



PATIENT PRESENTING CLINICAL SIGNS

PATIENT Gracie DiSante **History:** Several month hx of waxing/waning, lethargy, hiding more, hyporexia, and occasional vomiting. Weight loss of 1.5 lbs since 3/31/22. Treated for UTI in 3/22 with convenia but no improvement. Uncomfortable in mid abdomen on palpation.

SPECIES

Feline

Abnormal PE/Chem/CBC/UA Results: 3/31/22 no significant findings other than bacteria in urine, no rads taken. Mirataz to stimulate appetite.

BREED

DSH

SEX

FS

AGE

13

WEIGHT

9.8

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Jessica Green

HOSPITAL NAME

Stanglein Veterinary
Clinic

REFERRING VET

Dr. DiNello-Schleicher

INVOICE

10859ag

DATE

06/20/2022

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.

Right kidney is normal in size (3.91 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.

Left kidney is normal in size (3.57 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A small chronic infarct in the cranial pole was noted. There is no evidence of pyelectasia or mineral observed.

Adrenal Glands

Right adrenal gland is normal in size (0.37 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Left adrenal gland is normal in size (0.21 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

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 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. Focal nodules of mixed echogenicity, primarily hyperechoic in echogenicity but containing multiple cysts of varying size. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is very small 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. Normal ingesta is possible but is considered less likely.



PATIENT

Gracie DiSante

The visible small intestines are normal in wall thickness and layering (duodenum < 0.4 cm). 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

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.

BREED

DSH

Free Abdomen

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

SEX

FS

ULTRASONOGRAPHIC FINDINGS

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- Gastric hairball-similar density soft foreign material or ingesta cannot be ruled out.
- 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.
- Urinary 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.
- Chronic infarct cranial pole of the left kidney

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DACVIM

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the history of bacteria in the urine and no response to Convenia, a follow up urine C/S a week following any antibiotics in her system is recommended to rule out an infection.

IMAGING PERFORMED BY

Jessica Green

Given the weight loss, 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.

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T4 and FT4 are recommended if not recently evaluated.

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Following further investigation of the possible UTI as a contributing factor to this patient's illness, and supportive medical management of GI signs, if vomiting/anorexia persist, recheck of a fully fasted stomach is recommended to rule out the presence of an obstruction from the suspected hairball.

