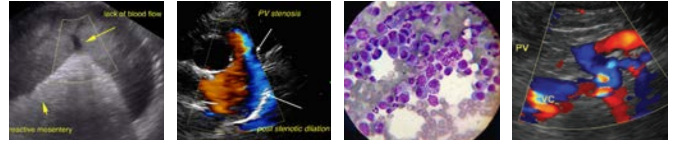

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1-800-838-4268 info@sonopath.com

PATIENT

Kitty Meisel

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

7.18 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Saum Hadi

HOSPITAL NAME

Bethany Family PC

REFERRING VET

Dr. Saum Hadi

INVOICE

33636

DATE

12/21/21

PRESENTING CLINICAL SIGNS

P presented on 11/5/21 for weight loss. P was icteric with a positive thyroid slip. BW revealed a marked hepatopathy and a marked elevation of T4. On exam, a 0.5x0.5x0.3 cm hairless, white, non-painful mass on the R lateral abdomen was noted and FNA'ed. FNA revealed a mast cell tumor. Since initial presentation, P was started on 2.5 mg of methimazole PO BID. On thyroid recheck on 12/11, T4 was normalized, P had gained weight, Liver values were still mildly elevated, and P's renal values were WNL. See labs. Presented today for AUS to evaluate liver and to stage P prior to surgical removal of MCT. Abnormal PE/Chem/CBC/UA Results: 11/5/21 (CBC, Chem 27 with SDMA, UA, T4/fT4): Weight: 5.6 lbs T-Bili: 6.4 mg/dL ALP: 352 U/L ALT: 455 U/L AST: 96 U/L T4: 9.6 ug/dL fT4-ed: 128.7 pmol/L Rest NSF 12/11/21 (thyroid recheck panel) Weight: 7.1 lbs T4: 1.2 ug/dL ALT: 168 U/L AST: 81 U/L ALP: 187 12/21/21 (today) P still icteric on exam.

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 (3.3 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (3.5 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. 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.

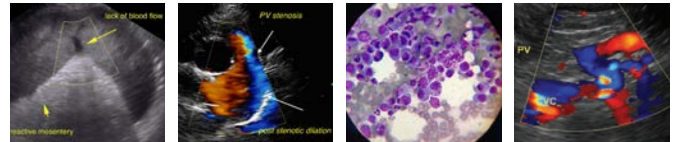
Spleen

The spleen is large and mildly heterogeneous with a width of 1.1 cm at the hilus. 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 heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder appears thickened and slightly hyperechoic, measuring between 0.22-0.32 cm. There is a small accumulation of hyperechoic debris present. The cystic and common bile ducts appear dilated and tortuous with thickened walls. No intraluminal obstruction is observed, and there appears to be prominent dilated bile duct at the level of the duodenal papilla measuring 0.68 cm.



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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. The duodenum measured as normal (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) 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 mottled compared to the surrounding isoechoic mesentery, with what I suspect is a dilated, tortuous pancreatic duct measuring 0.83 cm. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

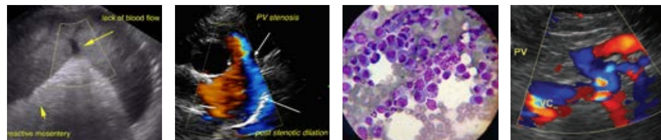
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Thickened gallbladder wall with dilated tortuous common 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).
- Heterogeneous liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Mottled, large spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Mottled pancreas with dilated tortuous pancreatic duct – could be consistent with mild pancreatic inflammation, Triaditis, or an obstruction of the pancreatic duct.

SECONDARY FINDINGS

- Moderate gastric dilation with shadowing material – These findings are most consistent with kibble. If the patient was adequately fasted, consider such differentials as delayed gastric emptying, or a partial gastric outflow obstruction (no obstruction is observed).



