



PATIENT

Thor Latham

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

7.4 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Jack Reese

HOSPITAL NAME

Willow Run VC

REFERRING VET

Dr. Jessica Latham

INVOICE

39273

DATE

7/6/22

PRESENTING CLINICAL SIGNS

Several day history of decreased appetite and vomiting episodes. Gradual weight loss over last year. Abnormal PE/Chem/CBC/UA Results: WBC 25.05 (2.87 - 17.02 K/ μ L) Neutrophils 13.36 (2.30 - 10.29 K/ μ L) Lymphocytes 10.81 (0.92 - 6.88 K/ μ L) Phosphorus 3.0 (3.1 - 7.5 mg/dL)

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 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. There is no evidence of pyelectasia, mineral or infarcts observed.

The left 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. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.35 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 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 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. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is mildly distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. It has an incidental anatomical variant bilobed appearance. The cystic and common bile duct are mildly but not pathological dilated and tortuous, which can be a common aging change and should be interpreted in combination with clinical signs such as abdominal pain and/or laboratory changes such as increased liver enzymes.

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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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.

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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

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The pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Pancreatic duct dilation is noted.

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Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

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

PRIMARY FINDINGS

- 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.

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- Chronic active pancreatitis
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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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.

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- Age related kidney change – This finding is expected/consistent with age-related mild degenerative disease and should be interpreted clinically in combination with laboratory changes.

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- Anatomical variant of bilobed gallbladder with an age related variant of a cystic, mildly but not pathologically distended duct.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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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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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.



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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.

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If cranial abdominal pain is present and/or liver enzymes indicate inflammatory process in the hepatobiliary tract, cholangitis or cholangiohepatitis could be considered in addition to the suspected inflammatory bowel disease, in which case empirical antibiotics +/- hepatic nutraceuticals such as Ursodiol could be considered. Otherwise, this is likely a normal anatomic variant and should be monitored.

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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.

AGE

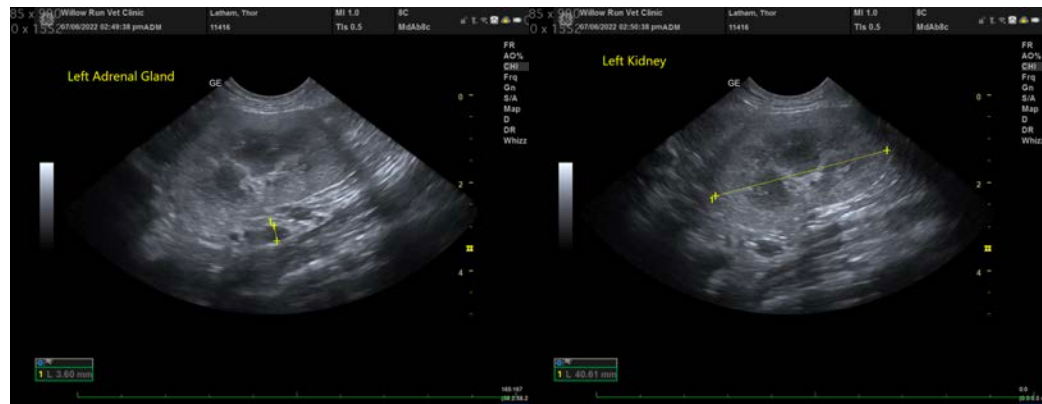
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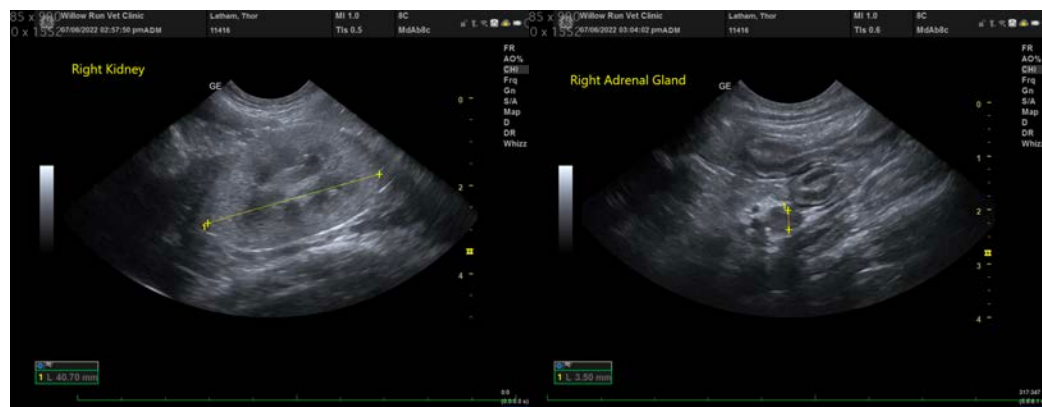


