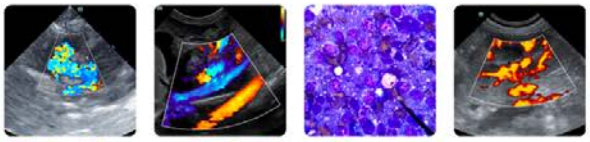

PATIENT

Sebastian Nich

SPECIES

Feline

BREED

Maine Coon

SEX

Neutered Male

AGE

14 Years

WEIGHT

4.8 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Bridgeland Vet Clinic

REFERRING VET

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PRESENTING CLINICAL SIGNS

Sebastian, a 14-year-old patient, presents with a history of chronic vomiting, weight loss, and increased thirst. Significant clinical findings include a heart murmur and renal azotemia discovered on recent blood work.

The primary issue is chronic vomiting, which has been ongoing for at least three weeks. The frequency of vomiting has recently progressed from SID to two to three times per day. The vomitus consists of a mix of undigested food, foam, and water. The patient has also experienced documented weight loss since his visit last week. Blood work revealed renal azotemia, staged as IRIS stage 2, and a mildly elevated pancreatic specific lipase (PSL) of 51. Despite these signs, his energy and appetite were reported as normal during the previous week's visit. An abdominal ultrasound has been scheduled for further evaluation.

During the physical examination, a heart murmur was detected, described as a grade 3 to 4 out of 6 with a high-pitched whistle character. It is loudest over the left heart base but is also audible on the right. An echocardiogram was offered to investigate the murmur, but this was declined at this time.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately 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 is size (3.4 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 is size (3.3 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

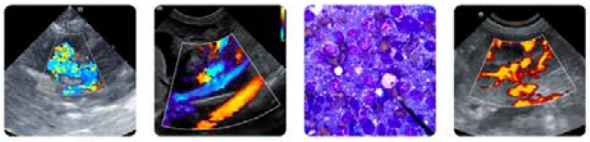
The areas of the adrenal glands are examined without evident adrenal gland pathology.

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. *See pancreas section.



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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness 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 intestine demonstrates areas of moderately 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 of the small intestine is empty with no evidence of obstruction or foreign material.

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

Pancreas

In the right cranial abdomen there is an approximately 2.3 cm in diameter irregular echogenic density characterized in part by nodular solid tissue and multiple cystic areas that I believe is originating from the body or cranial right limb of the pancreas, most clearly visualized especially near the end of the study. Having said that, liver origin, while thought less likely, can't be definitively ruled out.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Suspect cystic right pancreatic density with both benign nodular hyperplasia, chronic low-grade smoldering pancreatitis with cysts, other, as well as infiltrative neoplastic disease being possible differentials. As described above, however, a liver density including benign feline biliary cystadenoma versus infiltrative neoplasia affecting the liver, while thought less likely can't be definitively ruled out.

- Moderate 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 loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.

- Very mild gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be 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 ALP and/or increased Tbili.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

A blood pressure is also recommended.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the suspect right pancreatic mass are recommended if patient's coagulation status is appropriate.

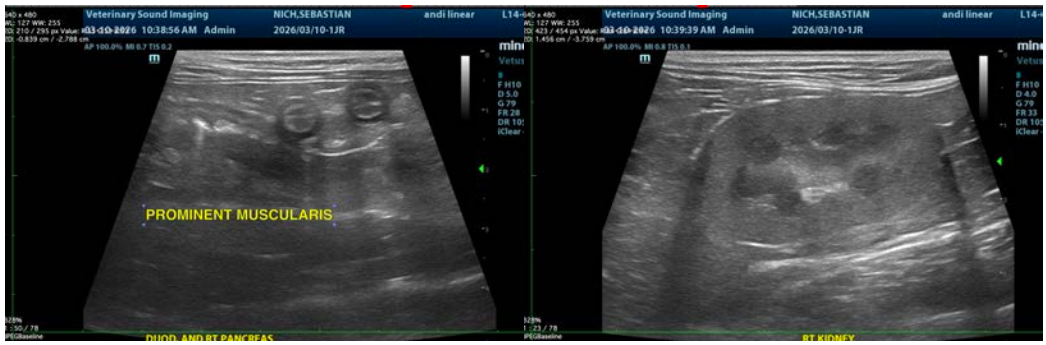
Ultimately, pending results of above, especially if a diagnosis is not obtained:

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 a probiotic (if diarrhea is present, such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.

Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



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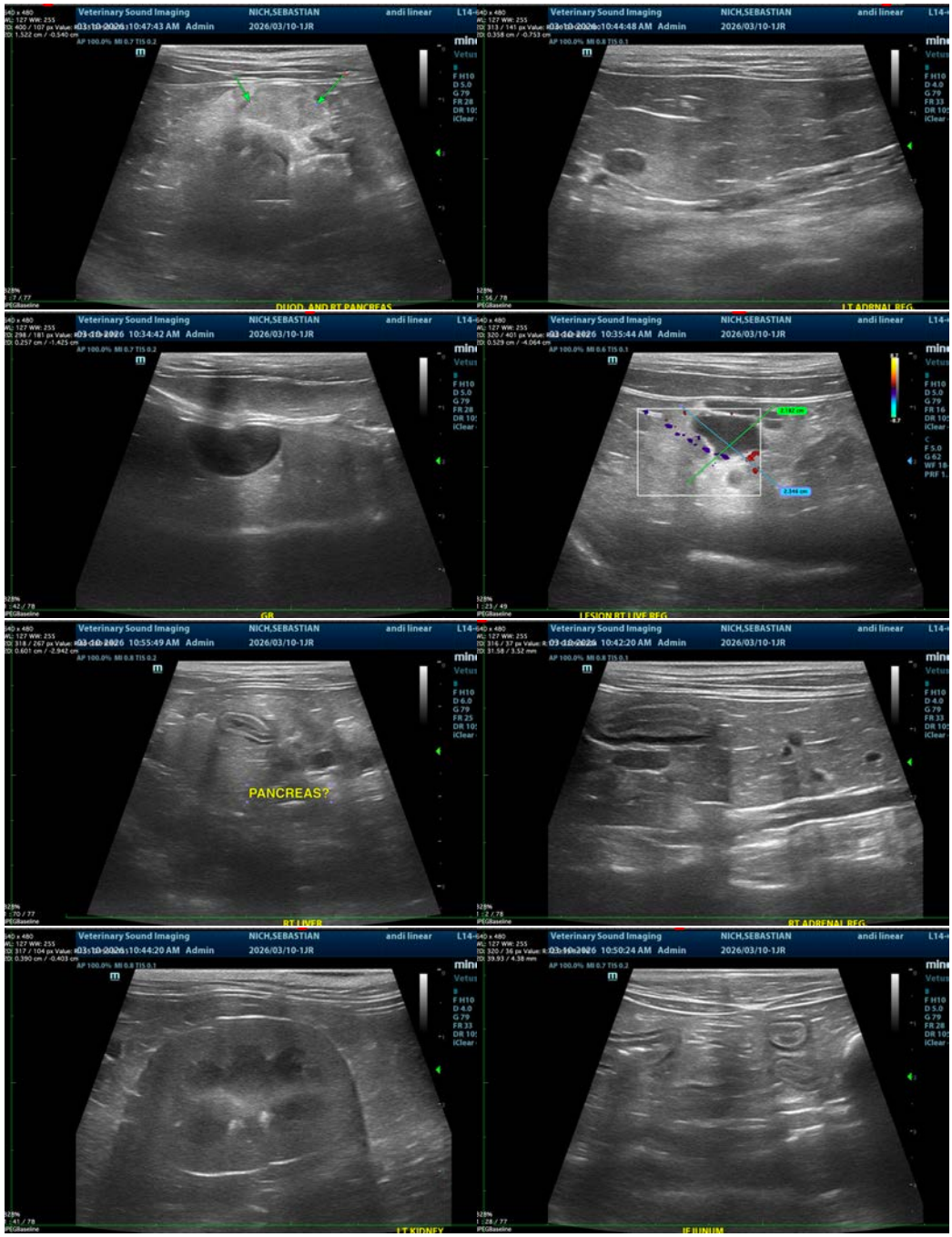

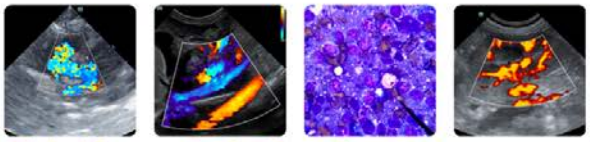

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com