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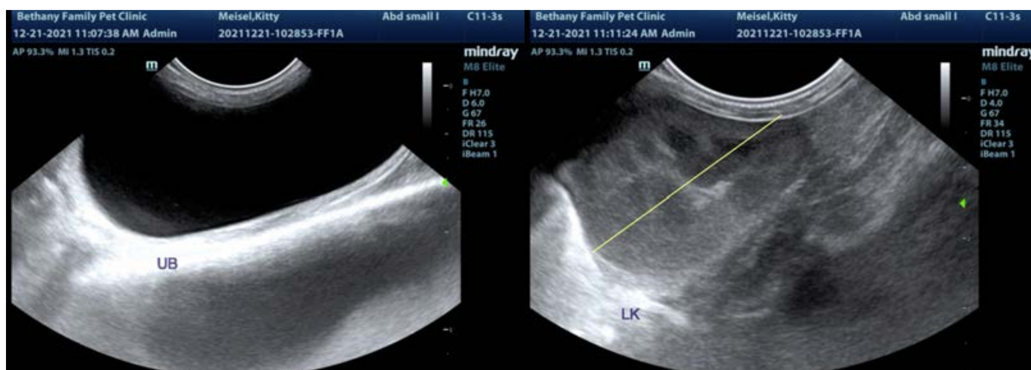
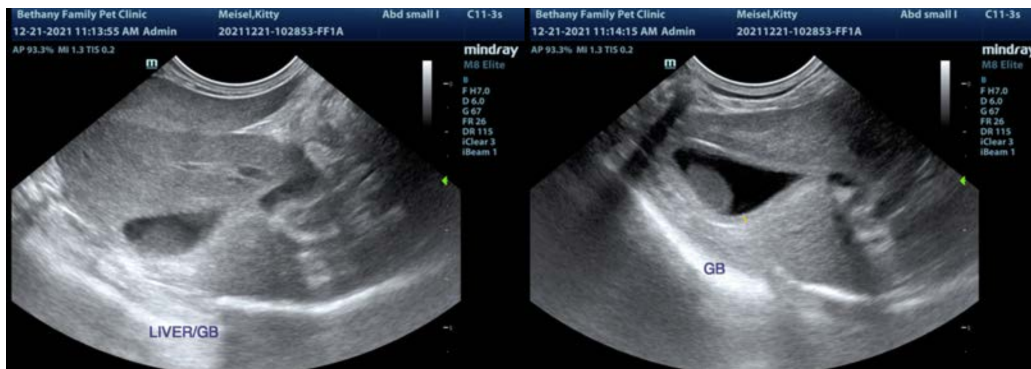
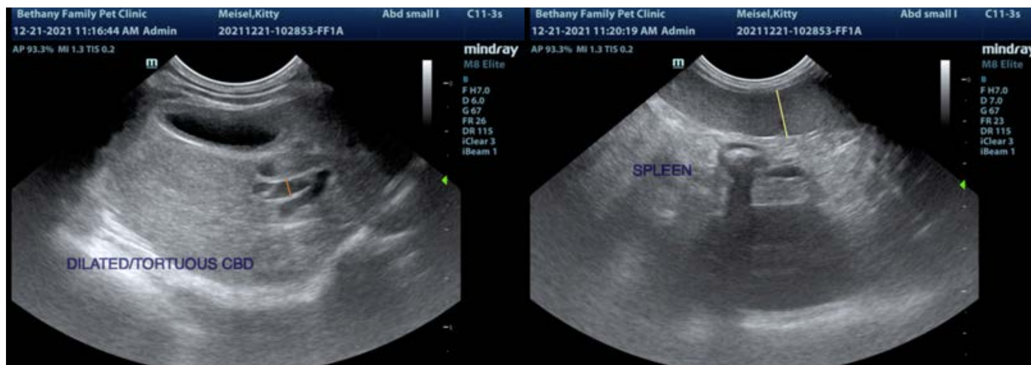
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

