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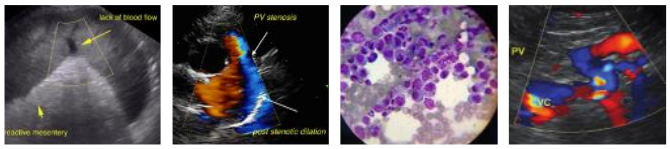

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Mooshu George

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

8 Years

WEIGHT

7.3 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Chrissy Krell, DVM

HOSPITAL NAME

Paws & Prairie AC

REFERRING VET

Chrissy Krell, DVM

INVOICE

21323

DATE

2/28/23

PRESENTING CLINICAL SIGNS

History: Mooshu has been skinny and not gaining weight for some time. He has decreased from 8lbs on 1/6/23 to 7.3 today (2/28/23). From his visit in early January, Mooshu has been vomiting once daily. Going on a few years. Indoor/outdoor cat. O has tried worming him and tried a senior diet. Still getting around okay. Not as energetic as in the past. Normal stool and urinating normal. BW done in January was unremarkable. Trial of Cerenia and Albon did help reduce the vomiting, had some inflammatory changes and increased proteins, SDMA 20. But as soon as the medication was discontinued, he started vomiting again and became more lethargic. He did okay on GI diet as well. Mooshu received Gabapentin prior to visit for anxiolytic purposes.

Abnormal PE/Chem/CBC/UA Results: Exam - 2/9 BCS, unkempt fur, painful/reactive on palp of cranial abdomen, "ropey" intestines, vital ownl. 1/6/23 THP: CBC: WBC 21.0 Neutrophils 15729 Chemistry: IDEXX SDMA a 20 Total Protein 8.9 Globulin 6.0 T4 - normal 1.7

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 large in size (left kidney measures 4.67 cm, right kidney measures 4.89 cm) with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. 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

Left adrenal gland is normal in size (1.23 cm long x 0.36 cm at cranial pole and 0.43 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.44 cm at cranial pole and 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.1 cm thick) with a generally normal shape and smooth capsular contour. Parenchyma is diffusely nodular in appearance, characterized by small discrete hypoechoic nodules. 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.

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.

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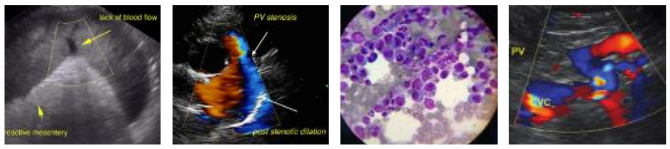

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is markedly overdistended with anechoic fluid and chyme.

The visible small intestines are normal in wall thickness and layering. Bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material. In the cranial abdomen, the bowel (primarily the proximal duodenum) is more moderately distended with echogenic fluid than the remainder of the bowel. Small intestinal hyperperistalsis is noted.

The visible colon is normal in wall thickness 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

A scant amount of anechoic free fluid is present. The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hypoechoic hepatomegaly-This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- The splenic pattern described above can be associated with a benign aging nodular hyperplasia, however, infiltrative neoplasia, including round cell neoplasia vs other, can mimic a benign change and cannot be ruled out.
- Feline renomegaly – These renal changes can be seen with glomerular or interstitial nephritis, FIP, amyloidosis, acute tubular necrosis or infiltrative neoplasia such as lymphoma. Normal variant due to fat deposition cannot be ruled out but is less common in an enlarged kidney.
- Gastroenteritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other.
- The gastric distention may be related to the same underlying cause (causing the suspect gastroenteritis) and there is no definitive visible evidence of foreign material. However, partial obstruction, emerging obstruction or an obstruction just not visible in these images is absolutely possible and cannot be ruled out.
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Chronic active pancreatitis

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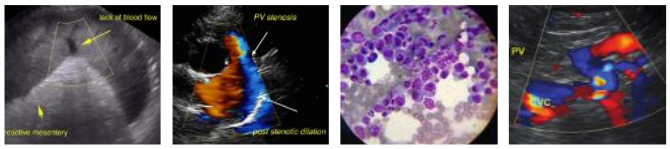

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Secondary Findings

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fecal exam is recommended if not recently evaluated.

