SonoPath
Clinical Sonography & Telecytology
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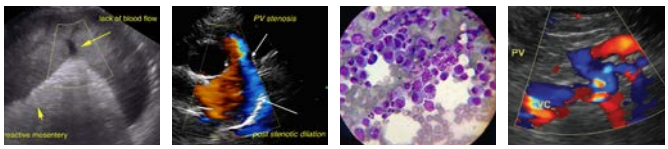


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Baby Reisinger

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

16 Years

WEIGHT

9.2 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Jack Reese

HOSPITAL NAME

Willow Run VC

REFERRING VET

Dr. Anna Leppien

INVOICE

43939

DATE

1/4/23

PRESENTING CLINICAL SIGNS

Presenting Complaint: Losing weight, decreased appetite, and not as active and has less energy. Coughing like a hairball is coming but doesn't produce anything.

Abnormal PE/Chem/CBC/UA Results: CBC - nsf Chem: Glob - 5.7 (2.8-5.1); GGT - 13 (0-4) Chest Rads - generalized bronchointerstitial pattern - suspect asthma, but can't fully r/o early metastatic neoplasia Abdomen - some loss of detail in right cranial abdomen on v/d view; no obvious masses seen

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.59 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.7 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.36 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

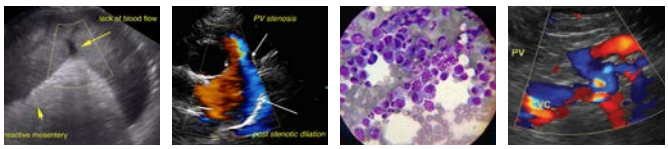
Spleen

The spleen is subjectively normal in size (0.89 cm) and the parenchyma is slightly hypoechoic. The splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile duct appear diffusely dilated and tortuous, measuring approximately 0.60 cm. No point of obstruction is visualized.



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Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.35 cm. Jejunum wall measures 0.26 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid. Prominent pancreatic duct noted at 0.96 cm.

Free Abdomen

There is a moderate to large amount of free abdominal fluid. No lymphadenopathy. The omentum is generally hyperechoic.

PRIMARY FINDINGS

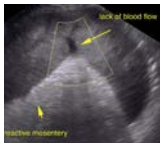
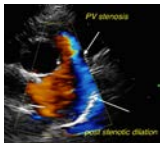
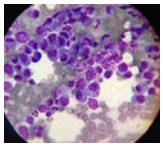
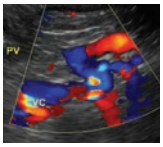
- Subjectively hypoechoic spleen – This could be artifact secondary to the effusion or could be an indicator of infiltrative disease. A fine needle aspirate could be considered.
- Prominent, hypoechoic pancreas with a dilated pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation. Pancreatic inflammation could be secondary to duct obstruction or be a cause of it.
- Significantly dilated, tortuous bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).
- Moderate to large amount of free abdominal fluid – Recommend fluid analysis and cytology.

SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I'm surprised that there are no significant liver enzyme elevations with the degree of bile duct dilation observed on today's scan. This could be an indicator that this has been a more chronic problem and may or may not be related to the symptoms currently present. An obvious point of obstruction is not observed, but I would be concerned about a distal obstruction such as the duodenal papilla, duodenum

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itself, etc. If liver enzyme elevations develop/progress, then a contrast CT scan may be necessary to further evaluate.

