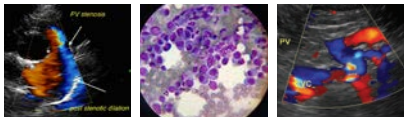
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

12/27/22

PATIENT

Blue Anshel

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

1/26/16

WEIGHT

8.5 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Chadwell AH

REFERRING VET

Dr. Jones

INVOICE

43743

PRESENTING CLINICAL SIGNS

Vomiting, weight loss, icterus

Current Medications: Started IVF, Cerenia, ampi, gaba, Zorbium 12/26
Lab Results: TP 9.3; alb 3.8; glob 5.5, chol 252, glu 240, ALT >1000, ALP 477, GGT 79, Tbili 9.2
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Stephanie Warga RDCS, RVT.

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 (3.97 cm). Overall echogenicity is normal with adequate 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 (3.63 cm). Overall echogenicity is normal with adequate 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 0.44 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 (0.96 cm), echotexture is homogenous, and 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. The biliary tract appears severely dilated and tortuous with some intraluminal material, but no focal obstruction visualized. Additionally, the vasculature appears prominent. No focal nodules or cystic lesions are observed.

The gallbladder lumen is mildly to minimally distended. It has a moderate amount of slightly echogenic intraluminal material, and the gallbladder wall appears hyperechoic and prominent, measuring at 0.26 cm. The cystic and common bile ducts are severely dilated and tortuous with some wall thickening and intraluminal mucoid material. Bile duct dilation approaches 0.95 cm, and no point of obstruction is visualized.

Gastrointestinal

The stomach contains moderate fluid and ingesta. 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 layers 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 mild to moderate dilation with fluid and ingesta. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measures 0.15 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 mottled 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.

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.

ULTRASONOGRAPHIC FINDINGS

- Severe bile duct dilation with wall thickening and some intraluminal material. The gallbladder is not dilated but has a hyperechoic wall – Findings are concerning for a biliary obstruction, although this cannot be visualized. Concurrent cholecystitis is likely.

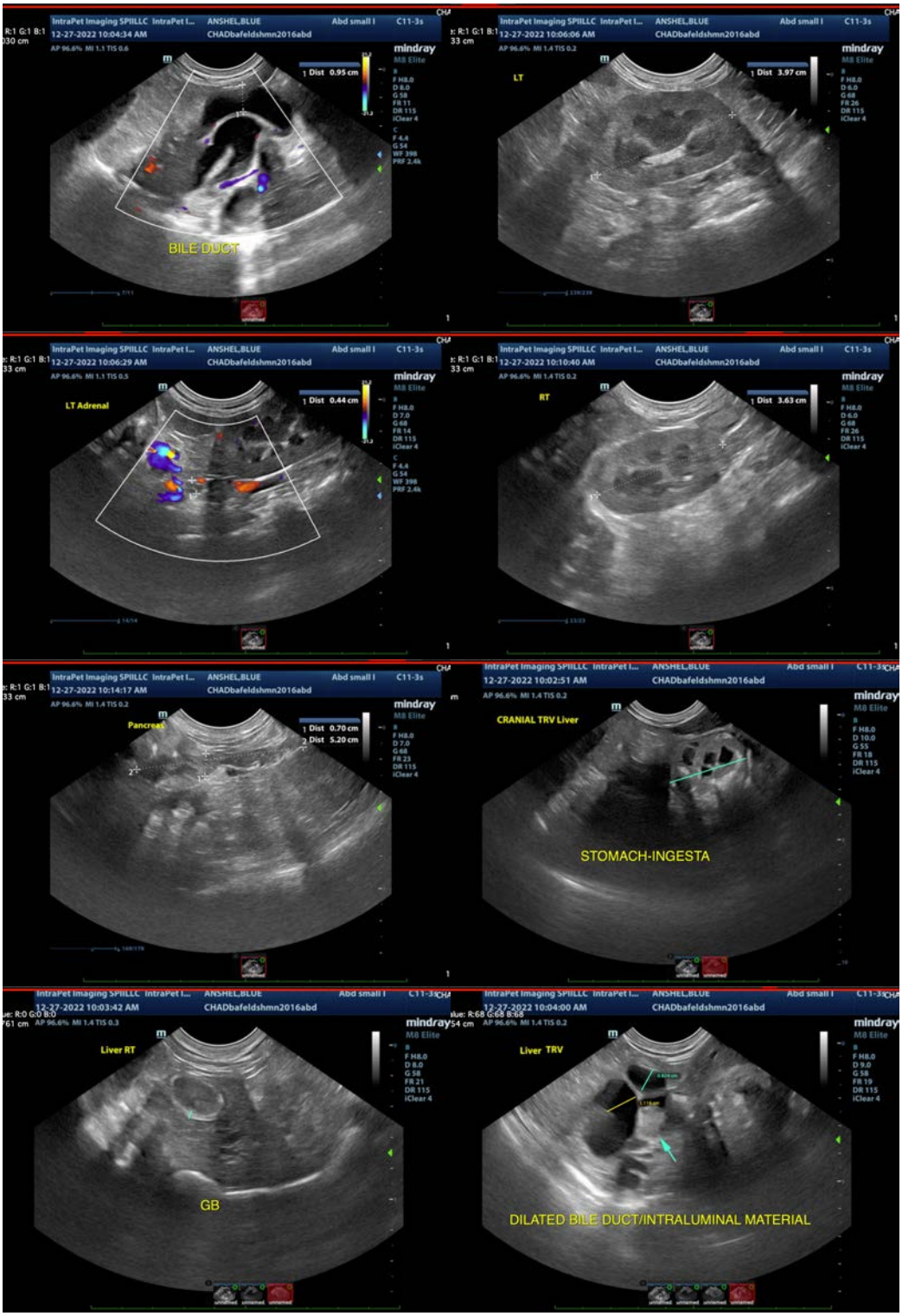
- Hypoechoic, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

