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SVS Mobile Imaging MI 734-637-7711
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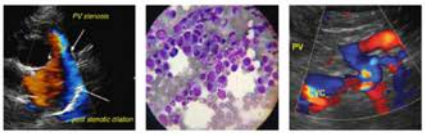

SonoPath
Clinical Sonography & Telecytology
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PATIENT
Theo Dawson

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
8 Years

WEIGHT
12 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Cat Care of Rochester Hills

INVOICE
39150

DATE
6/30/22

PRESENTING CLINICAL SIGNS

Waning appetite for ~ 1 month, periodic vomiting, not quite as active
Abnormal PE/Chem/CBC/UA Results: Weight loss of ~ 3# in last 3ish years. See attached labs Just started on Orbax, Miratraz, Zofran, and Cobalequin this week

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 kidneys are normal in size (left measures 4.19 cm, right measures 4.27 cm) with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. Infiltrative disease cannot be ruled out but is considered less likely with a normal size kidney.

Adrenal Glands

The right adrenal gland is normal in size (0.38 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively enlarged in size with rounded margins but intact capsule. Parenchyma is homogenously coarse/mottled in echotexture and normal to hypoechoic in echogenicity. 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 moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. The common bile duct is mildly tortuous but not overly distended. There is no evidence of effusion or inflammation.

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 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 empty with no obstruction or foreign material. A focal, slightly asymmetric thickening of the duodenum measures 0.55 cm in diameter.

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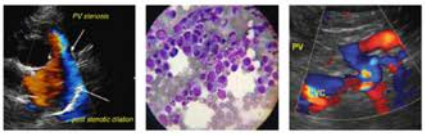

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

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

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

No appreciable free fluid noted in these images.

PRIMARY FINDINGS

- Inflammatory bowel disease (IBD) pattern - This finding has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. The focal asymmetric duodenal thickening could be secondary edema, duodenitis related to suspected cholangiohepatitis/Triaditis. However, emerging neoplasia such as lymphoma can't be ruled out.
- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- 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.

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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the hepatobiliary changes and the GI changes, cholangiohepatitis/Triaditis is a consideration. However, infiltrative neoplasia such as lymphoma cannot be ruled out. Therefore, if further diagnostics are elected, a fine needle aspirate of the spleen and liver is recommended, if patient's coagulation status is appropriate. If a diagnosis is not obtained cytologically from the aspirates, ideally biopsies of the GI tract, being sure to include the focal duodenal thickening, as well as the ileum, if possible, are recommended to definitively diagnosis and therefore manage the suspected infiltrative bowel disease.
- 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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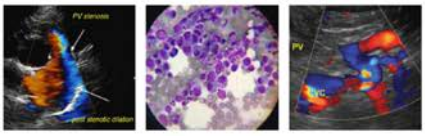

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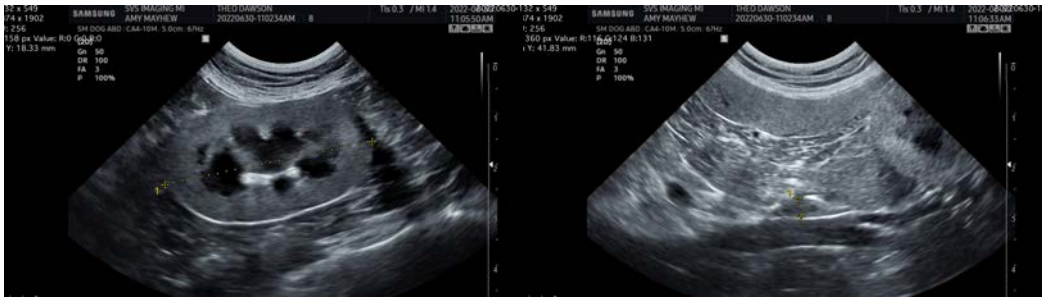
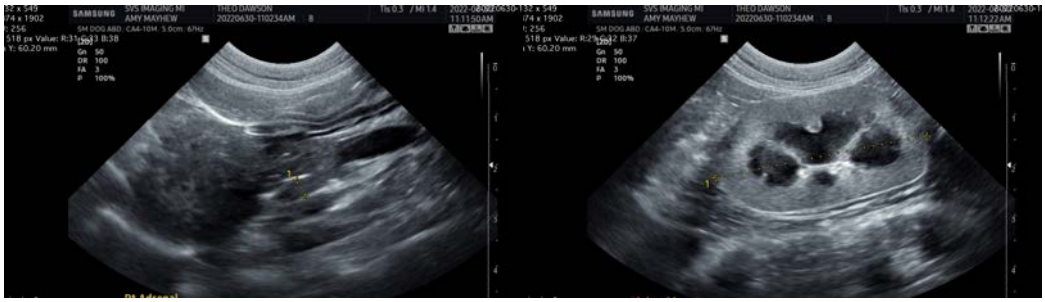
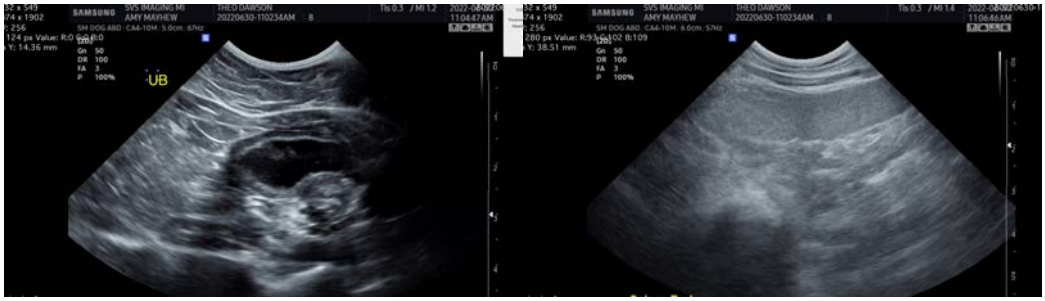
- Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.
- If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Other supportive therapeutic considerations could include fiber supplementation, especially with large bowel diarrhea and/or a probiotic.
- 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 ration is recommended.
- If a less aggressive approach is elected first, medical management of suspected cholangiohepatitis/inflammatory hepatopathy is recommended with supportive care of clinical signs in addition to broad-spectrum antibiotics and hepatic nutraceuticals with monitoring of clinical signs and laboratory values for improvement.







