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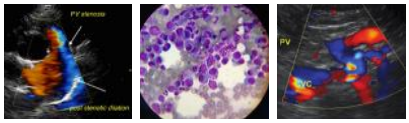

SonoPath
Clinical Sonography & Telecytology
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DATE

5/20/22

PATIENT

Benny Hensler

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2/22/15

WEIGHT

14 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Stephanie Pearce RDCS, RVT

HOSPITAL NAME

Cat Sense Feline AH

REFERRING VET

Dr. Sinclair

INVOICE

37806

PRESENTING CLINICAL SIGNS

Had u/s in February for losing weight, not eating well. After the ultrasound, we started him on sucralfate and omeprazole and increased the prednisolone. He has been on and off with his appetite but it seems to have stabilized and he is now off of the omeprazole and sucralfate.

Current Medications: Had been on omeprazole and sucralfate for several weeks after the utlrasound on 2/15 but they have been discontinued since 4/11. He is currently on 6mg cerenia once daily, Mirataz once daily and Cobalequin once daily.
Date of Previous IntraPet Ultrasound: 2/15/22. See attached.
Sedation: Gabapentin PO, Torbugesic IV.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is moderately distended. It has a normal uniform wall thickness (<0.2 cm). Contents include primarily anechoic fluid combined with suspended echogenic non-shadowing debris within the fluid. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (4.24 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 (4.39 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 right adrenal gland is subjectively flat in appearance, measuring 0.31 cm thick. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland is subjectively flat in appearance, measuring 0.26 cm thick. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. This is likely normal appearance, given the chronic steroid administration in this patient.

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 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. A 0.90 cm, hyperechoic curvilinear foci with strong acoustic shadowing is noted, consistent with a cholecystolith.

Gastrointestinal

Gastric fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present. The stomach is empty.

The visible small intestines are normal in wall thickness. Normal layering is maintained except for that the muscularis is mildly thicker than expected relative to the mucosal layer. 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.

PRIMARY FINDINGS

- 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.
- Gastritis – Microulceration cannot be ruled out.
- 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.
- Cholecystolith

SECONDARY FINDINGS

- Urinary bladder sediment – Urine changes are most consistent with incidental suspended lipid in a cat, however, cellular debris or crystalluria cannot be ruled out and should be interpreted in combination with urinalysis results. Overall, this study is similar in appearance to the previous exam except for the new presence of a cholecystolith of unknown clinical significance. Given the lack of progression in liver changes and/or stomach wall changes combined with the reported previous medical management of gastritis, these changes may be normal variants for this patient and are secondary to chronic medical management (i.e., steroids of presumed inflammatory bowel disease)