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.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

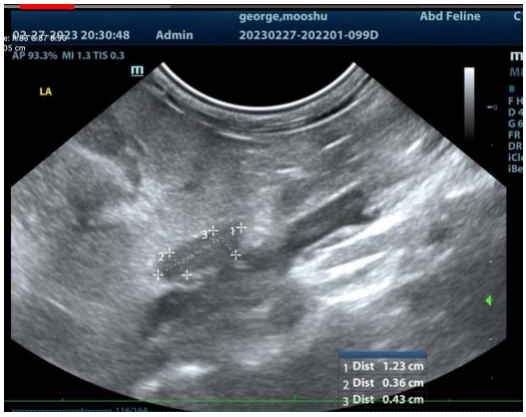
If a diagnosis is not obtained, further investigation of the high globulin could be considered via serum electrophoresis to help more definitively suspect infection disease vs infiltrative neoplastic disease as a cause for the high globulin count.

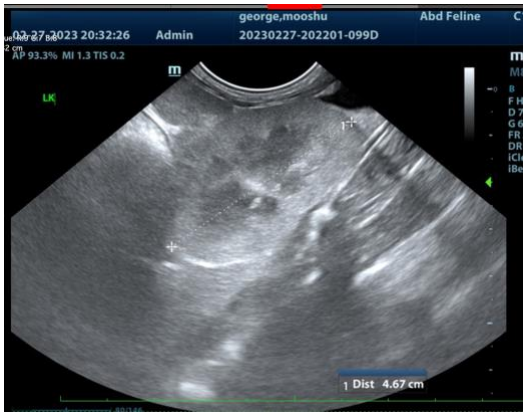
Additionally, fine needle aspirates of the liver and spleen +/- the kidneys could be considered if patients coagulation status is appropriate.

In the meantime, supportive/symptomatic medical management of gastroenteritis, dietary indiscretion, parasitic disease, etc., is recommended with antiemetics, gastroprotectants, an appetite stimulant, or nutritional support (as needed), pain management (if indicated), empirical deworming with a 5-day course of Panacur, +/- broad spectrum antibiotics and/or fluid therapy (if clinically indicated).

Given the marked gastric distention, a nasogastric tube could also be placed to both empty the stomach and offer some patient relief, if this is just gastric status or delayed gastric outflow/ileus, as well as allow a way to provide nutritional support.

Additionally, full assessment of these images is hindered by the marked diffuse distention of the gastrointestinal tract, so, if the stomach is able to be emptied, recheck imaging could be considered to help further identify subtle pathology that may have been missed.





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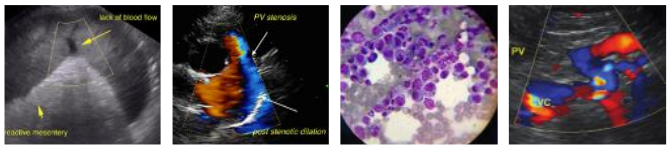

