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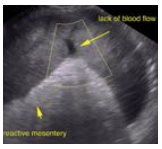
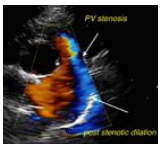
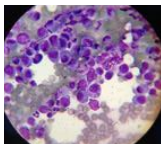
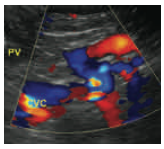
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Bauer Cheung

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
9 years

WEIGHT
4.7 kg

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Dr. Belan

HOSPITAL NAME
McKnight 24 Hr

REFERRING VET
Dr. Gruffydd

INVOICE
94923

DATE
1/3/22

PRESENTING CLINICAL SIGNS

Patient 3/6 murmur diagnosed as hyperthyroid but not on meds at this time and has tachycardia .
Vomiting and lethargic
Abnormal PE/Chem/CBC/UA Results: Polycythemic with severe elevation of T4

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The right kidney measured 4.18 cm. The left kidney measured 3.84 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 0.36 cm. The left adrenal gland measured 0.4 cm.

Spleen

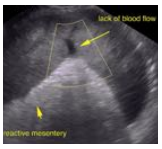
The **spleen** was folded upon itself caudally and was mildly enlarged at 1.25 cm with subtle, micronodular changes.

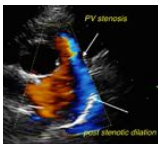
Liver

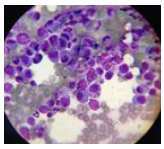
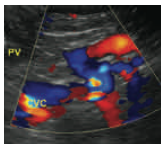
The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. A hyperechoic 1.23 cm nodule was noted in the left caudal liver. This is consistent with cystadenoma. There is a possibility of carcinoma. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal.

Gastrointestinal

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio.





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The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. No concerning lymphadenopathy was visible. No evidence of obstruction was present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as lymphoma. Full thickness tissue biopsies via open laparotomy, ideally guided by intraoperative ultrasound in order to obtain the most representative mural sample, would be necessary to rule out this possibility.

Pancreas

The left limb of the **pancreas** was hypoechoic, irregular and nodular measuring up to 0.6 cm in width.

ULTRASONOGRAPHIC FINDINGS

Variable intestinal thickening.

Left lateral liver nodule, not likely clinical.

Heterogenous pancreas. Suspect pancreatitis.

Enlarged spleen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

FNA of the left lateral liver nodule is warranted to assess cystadenoma versus carcinoma. FNA of the spleen is indicated to rule out round cell neoplasia versus splenitis or reactive hyperplasia. Treatment for inflammatory bowel/pancreatitis is warranted in the meantime. A clinical trial of the following could be considered. However, FNA of the spleen and liver is recommended prior to any cortisone treatment.

Triaditis/Pancreatitis protocol

Part or all of this protocol may be considered based on your clinical impression of the patient:

Recommend pain management when anorexic with **Buprenorphine** (0.01-0.02 mg/kg IM or SC), clinical trial of **Zithromax** (50 mg sid/cat x 10 days, 3 weeks if bartonella +), **Prednisolone** (0.5-2 mg/kg tapering over 1 week to minimal effective dose), and **B12 injections** if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet (***Hydrolyzed diets have been shown to be more effective in dietary intolerance case management compared to hypoallergenic diets***)** or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes a persistent issue then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. One diet does not work for all patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.

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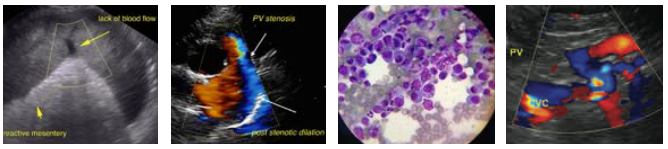

