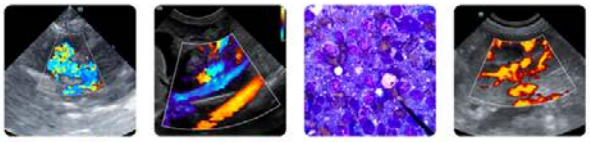

PATIENT

Pumpkin Tefft

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 Years

WEIGHT

7.2 kg

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Carlie Koltek, RVT

HOSPITAL NAME

Tuxedo Animal Hospital

REFERRING VET

Dr. Bongiorno

INVOICE

74829

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PRESENTING CLINICAL SIGNS

Inappetence, vomiting, and lethargy for 2 days. Pumpkin has a history of IBD, being managed with prednisolone as needed for flare-ups. Indoor only, no known toxin exposure. Current meds: fluoxetine, prednisolone PRN. Current tx plan: SQ fluids (0.9% NaCl), maropitant, buprenorphine, dexamethasone

Abnormal PE/Chem/CBC/UA Results: PE: T: 39C P: 140 bpm (sedated) R: normal MM/CRT: pink BCS: 4/5 NSF on abdominal palpation CBC: RBC 6.17 6.54 - 12.20 x10^12/L CHEM: GLUC 9.54 (3.95 - 8.84 mmol/L) GLOB 53 (28 - 51 g/L) GGT 7 (0 - 4 U/L) ALT 1686 (12-130 U/L) QPLi: 11.4 (0-4.4) T4 normal Abd rads: stomach appears to have ingesta, stool in colon, mild gas throughout length of small intestine with peristalsis

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 definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney presents normal size (4.3 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

The left kidney presents normal size (4.3 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The right adrenal gland is not visualized.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures 3.4 mm in width.

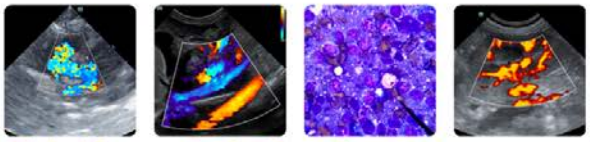
Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen. Normal blood flow.

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.

Within the lumen of the gallbladder there is a 1.0 cm in diameter hyperechoic, shadowing cholelith present. The gallbladder does not appear obstructed at this time. Diffusely the gallbladder wall appears normal. However, given the patient's elevated liver values, the cholelith is possibly the cause of the



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patient's clinical signs. The common bile duct is prominent but not overly dilated, measuring 2.8 mm in width.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out. The pylorus was visualized. No pyloric outflow tract obstruction seen.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

The intestines have normal wall layering and thickness. Diffusely the small bowel is mildly to moderately food and fluid dilated. Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is hypoechoic with moderate surrounding steatitis.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic hepatomegaly – Most likely due to reported chronic Prednisolone administration causing a vacuolar hepatopathy.
- Cholelith.
- Prominent common bile duct – Most likely due to presence of the cholelith.
- Possibly clinically significant pancreatitis.
- Full stomach and small bowel.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend either cholecystectomy with submission of the gallbladder for aerobic and anaerobic bacterial culture, or, if owners elect not to pursue surgical management, attempt at medical management (not suspected to be highly successful) could be considered with Ursodiol at 15 mg/kg by mouth split into two daily doses. Consider adding an antibiotic such as Amoxicillin and recheck the appearance of the gallbladder and liver values in 6-8 weeks to determine if this problem is resolving or has resolved. If no resolution seen in that time, then cholecystectomy would be recommended.

Confirm pancreatitis via fPLI testing. Patient's pancreatic inflammation is most likely reactive. It is uncommon in a feline for pancreatitis to be a primary disease. The presence of the cholelith could also be contributing to pancreatic inflammation.

Given that the patient's stomach and small bowel are dilated with food material and fluid, it does appear that the patient has a functional ileus present. No mechanical obstruction is seen. Recommend submitting an entire GI panel (which would include aforementioned fPLI) to screen the patient for possible chronic enteropathy that is not being effectively treated by the patient's current glucocorticoid steroid therapy. Differentials include refractory inflammatory bowel disease versus small cell

