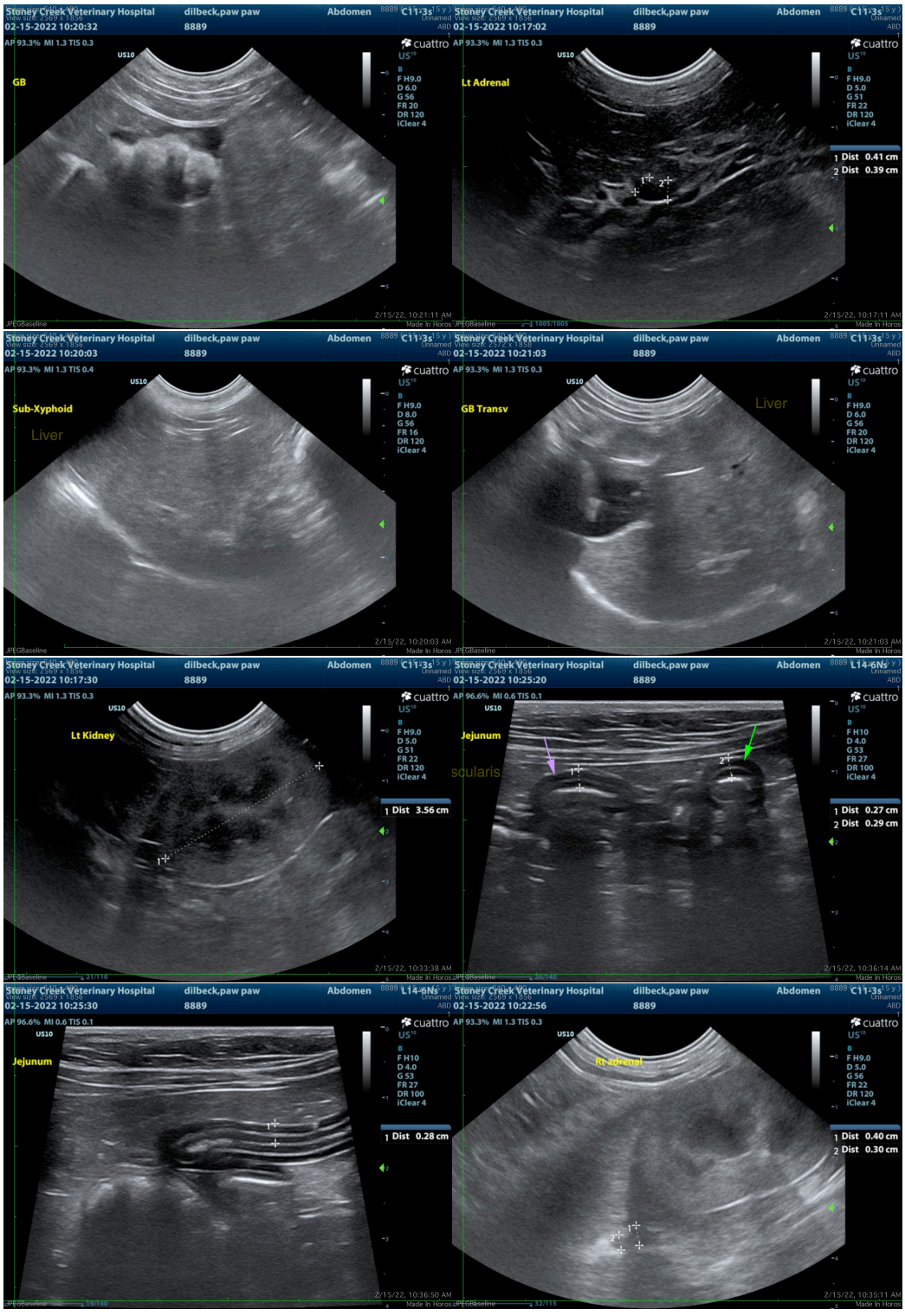
kidney disease, other diets may be more indicated.



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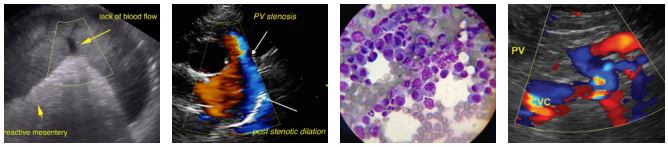

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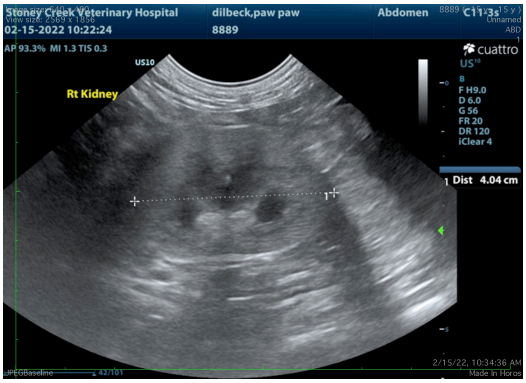

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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