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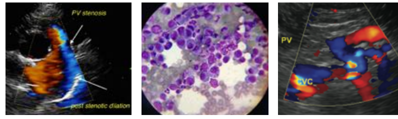

SonoPath
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DATE
8/8/22

PATIENT
Mojo Bohlen

SPECIES
Feline

BREED
Ragdoll

SEX
Neutered male

AGE
2/14/05

WEIGHT
13.9 lbs

INTERPRETED BY
Beth Johnson, DVM DACVIM

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Willer

INVOICE
32204

PRESENTING CLINICAL SIGNS

Referral for vomiting and suspected pancreatitis mild elevation in ALT- 186; T.bil- 1.8 continued to vomit after eating at Dr. Sinclair despite getting maropitant, ondanestron seen last week (Thursday) for a swelling on the head- suspect abscess- started on clindamycin and gabapentin had been doing well; last night- ate a small amount and then vomited- then was hiding and did not continued to eat; this morning- still not eating; took to Dr. Sinclair- bloodwork- elevation in ALT and t.bil; x-rays no obvious FB; SQ fluids and cerenia- waited a couple of hours- offer treats- vomited soon after; gave a dose of ondanestron- waited again- vomited again after eat a couple of treats abscess was clip/clean and lance films repeated- stomach may have something in it; referred for continued care indoor only arthritis. PE slightly dehydrated, 3/6 murmur, painful upon palpation of abdomen.
Current Medications: Buprenorphine, Pantoprazole, Elura oral, Maropitant, Maoxicillin, Mirtazapine, Buprenorphine, Denamarin, Ampicillin, Metoclopramide
Lab Results: Attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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.

Kidneys are overall normal in size 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 cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measured 4.36 cm and the right kidney measured 4.12 cm.

Adrenal Glands

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

Right adrenal gland is normal in size (0.58 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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 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. An approximate 3.0 cm mass of mixed echogenicity, primarily hyperechoic in echogenicity, but

containing multiple cysts of varying size in the mid caudal liver. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. A dilated tortuous and cystic and common bile duct was noted measuring up to 0.61 cm dilated and tortuous. This extended all the way to the duodenal papilla.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. 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 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

A small amount of anechoic free fluid is noted throughout the abdomen and enhanced hyperechoic fat and mesentery is present primarily around the left limb and body of the pancreas.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

Moderate to severe acute pancreatitis. Dilated tortuous common bile duct and gallbladder debris is consistent with concurrent cholangitis or cholangiohepatitis creating what is commonly known as “triaditis”.

Feline biliary cystadenoma – In a senior cat, this liver lesion is most consistent with a/multiple benign biliary cystadenoma(s). Malignancy cannot be ruled out without tissue sampling, but is considered less likely.

Secondary Findings

Urinary bladder debris.

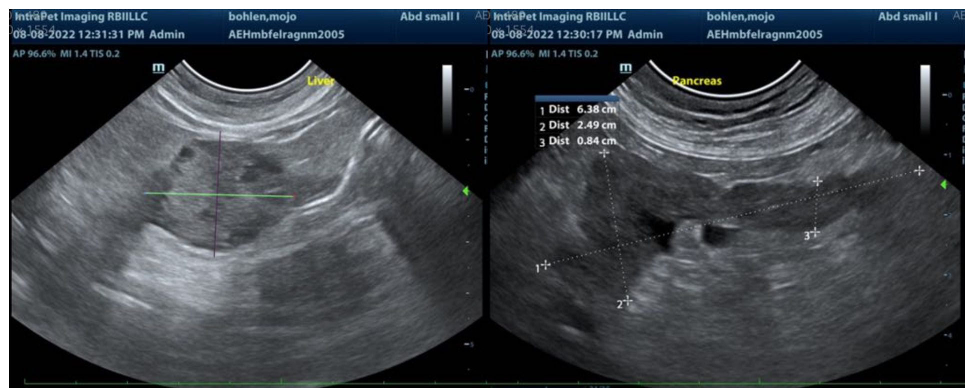
Age related renal changes.

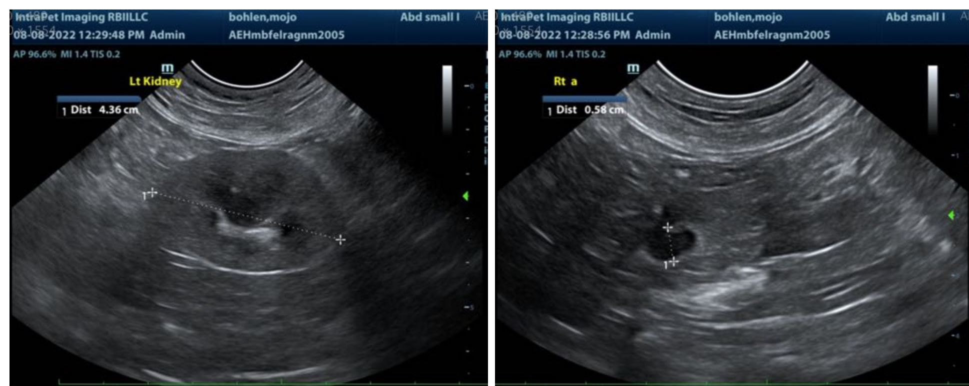
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

