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Clinical Sonography & Telecytology
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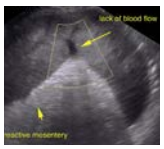
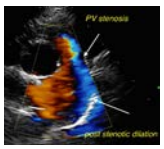
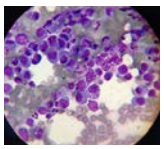
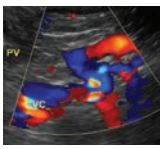

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1-800-838-4268 info@sonopath.com

PATIENT

Jax Rothwell

SPECIES

Feline

BREED

Bengal

SEX

Neutered Male

AGE

6 Years

WEIGHT

10 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Christina Sitton

HOSPITAL NAME

Sherwood Family PC

REFERRING VET

Dr. Christina Sitton

INVOICE

39948

DATE

7/29/22

PRESENTING CLINICAL SIGNS

ADR, inappetence, weight loss
Abnormal PE/Chem/CBC/UA Results: GLUCOSE (blood) 187 mg/dL 72 - 175 CREA 0.9 mg/dL 0.9 - 2.3 BUN/UREA 8 mg/dL 16 - 37 PHOS 2.7 mg/dL 2.9 - 6.3 Chloride 113 mmol/L 114 - 126 TP 6.1 g/dL 6.3 - 8.8 ALT 182 U/L 27 - 158 AST 91 U/L 16 - 67 ALKP 117 U/L 12 - 59 GGT 3 U/L 0 - 6 TBIL 5.6 mg/dL 0.0 - 0.3 IBIL 2.3 mg/dL 0.0 - 0.2 DBIL 3.3 mg/dL 0.0 - 0.2 CHOL 35 mg/dL 91 - 305 AMYL 282 U/L 623 - 2239 UA SP GRAVITY 1.034 GLU (urine) 2+ BILIRUBIN 3+ KETONES TRACE BLOOD 3+ PH 6.0 PROTEIN 2+ CRYSTALS OCCASIONAL BILIRUBIN (0-1)/HPF SPEC fPL 7.7 ug/L 0.0 - 3.5 rest of chem/cbc wnl

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.

The right kidney is normal in size (4.3 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 (4.3 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 areas of both adrenal glands are examined without evident pathology.

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 (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. 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.

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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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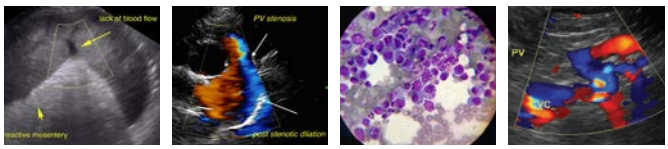

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The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine 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 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 free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS

- **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.

SECONDARY FINDINGS

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The top differential for this patient's cholestasis appears to be intrahepatic cholestasis, likely secondary to hepatic lipidosis versus other infiltrative hepatopathy. There is no evidence of post-hepatic cholestasis and no reported anemia to support pre-hepatic.

Therefore, recommendations include a fine needle aspirate of the liver, if patient's coagulation status is appropriate, followed by fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad spectrum antibiotics. Nutritional support is critical in the management of hepatic lipidosis, so appetite stimulants and/or, if necessary, feeding tube placement is also recommended.

Given the suspicion for hepatic lipidosis, supplementation with L-carnitine and taurine could be considered as well.

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.

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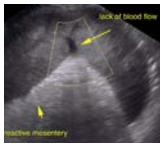
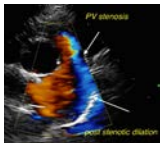
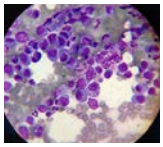
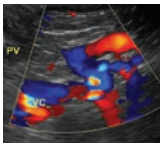

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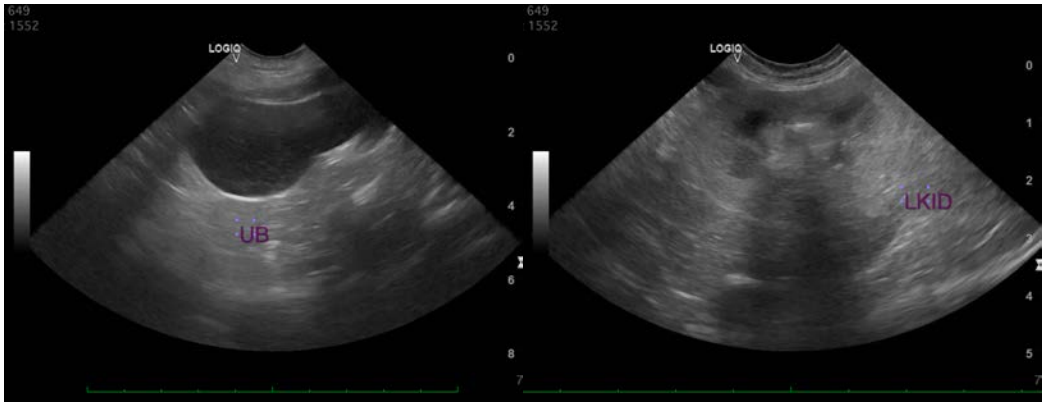

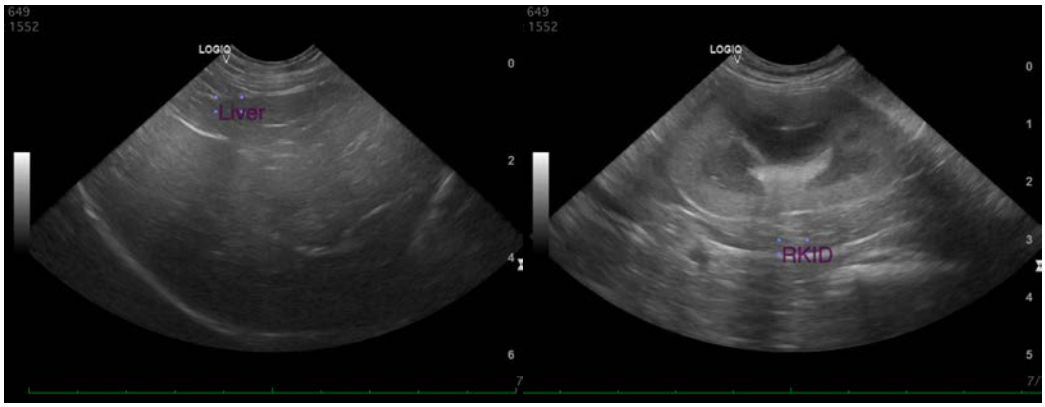

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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