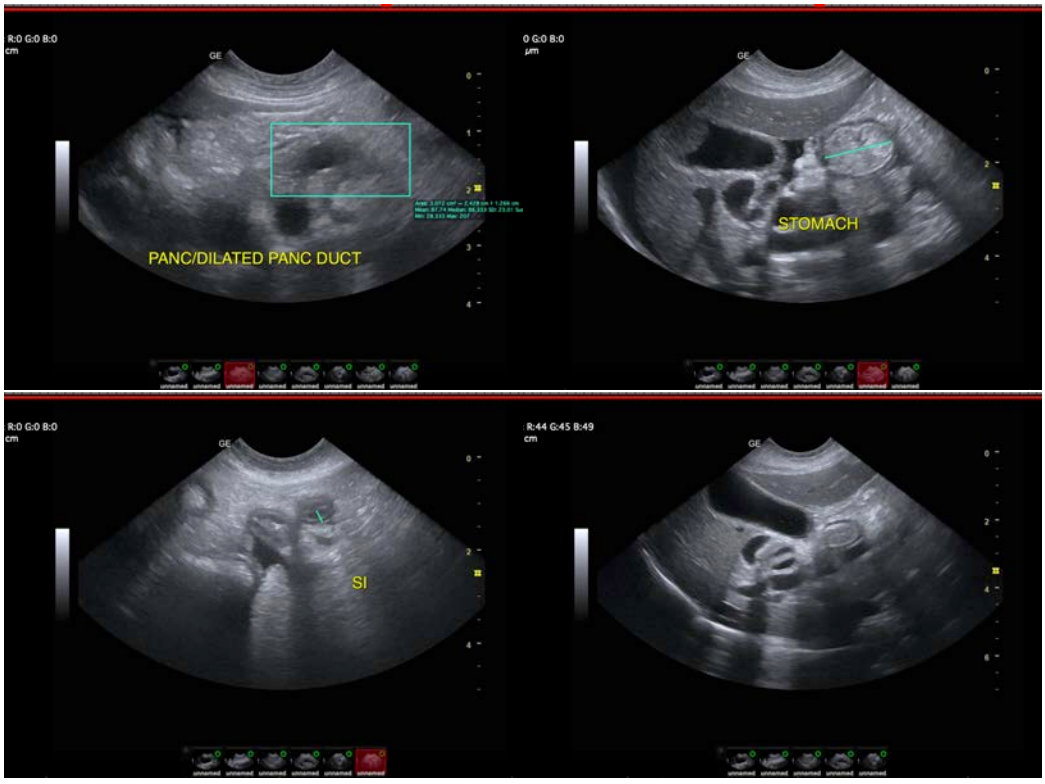
The pancreas is somewhat prominent with a prominent pancreatic duct, so this could be playing raole. Correlate findings with a quantitative fPLI level. Additionally, consider a fine needle aspirate of the liver, provided coagulation parameters are normal, as you can see lymphoma in this region.

There is a moderate amount of material visualized within the gastric lumen. Correlate this with the feeding history. If the patient was adequately fasted, then consider the possibility of ingested foreign material, hairball, etc., but a significant shadow is not observed.

No significant changes are observed associated with the GI tract, although there is some fluid dilation, which could be consistent with a non-fasted patient or enteritis, ileus, etc.

There is a moderate to large amount of free abdominal fluid. Recommend a fluid analysis and cytology in addition to 3-view thoracic radiographs to try and further pinpoint the cause of this fluid.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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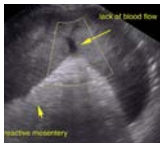
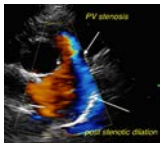
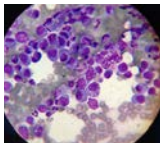
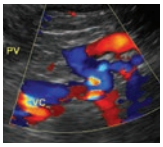

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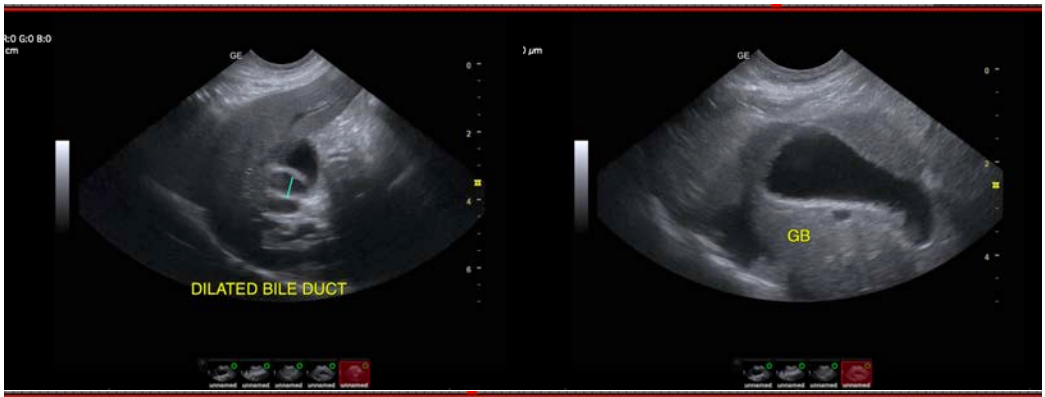