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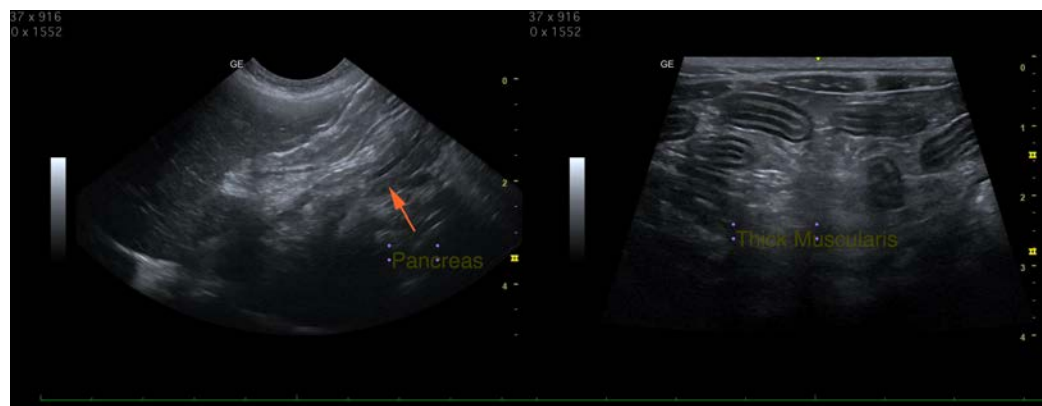
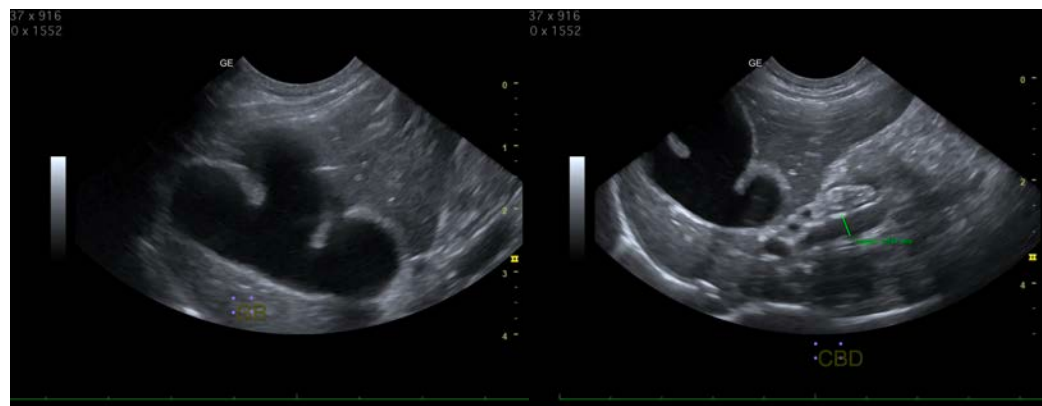
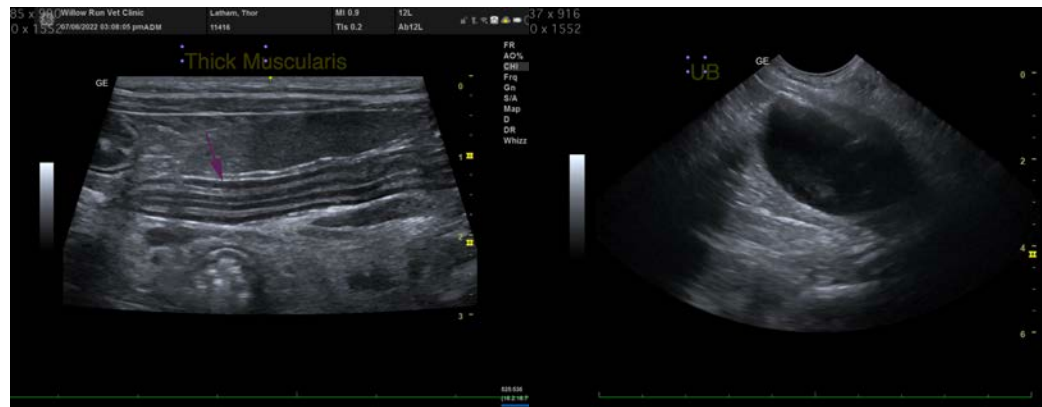
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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