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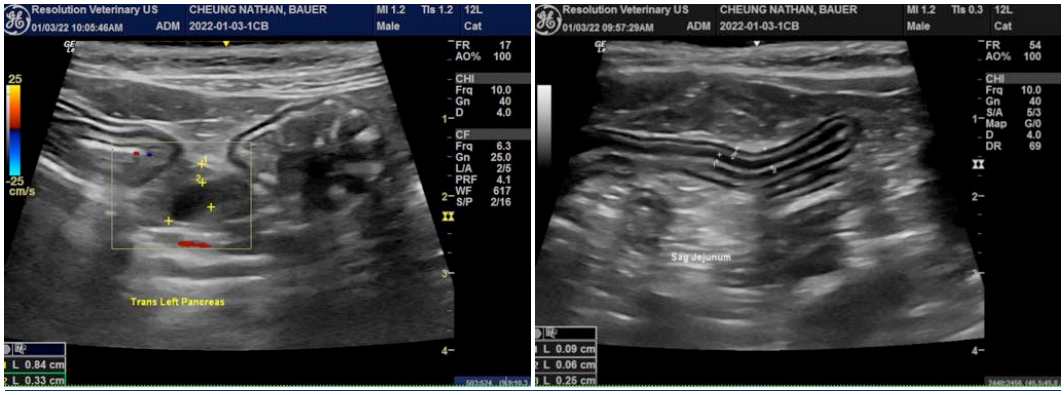