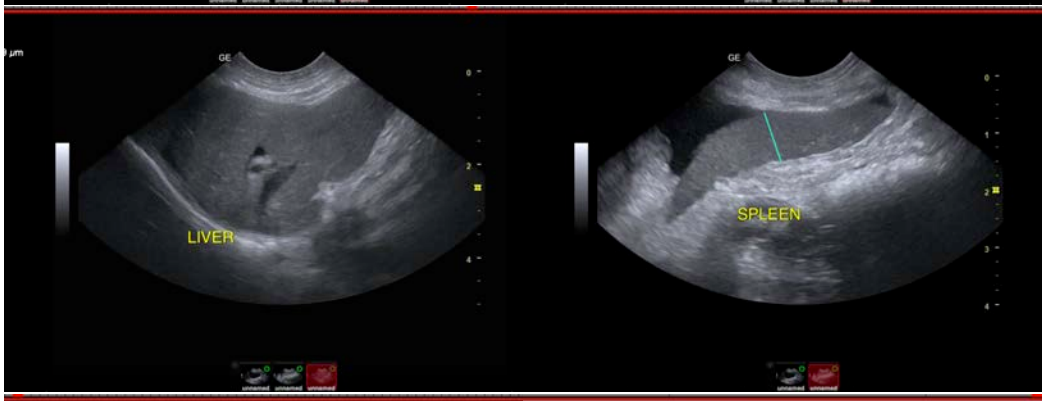

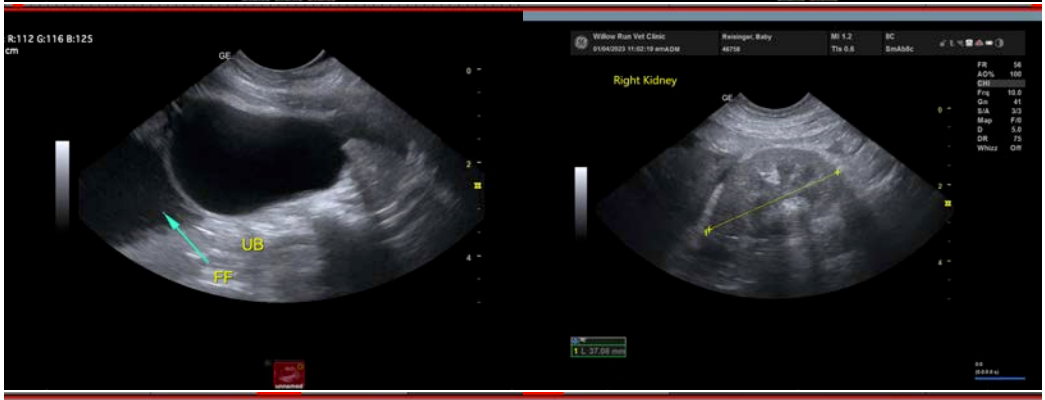

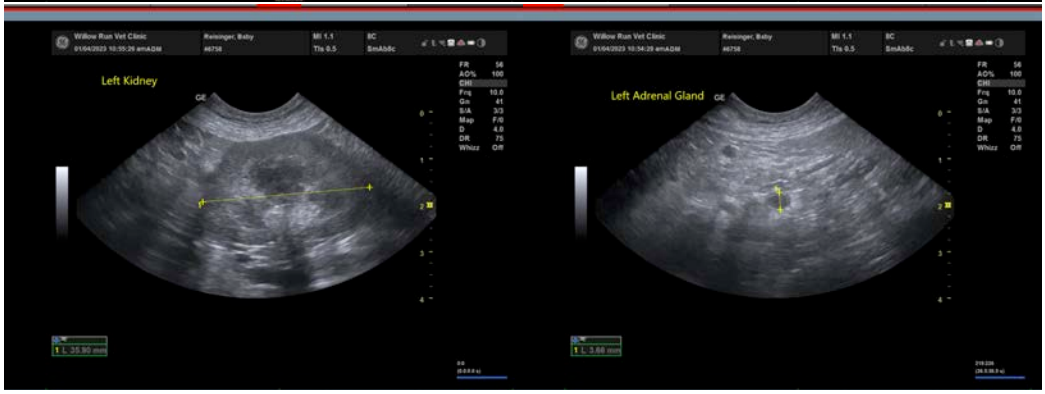

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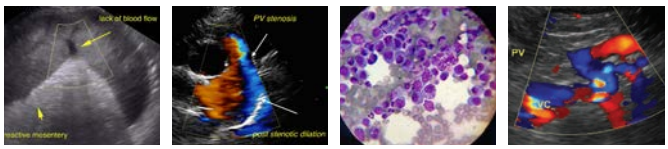

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com