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Clinical Sonography & Telecytology
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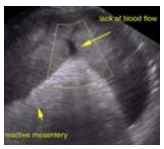
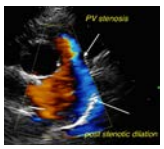
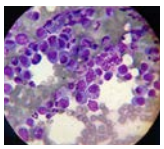
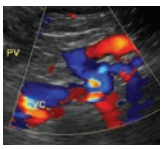

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1-800-838-4268 info@sonopath.com

PATIENT
Woody Pickering

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
17 Years

WEIGHT
10.6 Pounds

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Dr. Sarah Green

HOSPITAL NAME
Healing Spirit

REFERRING VET
Dr. Sarah Green

INVOICE
44979

DATE
2/8/23

PRESENTING CLINICAL SIGNS

Presented for exam due to pu/pd/polyphagia and increased vocalization. Overgrooming/ pulling fur from the dorsal thorax and abdomen on the left side only. No primary skin lesions, no fleas or fleas debris seen

Abnormal PE/Chem/CBC/UA Results: Slightly distended abdomen, NAF otherwise, ALT=231 (20-100) U/L, BUN=37 (10-30) mg/dL, Cr=2.8 (0.3-2.1) mg/dL, TP=8.4 (5.4-8.2) g/dL, CBC, T4 - WNL (2.8 ug/dL)

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. Additionally, there are larger echogenic strands of debris/mucus/other, subjectively more pathologic than incidental suspended lipid. 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 normal in size and contour. A relatively uniform hyperechogenicity is observed with mildly decreased corticomedullary distinction. There is no pyelectasia noted and no mineral is observed. No overt masses/nodules are observed. The left kidney measures 3.7 cm. The right kidney measures 4.1 cm.

Adrenal Glands

The **adrenal glands** are unable to be fully visualized in these images.

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

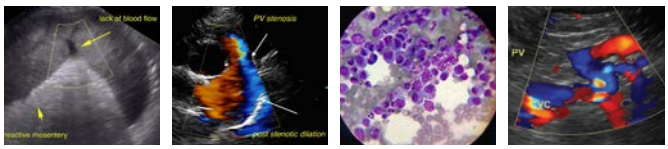
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. In the mid to caudal liver, there are multiple nodules/masses of mixed echogenicity, primarily hyperechoic in echogenicity, but containing multiple cysts of varying sizes. Visible vasculature and biliary tree appear normal without distension or congestion.

The 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.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is mildly distended and contains an echogenic interface with distal progressively shadowing material consistent with hairball density (or similar fluid absorbing material) noted.

The visible small intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen is mildly distended with echogenic



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non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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.

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

- **Nephritis –** This appearance can be consistent with chronic interstitial nephritis or glomerulonephritis. Toxic insult and/or infectious disease (pyelonephritis, Leptospirosis, etc.) cannot be ruled out. This finding should be interpreted in combination with suspicion for renal disease and/or supporting laboratory or urinalysis changes.
- **Feline biliary cystadenoma –** In a senior cat, this liver lesion is most consistent with a/multiple benign biliary cystadenoma(s). Malignancy cannot be ruled out but is considered less likely give lack of clinical signs and/or laboratory changes.
- **Gastric Hairball –** similar density soft foreign material cannot be ruled out.
- **Inflammatory bowel disease (IBD) pattern –** Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Chronic active pancreatitis

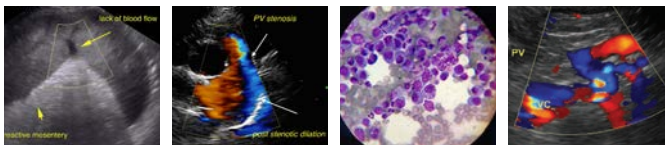
SECONDARY FINDINGS

- Urinary bladder debris – subjectively more prominent than is suspected with incidental suspended lipid in a cat.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's reported azotemia and urinary bladder appearance, if not already 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 ratio is recommended.

