

PATIENT

Eli C.L.A.W.S.

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6 Years

WEIGHT

6.4 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Animal General
on the Hudson

REFERRING VET

Dr. Stefanie Lang

INVOICE

35704

DATE

2/16/22

PRESENTING CLINICAL SIGNS

Foster reports cat has a ravenous appetite, gray color to stool, diarrhea and hematuria. Thin body condition. Patient is FIV +.

Abnormal PE/Chem/CBC/UA Results: Fecal (-), FIV (+), anemia, high ALT, USG 1.020, 3+ protein, (RBC), urine culture negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. There is a 1.3 cm irregularly shaped, amorphous, echogenic, non-shadowing density along the dependent inner wall. The material does not appear to have blood flow. No 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 (4.05 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 (3.42 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

Bilaterally uniformly plump egg-shaped adrenals (left adrenal gland measures 1.07 cm long x 0.57 cm at the cranial pole and 0.46 cm at the caudal pole, right adrenal gland measures 1.1 cm long x 0.52 cm thick), hypoechoic in echogenicity.

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.

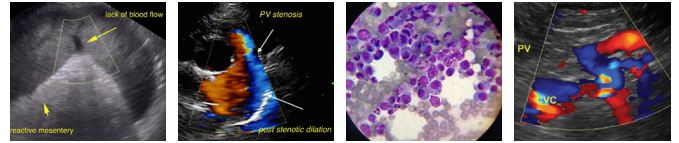
Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is not overtly distended, but contains echogenic, non-shadowing, amorphous, organized, aggregated (some centralized, some gravity dependent) sludge. The wall is smooth without visible thickening. There is no evidence of cystic or 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.



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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.

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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

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The pancreas is diffusely prominent and hypoechoic to surrounding tissue. The visible capsule is smooth and normal in contour. Parenchyma is diffusely coarse, mildly heterogeneous. There is no overt dilation of the pancreatic duct visible. Mildly hyperreactive mesentery is noted around the pancreas. No free fluid is present.

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Free Abdomen

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

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PRIMARY 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.
- Chronic smoldering pancreatitis with some age remodeling change
- Gallbladder sludge/mucus of unknown clinical significance – Cholecystic sludge/mucus/debris can be an incidental finding and is not necessarily related to hepatobiliary disease. However, in feline patients it often is related to hepatobiliary disease. The presence of the debris should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased total bilirubin.
- Amorphous, non-shadowing urinary bladder debris – Most consistent with a blood clot, given the reported hematuria. Other inflammatory debris or non-shadowing mineral cannot be definitively ruled out.

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SECONDARY FINDINGS

- Age related adrenomegaly - likely a benign age-related change. This change can be caused by chronic stress/disease, so investigation for/management of other disease (chronic kidney disease, hyperthyroidism, etc.) is recommended.

INTERPRETED BY

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the ravenous appetite, gray stool and diarrhea combined with the thick muscularis, recommendations include a gastrointestinal malabsorption panel to include TLI, PLI, folate and cobalamin to Texas A&M GI laboratory to rule out exocrine pancreatic insufficiency as well as to further assess gastrointestinal absorption.

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Given the urinary bladder changes and the gallbladder changes, despite a negative urine culture, an empirical course of antibiotics could be considered +/- Ursodiol, given the gallbladder sludge. Both urinary bladder and gallbladder lesions should be monitored for progression, as either lesion could ultimately result in an obstruction of the urinary system and/or mucocele of the gallbladder.

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Recommendations include recheck ultrasound of those lesion in 4-6 weeks, especially if clinical signs



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persist and/or progress and/or laboratory changes such as increased Alk Phos or total bilirubin develop.

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If clinical signs of hyperadrenocorticism are present such as polyuria/polydipsia, concurrent diabetes mellitus and/or fragile skin, testing for hyperadrenocorticism could be considered. However, the bilateral adrenomegaly is considered a non-clinical, likely aging change.

