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SVS Mobile Imaging CT 262 - 366 - 5970
fredgromalak@gmail.com

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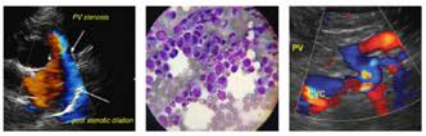

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Clinical Sonography & Telecytology
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PATIENT

Chloe Rawson 276149

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years 1 Month

WEIGHT

2.9 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC – Dr. Schulz

INVOICE

40594

DATE

8/18/22

PRESENTING CLINICAL SIGNS

Weight loss, decreased kibble intake, electrolyte abnormalities noted on bloodwork. Previous US at primary clinic raised concern for mass effect in the stomach. No V/D reported, normal appetite. Abnormal PE/Chem/CBC/UA Results: Hypokalemia 2.8, hypophosphatemia 2.9, hypocholesterolemia 57

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.

Kidneys are bilaterally small, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney measured 3.02 cm. The right kidney measured 3.03 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.43 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.35 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

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. A small 0.20 cm hyperechoic nodule is noted in the mid liver. 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 stomach is moderately to markedly overdistended with echogenic, non-shadowing luminal contents as well as gas, consistent with normal ingesta. There are occasional views with an echogenic curvilinear interface and stronger acoustic shadowing expected for typical gas that could be consistent with foreign material. However, most views are more consistent with normal gas and ingesta, and despite the distention, an obstruction/foreign material is considered much less likely. The 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.

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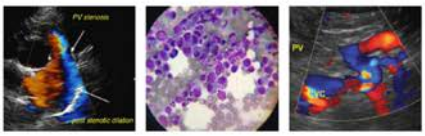

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The 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.

Free Abdomen

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

The mesenteric and ileocolic 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.

ULTRASONOGRAPHIC FINDINGS

- Acute pancreatitis suspected
- The gastric changes are most consistent with mild gastritis/ileus, likely secondary to pancreatitis. Foreign material and partial delayed gastric emptying cannot be definitively ruled out but is considered much less likely based on the majority of the images.
- **Reactive mesenteric and ileocolic lymph nodes –** infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- **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.
- **Chronic Kidney Disease –** This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's reported weight loss despite a reportedly normal appetite combined with the pancreatic changes noted here, recommendations include a T4, if not recently evaluated, as well as a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory.

In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support (including a feeding tube) as needed, pain management, broad spectrum antibiotics, and fluid therapy with electrolyte correction is recommended.

Finally, if patient's clinical signs persist and/or progress to include vomiting, recheck imaging of a fasted stomach is recommended. If the stomach is still fluid distended, gastric suction via a nasogastric tube could be considered for both patient comfort as well as recheck imaging.

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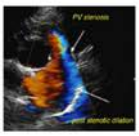
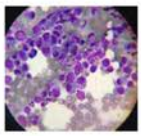
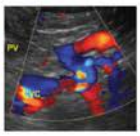

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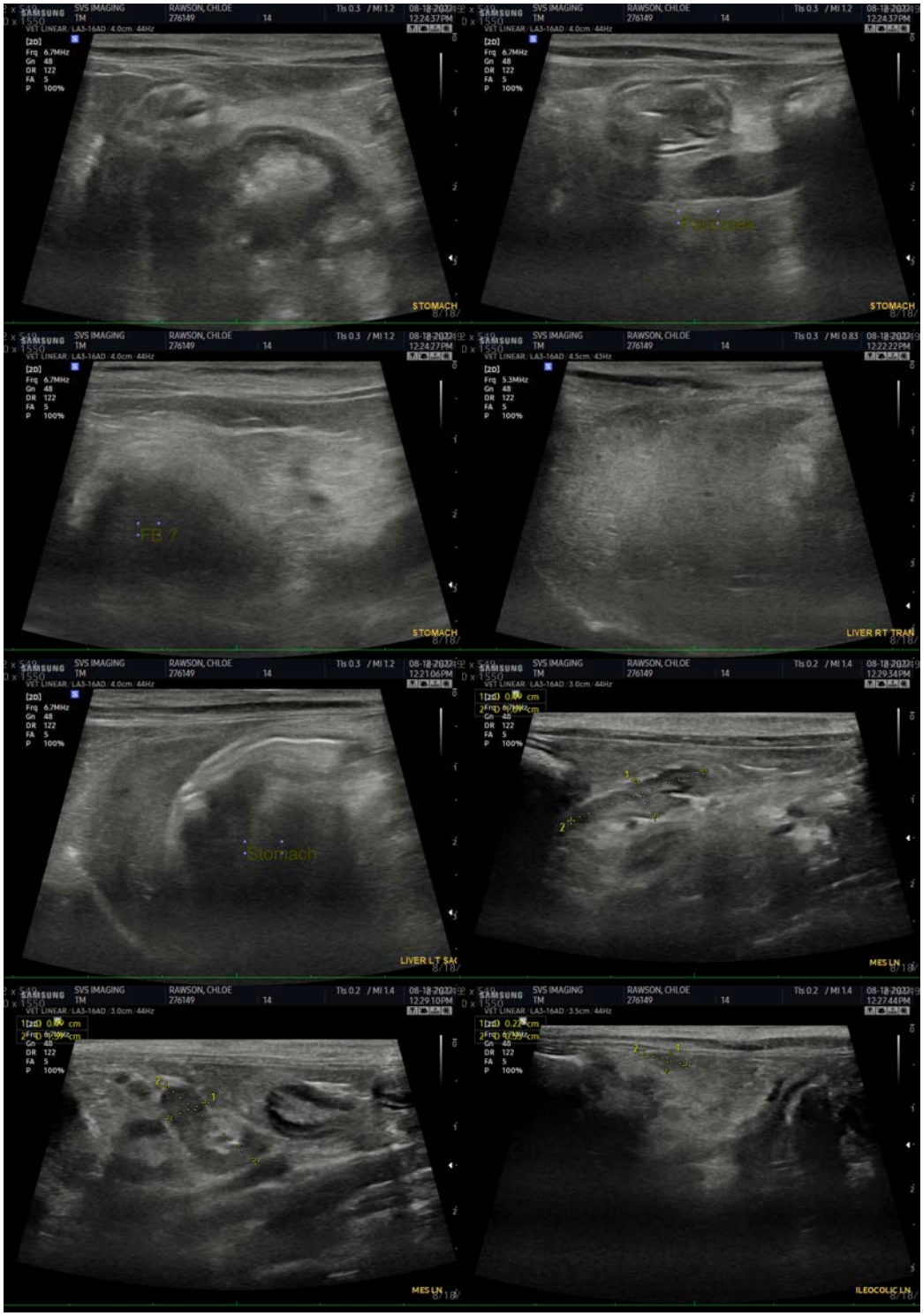

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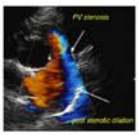
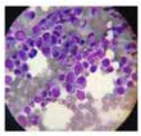
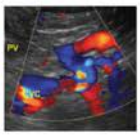

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com