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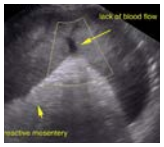
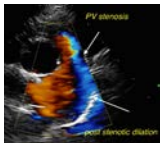
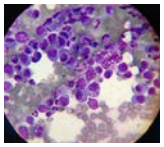
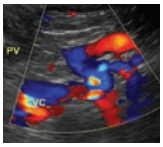

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1-800-838-4268 info@sonopath.com

PATIENT

Molly Short

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

15 Years 8 Months

WEIGHT

2.6 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Ave Vet Clinic

REFERRING VET

Dr. Jessie Evoniuk

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7/20/23

PRESENTING CLINICAL SIGNS

Had been gaining weight well for awhile but now is not Has recently been really picky about eating O thinks P has lost weight Is now very lethargic Started about 1mo ago O tried switching foods Did V+ this morning V+ every so often No D+ but not defecating much When O switches food P will eat well for a few days then stop Meds- Lantus 1/2U BID O has been checking BG at home, O had stopped giving insulin for awhile since P didn't seem to need it, stopped giving insulin for about a month, started again about 1mo ago O unsure exactly what BG readings have been PE Notes: General Appearance: weaker, BCS 3/9, lost weight from prev vet visit CRT/MM: WNL Eyes: iris changes consistent with the age, no ocular discharge Ears: No exudate observed, no redness present Oral Cavity: Minimal tarter/gingivitis; Grade Nasal Cavity: No nasal drainage, nares WNL Cardiovascular: Regular rhythm; no murmur detected Respiratory: Lungs auscultate clear bilaterally; trachea clear Abdomen: vocal and uncomfortable upon abdominal palpation Rectal: Did not perform rectal exam Musculoskeletal: Normal ambulation/no lameness reported, lost muscle mass Integument: more unkempt appearance Lymph Nodes: Lymph nodes normal in size Urogenital: External genitalia appears normal Neurologic: No apparent abnormalities noted normal T4

Abnormal PE/Chem/CBC/UA Results: Chronic weight loss, diabetes mellitus SDMA 15 µg/dL, AMY 1879 * U/L, BUN 38 * mg/dL, CRE 2.2 * mg/dL, ALP ALP 9 * U/L, WBC 27.83 10^9/l, NEU 24.93 10^9/l, NEU 24.93 10^9/l, HGB 9.4g/dl, RBC 7.21 10^12/l

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended. Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no mineral observed. Pyelectasia is noted bilaterally, 0.20 cm in the sagittal view in the left kidney and 0.69 cm in the sagittal view in the right kidney. The left kidney measures 3.63 cm. The right kidney measures 3.48 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.55 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is unable to be well visualized in these images.

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.

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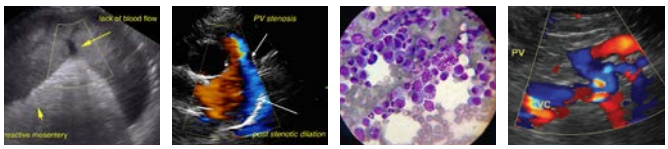

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Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. 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 and falciform fat. Non-obstructive multifocal intrahepatic biliary mineral is noted. 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 fluid, as well as echogenic nonshadowing luminal contents and gas consistent with normal ingesta/chyme. 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 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

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat is noted. A trace amount of anechoic free fluid is noted adjacent to the pancreas.

Free Abdomen

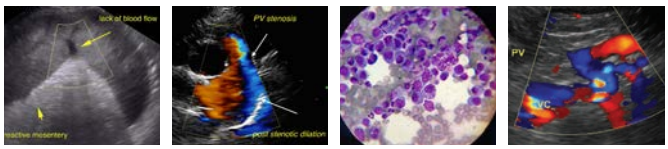
There is a trace amount of anechoic free fluid in the cranial abdomen, as described above.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Acute pancreatitis or potentially acute on chronic smoldering pancreatitis suspected on top of 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 aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible. The intrahepatic biliary mineral is likely an incidental and non-clinically significant finding and should be interpreted in combination with clinical signs



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and/or laboratory changes that suggest otherwise.

- Chronic Kidney Disease with bilateral pyelectasia – This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.. The pyelectasia is much more prominent in the right kidney versus the left. Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

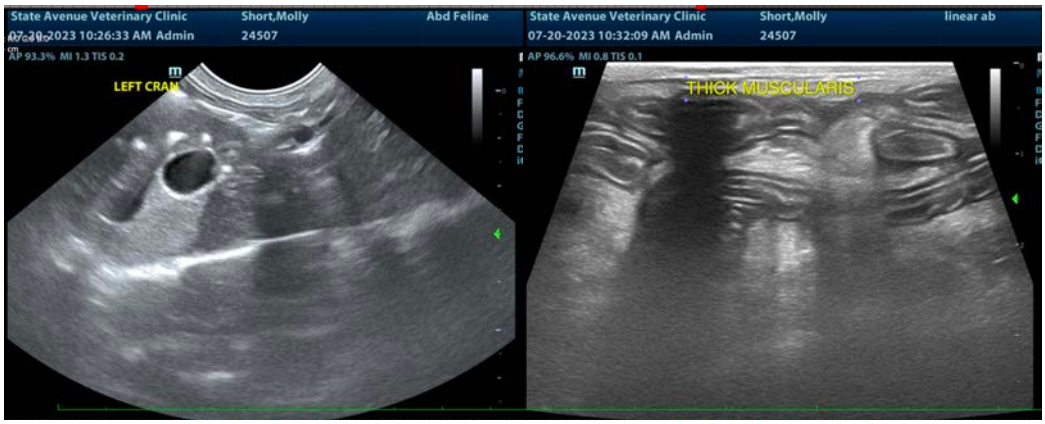
If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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.