There is visible evidence of suspected infiltrative bowel disease, which could be contributing to the weight loss and polyphagia. However, given the concurrent PU/PD, vocalizing, dermatologic presentation, etc., the total T4 is in the high-normal grey zone. Therefore, a free T4 is recommended if not already evaluated to rule out concurrent hyperthyroidism.



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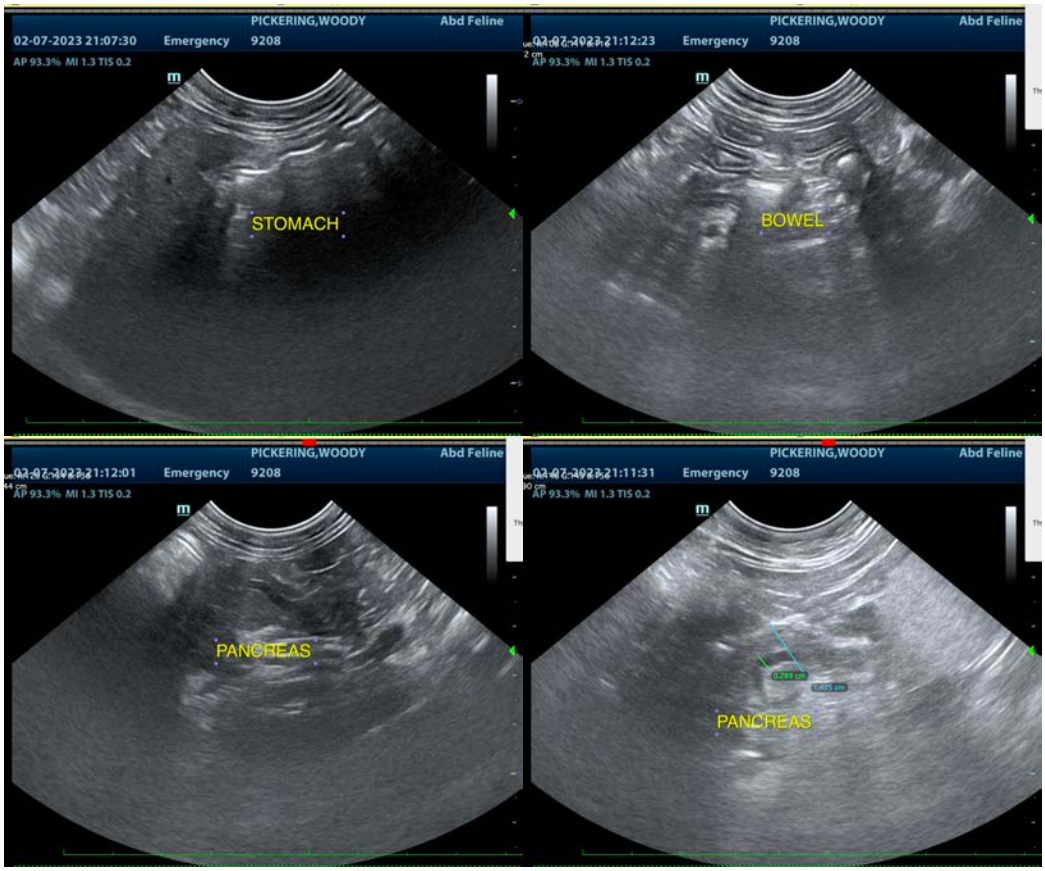
Beyond that, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.

If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).

While the liver nodules trend in appearance toward benign, malignancy is also possible. Therefore, a fine needle aspirate of the liver mass could be considered if patient's coagulation status is appropriate.

The suspicion of a gastric hairball fits the clinical history of overgrooming. Further intervention regarding this finding is dependent on clinical signs, either now or the development of them.