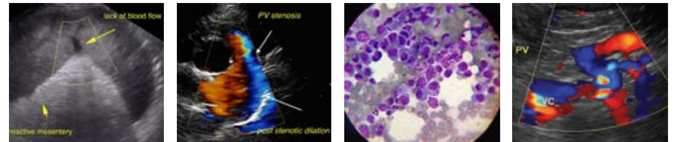
Today's scan is supportive of both a primary hepatic and a biliary disorder. Additionally, the pancreatic duct appears abnormal. I would be most concerned about cholangiohepatitis/pancreatitis/traiditis in this patient, or a neoplastic process such as round cell neoplasia. Recommend a fine needle aspirate of the liver and spleen. While awaiting cytology results, recommend medical therapy for cholangiohepatitis with antibiotics, Ursodiol and supportive care. If there is no response to this therapy, and cytology is not diagnostic, then I would consider a liver biopsy +/- biopsies of pancreas and bowel, and possible surgical exploration to ensure there is no evidence of an anatomic obstruction (mass lesion) causing an obstruction. Alternately, a CT scan could be considered of the abdomen to evaluate for a smaller mass lesion not visualized on today's exam.

Consider sending out a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to look for additional evidence of pancreatitis and small intestinal disease.









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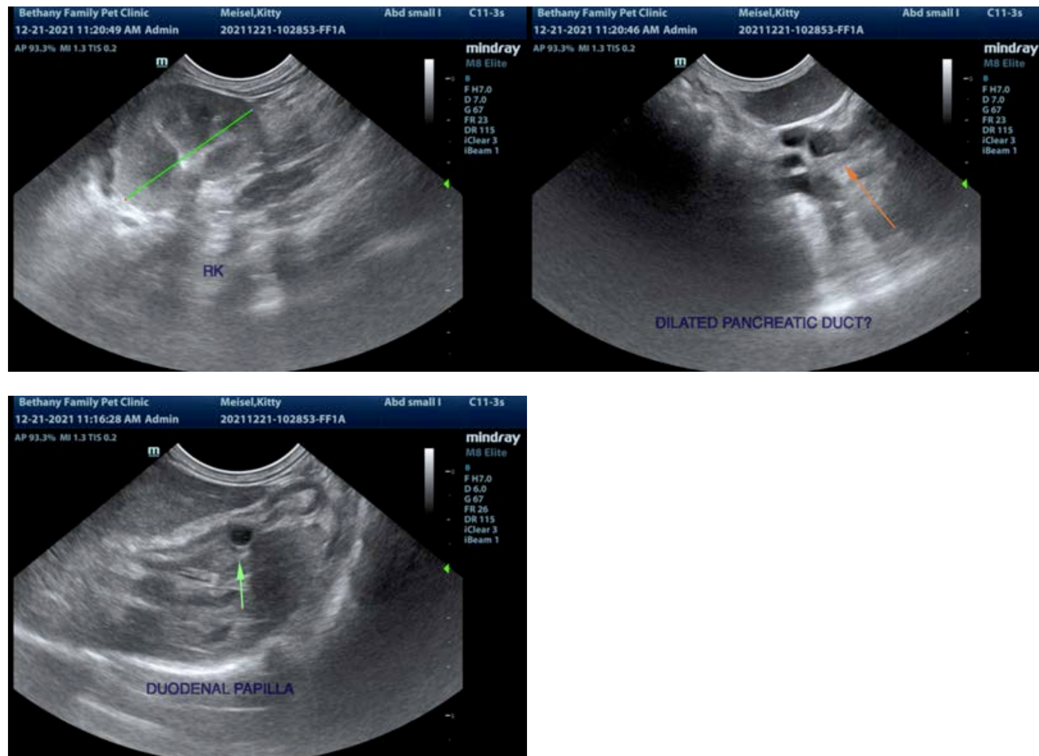

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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