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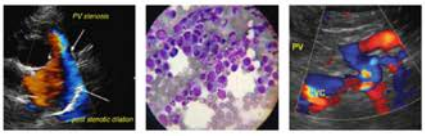

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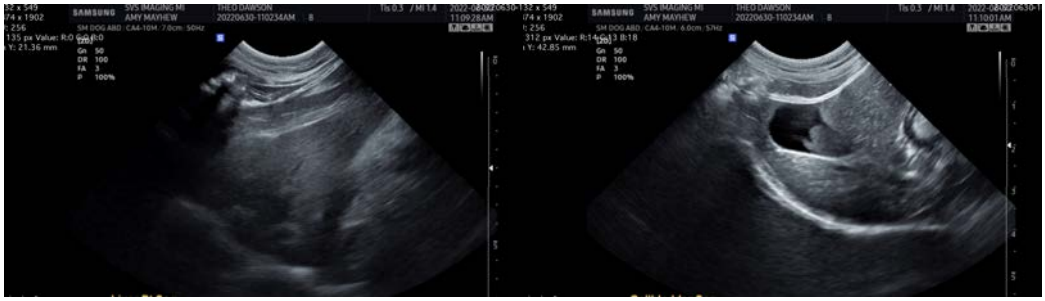

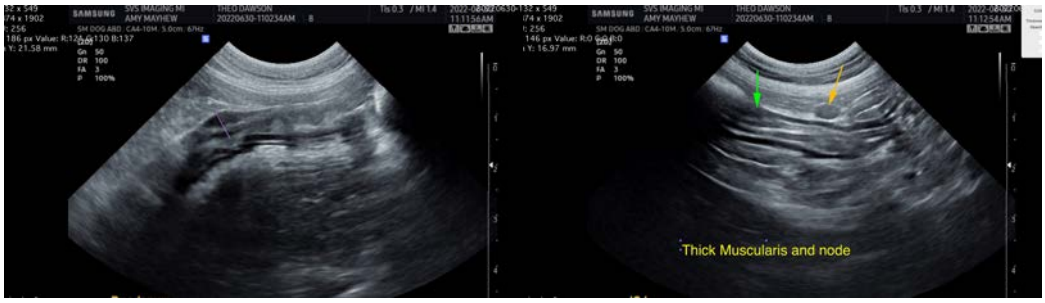

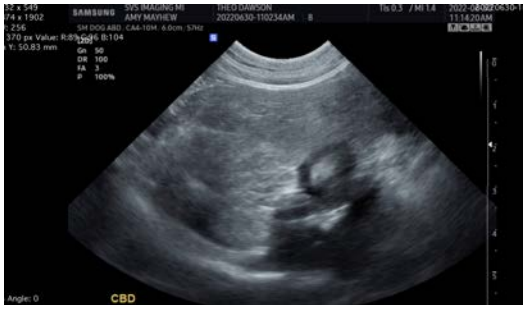

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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