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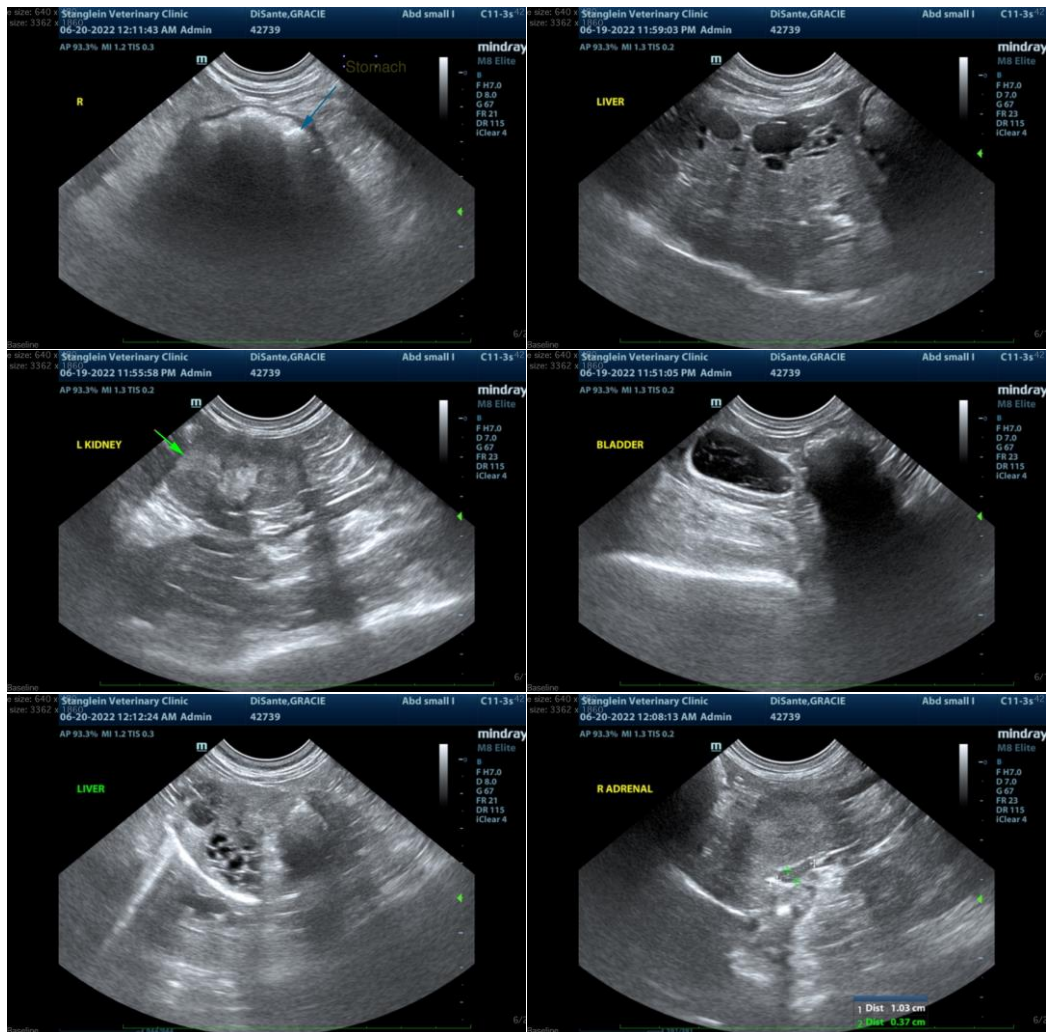
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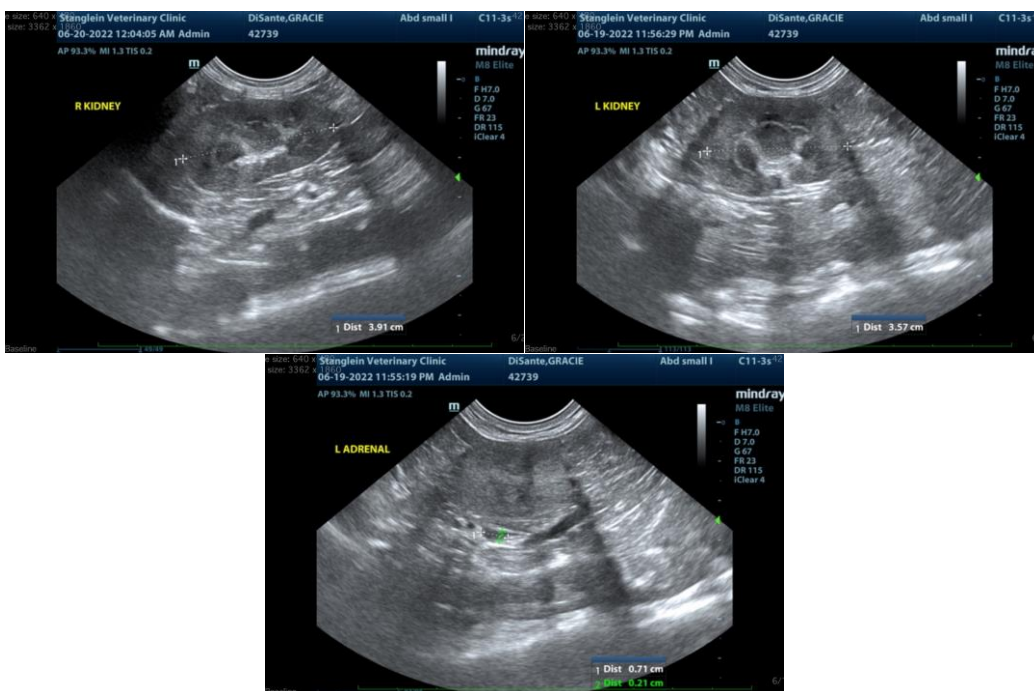
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

Beth.Johnson@SonoPath.com