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If exocrine pancreatic insufficiency is not diagnosed via the gastrointestinal malabsorption panel, next steps may include biopsies of the gastrointestinal tract to more definitively diagnose the infiltrative process. In the meantime, a diet change to a novel or hydrolyzed protein diet while increasing caloric intake could be considered while pending diagnostics.

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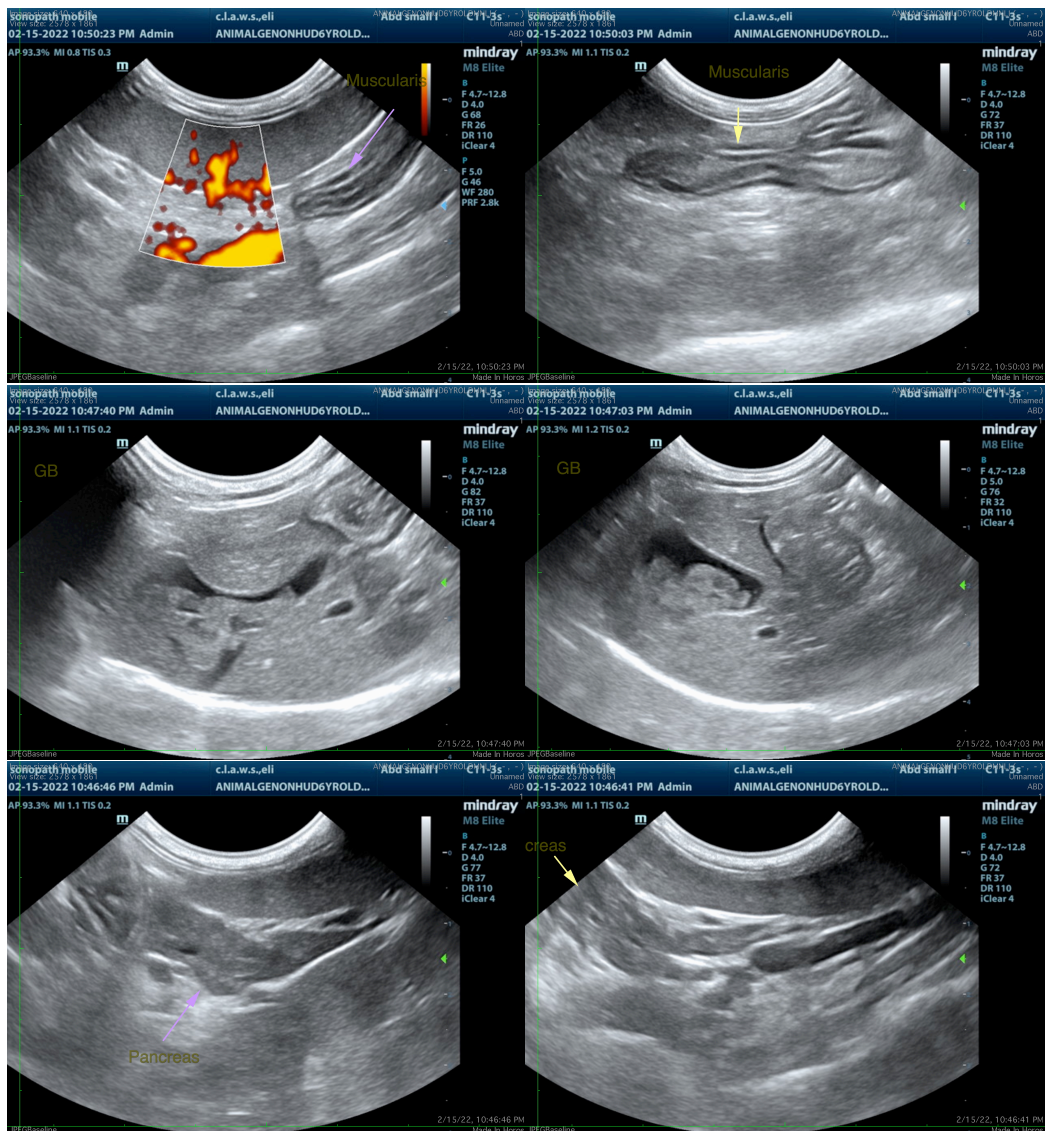
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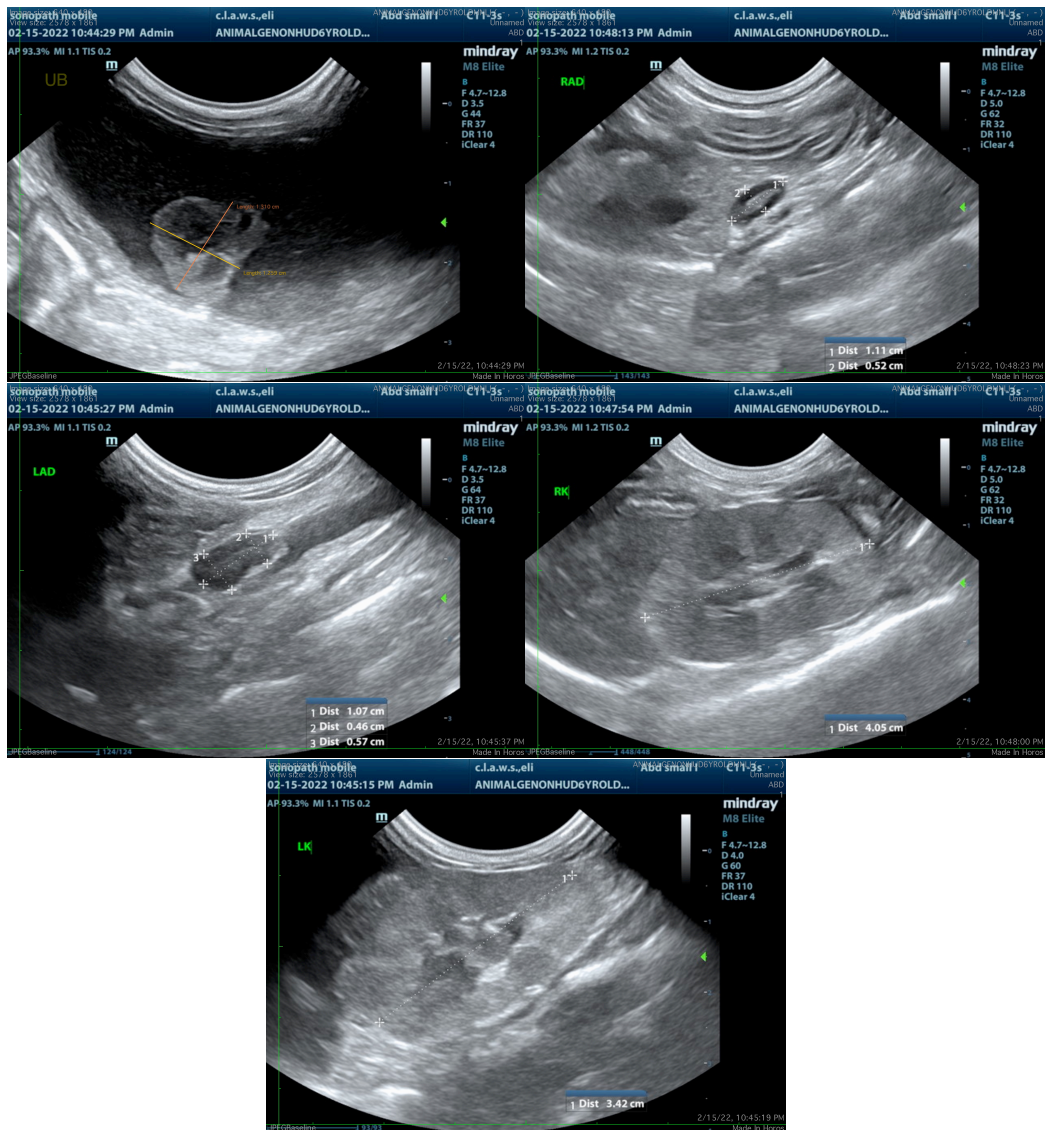
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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