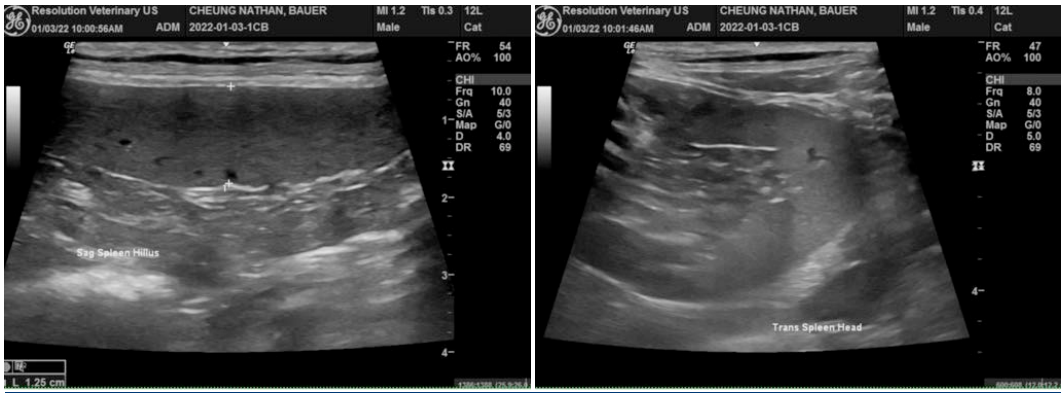

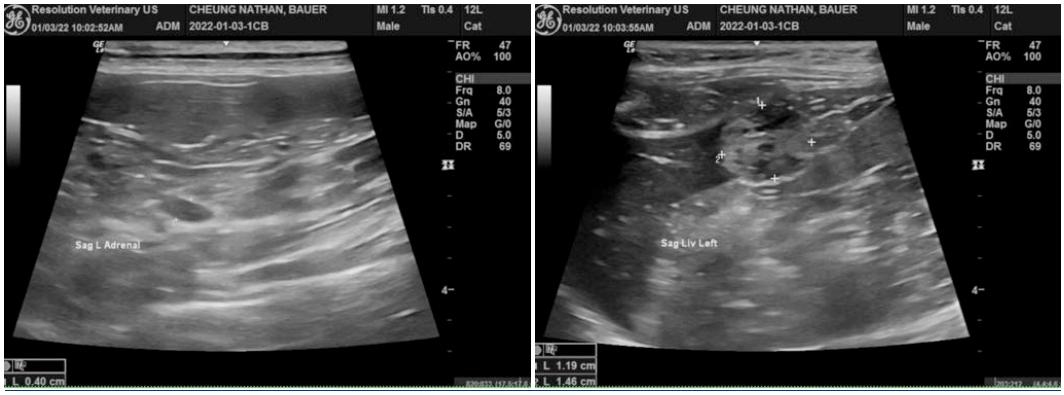

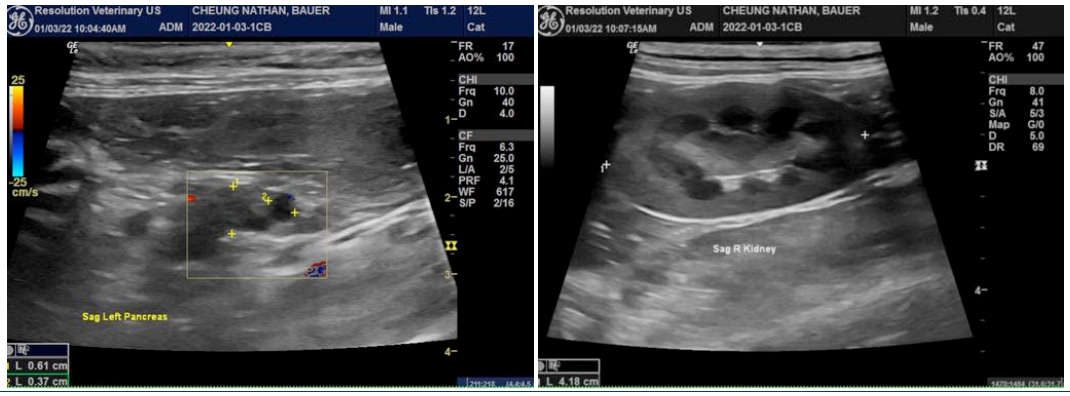

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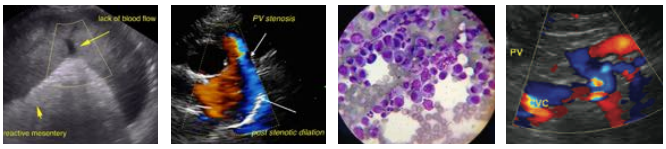

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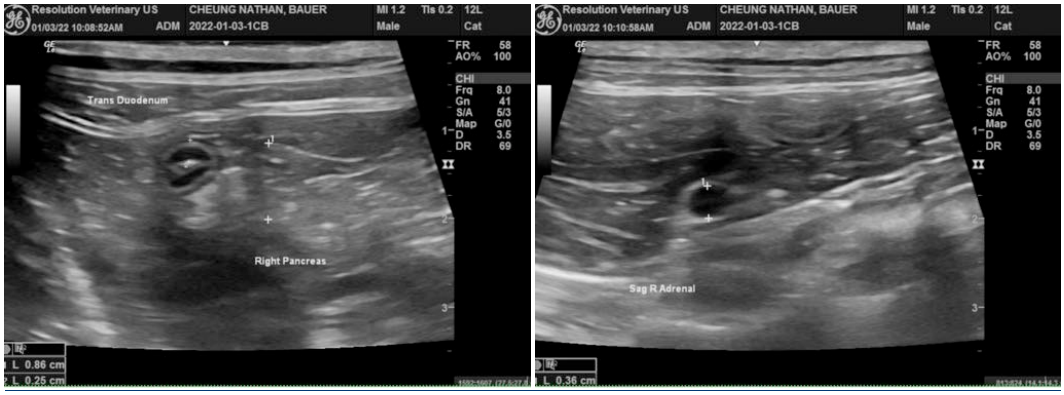

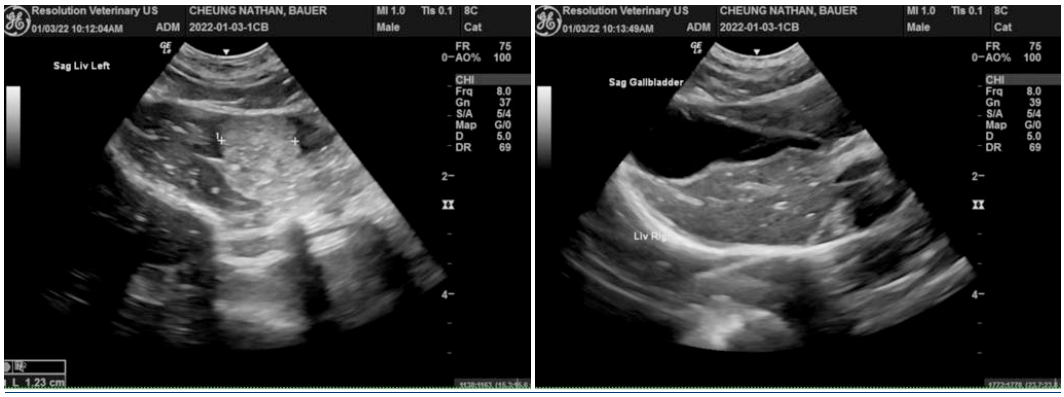

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com