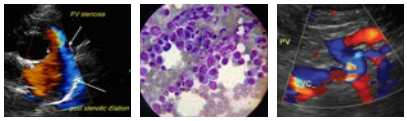
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

6/22/22

PATIENT

Jasmine Russell

SPECIES

Feline

BREED

DMH

SEX

Spayed Female

AGE

10/28/08

WEIGHT

11.14 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Paradise AH

REFERRING VET

Dr. Riehl

INVOICE

38995

PRESENTING CLINICAL SIGNS

Hx IBD; currently on budesonide 2 mg SID. Hx early hyperT4--recent increase from 2.5 mg SID to 2.5 mg BID. Presented on 6/18 for new intermittent cough. Slight jaundice noted on PE. Harsh lung sounds. Rads of chest mild bronchointerstial pattern. ALT--Marked elevation (3015 after dilution), ALP=890, GGT=9, Tibili 1.1, Bands, thrombocytopenia (78k)

Current Medications: Felimazole: 2.5 mg BID, Gabapentin (50 mg): 1/2 PO q 12 hr , 1/4 cyproheptadine, budesonide 2 mg SID, cerenia 6 mg/day, SQF 75 mL EOD, Adequan every other week, B12 every other week, Started veraflox 7.5 mg/kg/day
Date of Previous IntraPet Ultrasound: 2/3/21. See attached.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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 in size (4.0 cm) and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased echogenicity and mild loss of corticomedullary distinction. Minor pyelectasia is noted. There is no evidence of mineral or infarcts observed.

The left kidney is normal in size (3.6 cm) and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased echogenicity and mild loss of corticomedullary distinction. Minor pyelectasia is noted. There is no evidence of mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.30 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.30 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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 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.

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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 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.

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

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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

- Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

SECONDARY FINDINGS

- Age related renal changes with mild bilateral pyelectasia
- Age related pancreatic remodeling

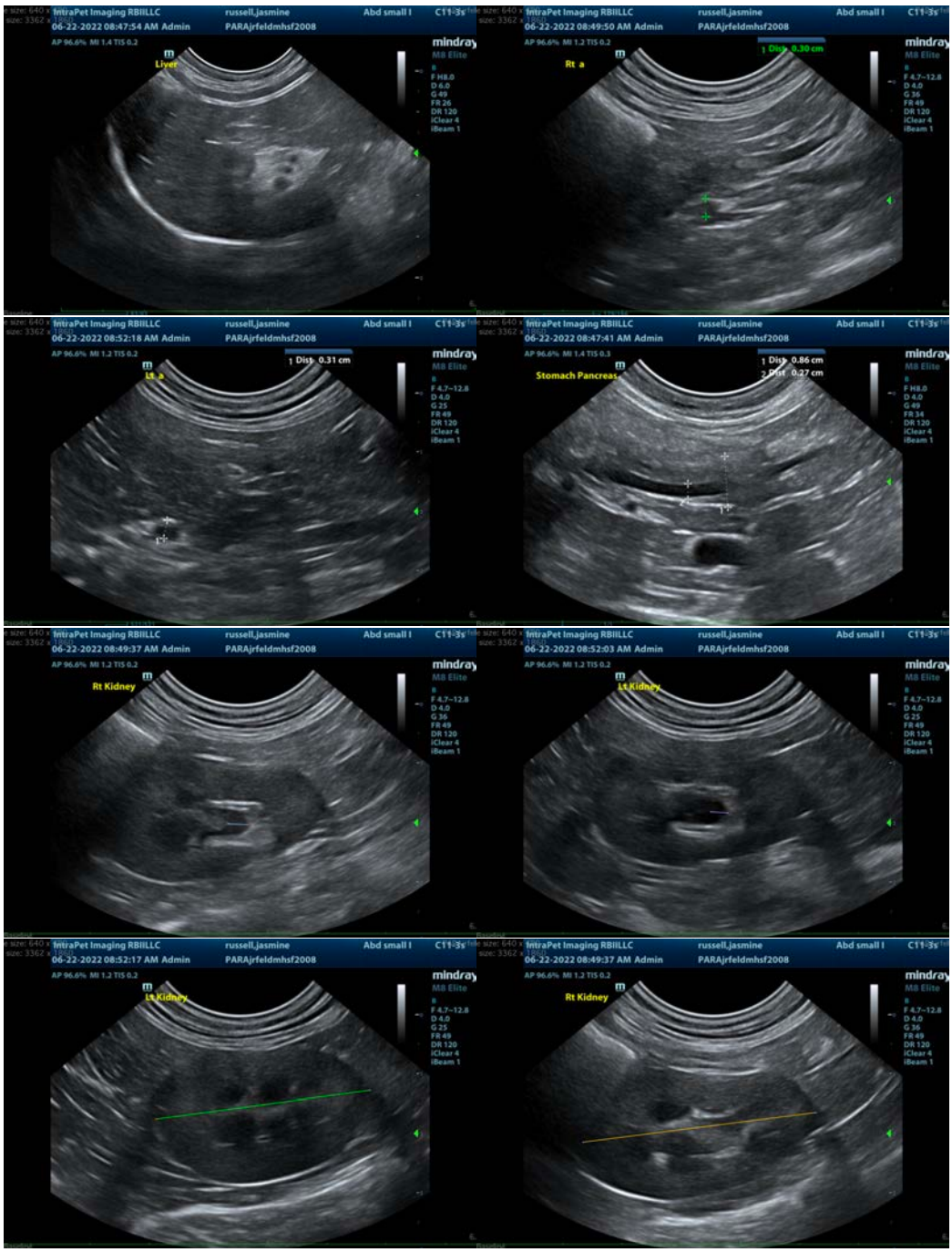
**Infiltrative gastrointestinal disease could be visually masked by the treatment with steroids.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's history and the appearance of the liver, top differential is an acute flare up of chronic cholangiohepatitis/Triaditis, possibly brought on by an ascending bacterial infection secondary to the chronic reported inflammatory bowel disease. Other differentials, while much more rare, include the recent increase in Methimazole. However, liver toxicity is a very uncommon presentation from Methimazole intolerance.

A fine needle aspirate of the liver is recommended if patient's coagulation status is appropriate to further evaluate possible infiltrative round cell neoplasia.

In the meantime, medical management is recommended with IV fluids, nutraceutical, hepatoprotectants, antiemetics, appetite stimulants (if needed), and broad-spectrum antibiotics. If medical management of cholangiohepatitis does not result in improvement of the ALT, then consideration could be given to Methimazole intolerance, and a trial off of Methimazole could be considered.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C11-3s
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Liver
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Rt a
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C11-3s
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Abd small I
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Stomach Pancreas
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Dist 0.27 cm
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Abd small I
C11-3s
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Rt Kidney
IntraPet Imaging RBIILLC
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Rt Kidney
mindray
M8 Elite

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
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