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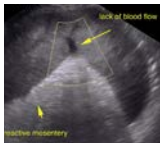
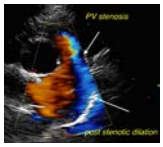
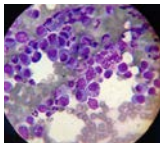
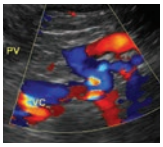

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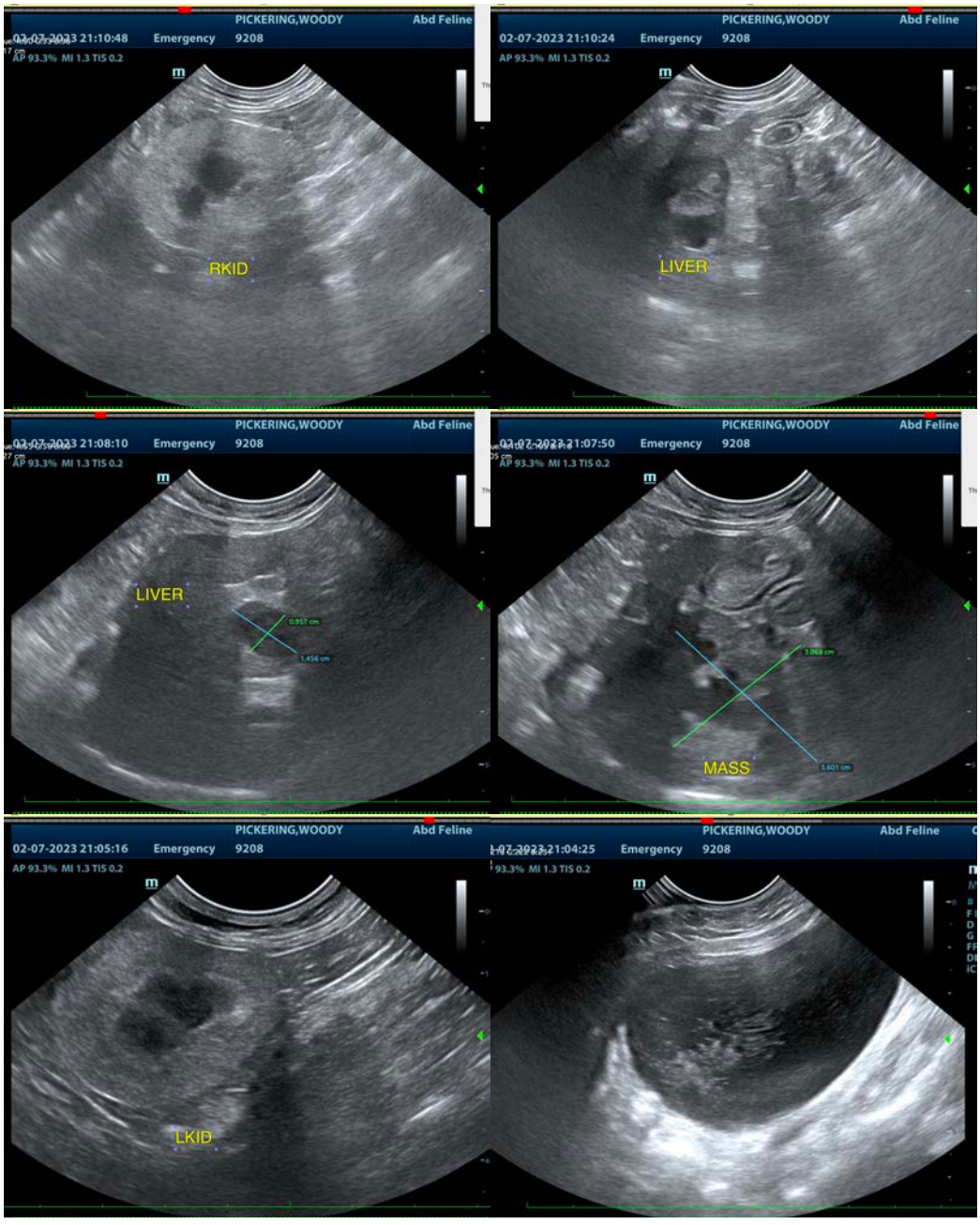

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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