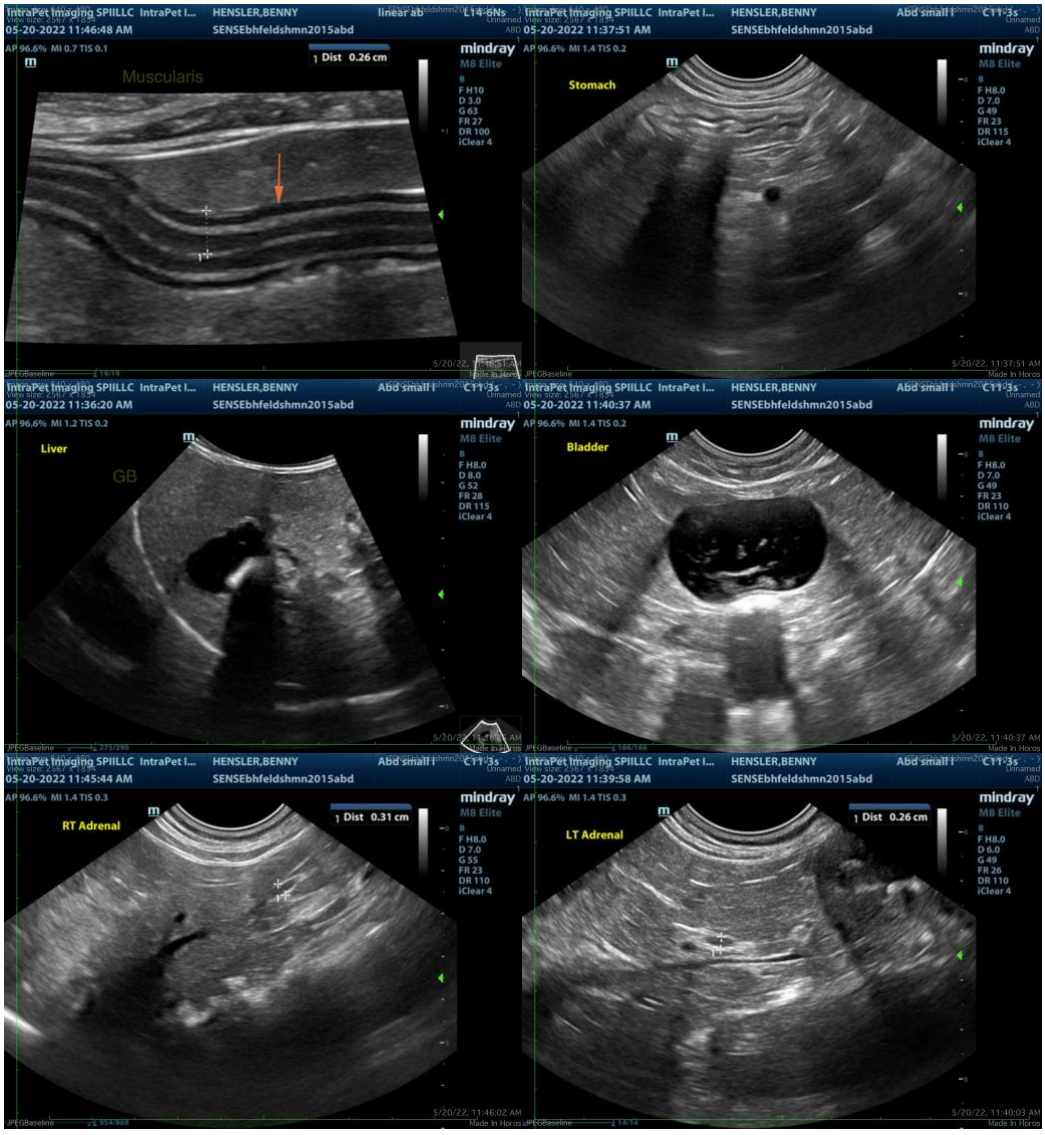
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

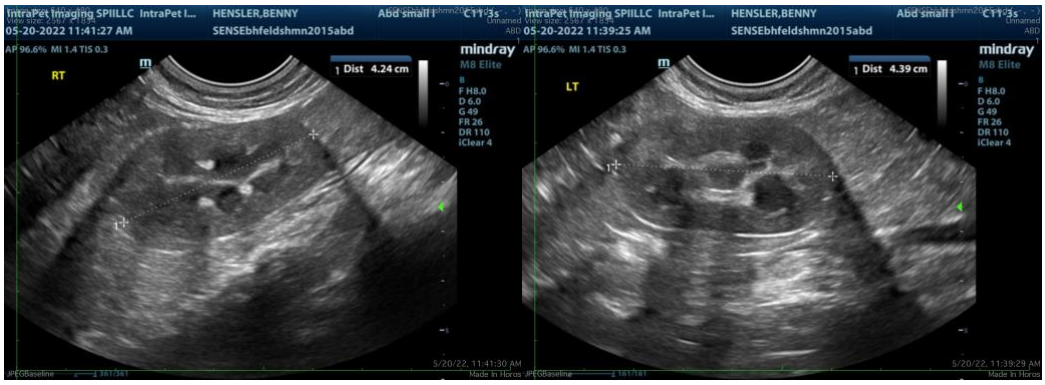
Recommendations include complete laboratory assessment with a CBC/Chem panel, electrolytes, urinalysis, as well as a urine culture if indicated based on urinalysis results with special attention paid to liver enzymes and/or bilirubin to further assess the gallbladder and liver, given the new presence of a cholecystolith.

Gastrointestinal malabsorption panel including TLI, PLI, folate and cobalamin is also recommended to Texas A&M GI laboratory if not recently evaluated. Ultimately, if this patient's clinical signs persist, biopsies of the

gastrointestinal tract, being sure to include ileum if possible, are recommend with concurrent removal of the cholecystolith, especially if there are clinical signs such as cranial abdominal pain that indicate the gallstone is having a clinical effect and may be contributing to the patient's intermittent decreased appetite.

If biopsies are not a possibility, and clinical signs persist, more aggressive management of the previously presumed inflammatory bowel disease could be considered with the addition of chlorambucil. However, given the patient's young age, obtaining a definitive diagnosis is strongly recommended over increasing empirical management to the level of adding chlorambucil.





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.

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