Ultimately, tissue sampling may be necessary to obtain a definitive diagnosis and help better manage this patient's reported gastrointestinal signs, and could be considered in the form of potentially a fine needle aspirate of the liver patient's coagulation status is appropriate, or ultimately biopsies of the GI tract, being sure to include ileum if possible.

However, if more invasive diagnostics are not elected, then in addition to addressing any urinary abnormalities such as concurrent infections, pyelonephritis, etc. based on urinalysis results and managing the historical diabetes, etc., therapeutic recommendations include supportive/symptomatic medical management of gastrointestinal signs, pancreatitis, etc. in the form of antiemetics, gastroprotectants, appetite stimulants, or nutritional support as needed, pain management if clinically indicated, broad-spectrum antibiotics, fluid therapy, etc.

Additionally, empirical deworming with a 5-day course of Panacur is recommended, as is cobalamin supplementation unless not warranted based on malabsorption panel results.



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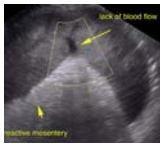
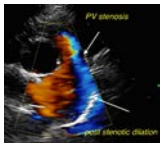
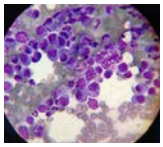
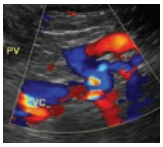

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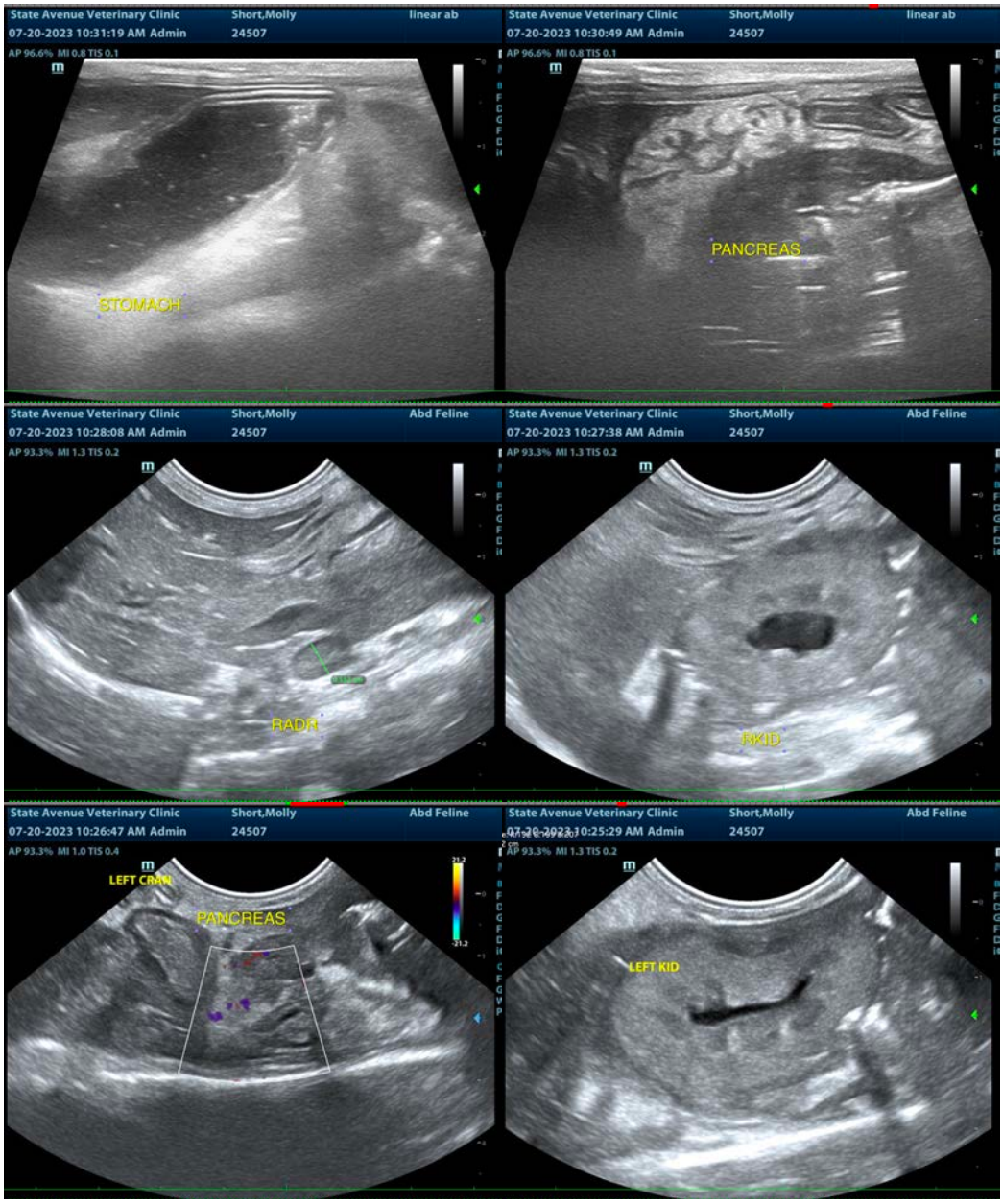

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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