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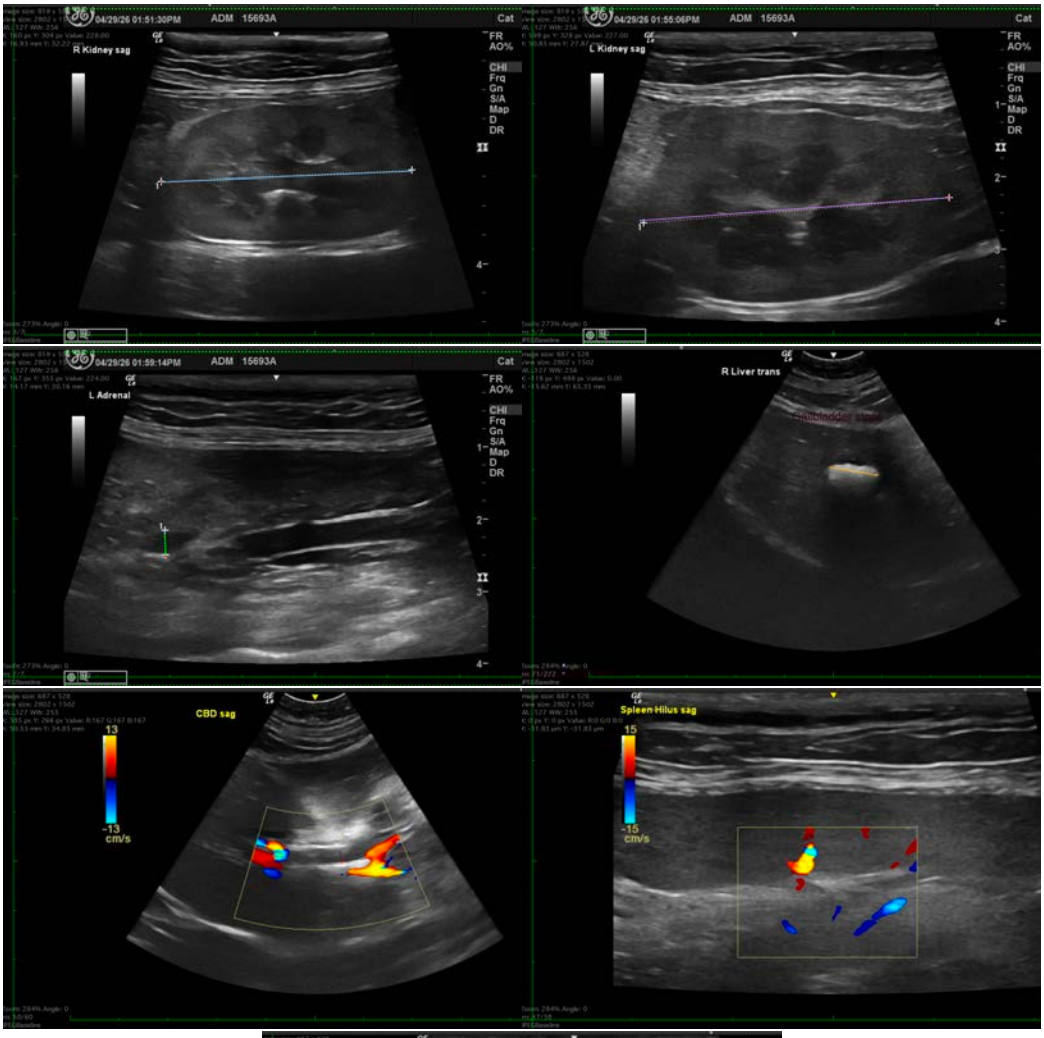
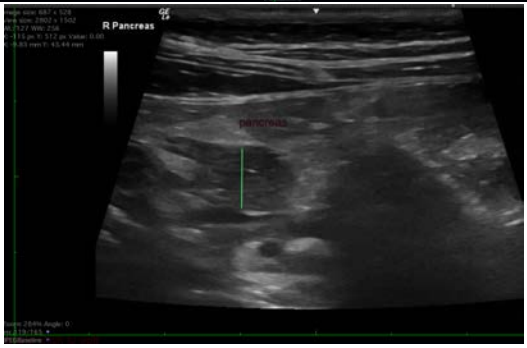
lymphoma versus mast cell disease, and if geographically relevant, consider infectious disease such as histoplasmosis, although unlikely if not endemic to patient's geographic region. If chronic enteropathy is confirmed via GI panel, recommend GI biopsies either surgically or endoscopically. If patient has surgery to remove the cholelith, recommend GI biopsies at that time. It would be best to have patient of glucocorticoid therapy prior to surgical intervention.





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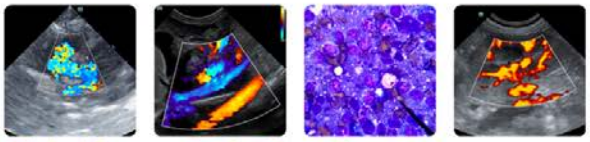

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com