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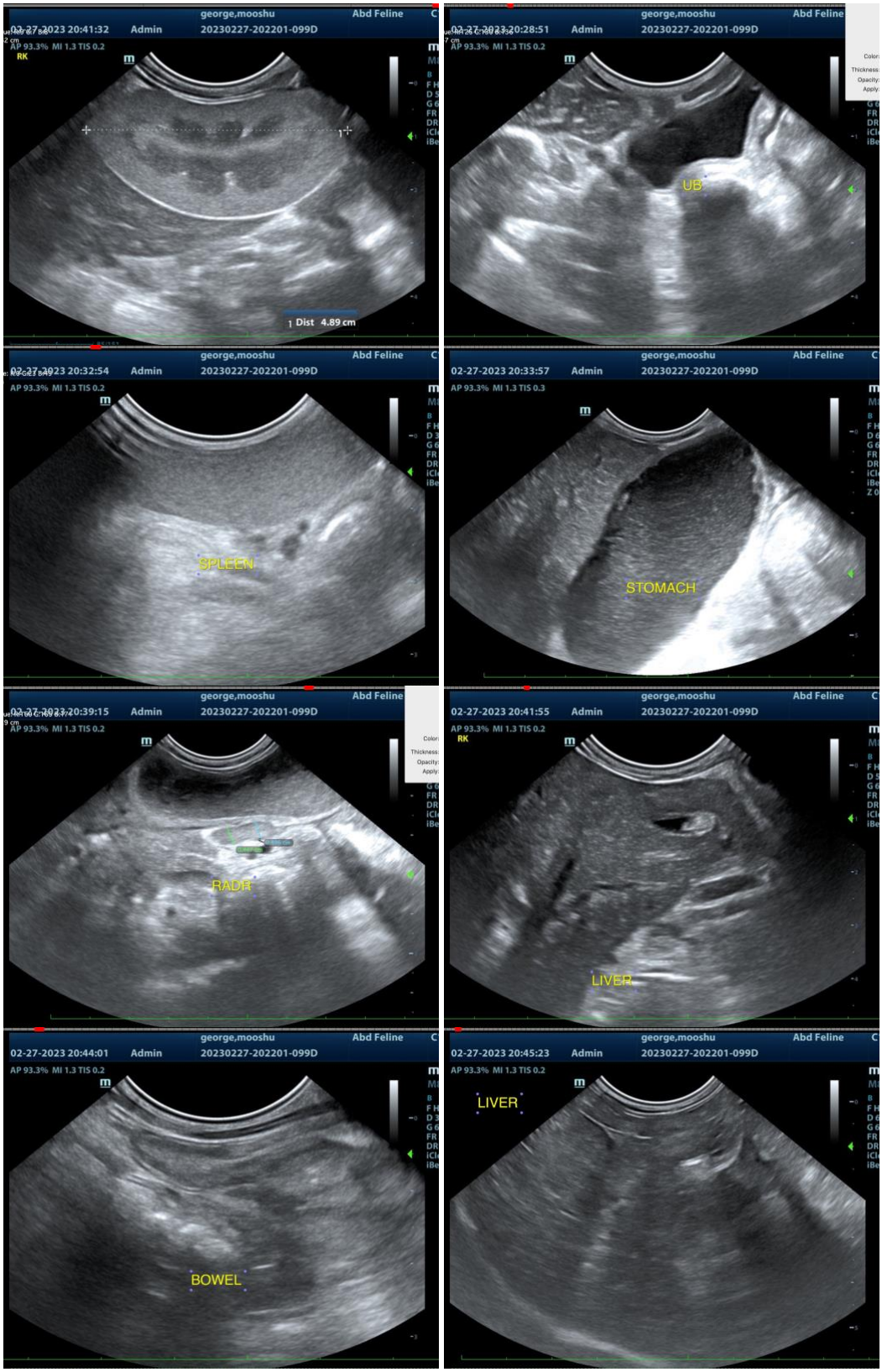

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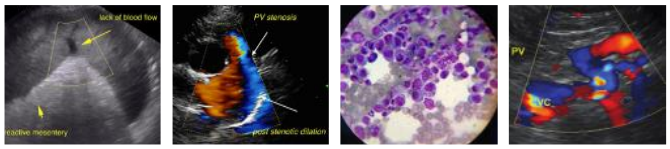

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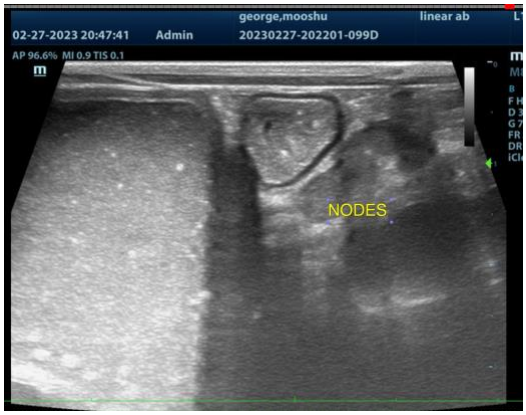

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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