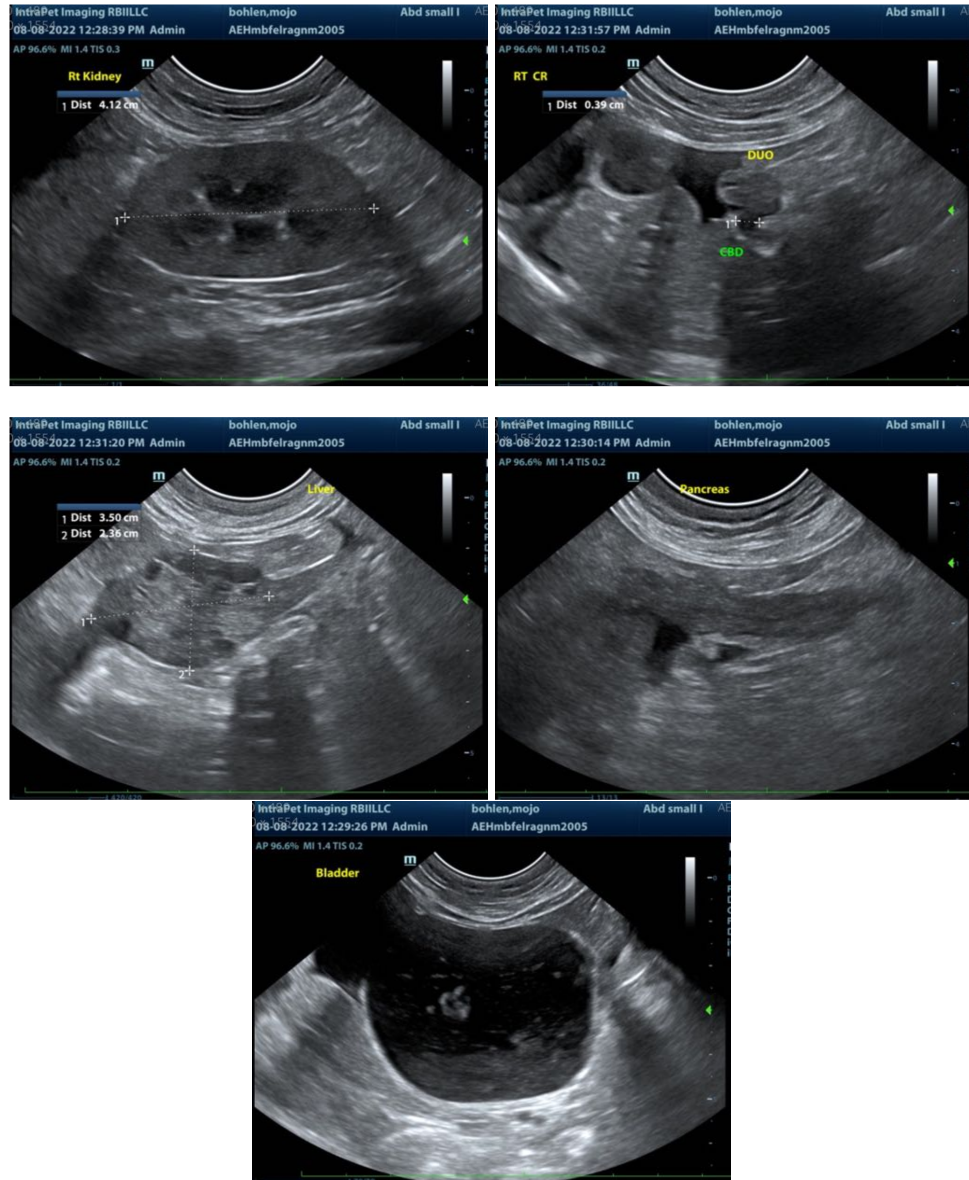
1. Quantitative PLI is recommended if not recently evaluated.

2. 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.

3. 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 is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc. If bilirubin continues to be increased and/or progresses reassessment of the biliary system is recommended for evidence of a persistent and/or progressive obstruction potentially caused by something other than the pancreatitis that could warrant surgical intervention in the future pending clinical patient response and laboratory changes, etc.







The information and recommendations provided are based on the images presented by the referring veterinarian. 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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