- Moderate distention of the stomach and small intestine with ingesta – Correlate with feeding history. If the patient was adequately fasted, this likely represents ileus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cystic and common bile ducts appear severely dilated and tortuous with some wall thickening and intraluminal debris most consistent with cholecystitis, but an obstruction is suspected although not clearly visualized. Additionally, the gallbladder is not distended but has a prominent hyperechoic wall, possibly consistent with fibrosis. Ideally, I would consider a contrast CT scan of the abdomen, looking for a possible source of obstruction. Additionally, a fine needle aspirate of the liver could be considered, looking for round cell neoplasia (provided coagulation parameters are normal). Additionally, you could consider medical management with Ursodiol, antibiotics, etc. The challenge with surgical intervention (although very possibly necessary) is that I'm not sure if the gallbladder is normal. Referral to a veterinary surgeon with access to critical care would be essential.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.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BILE DUCT
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Pancreas
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CRANIAL TRV Liver
STOMACH-INGESTA
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Liver RT
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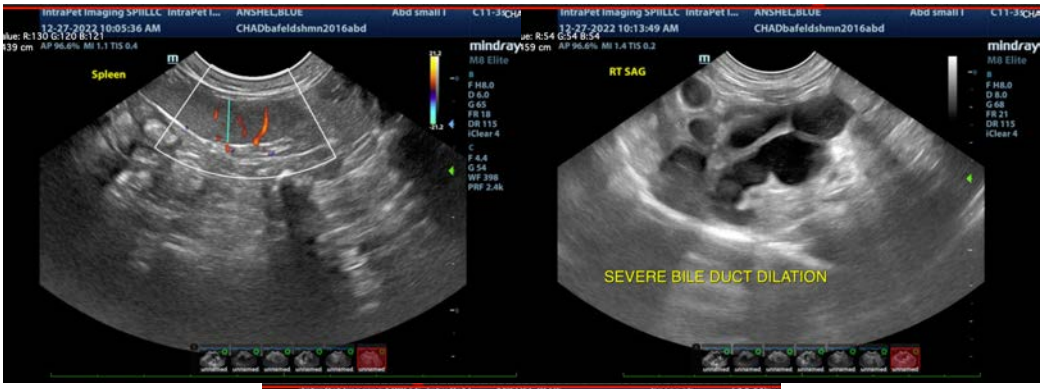
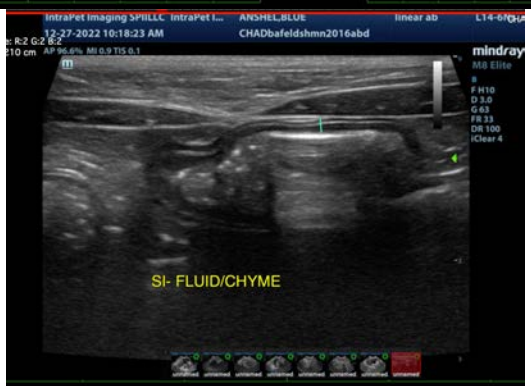
Liver TRV
DILATED BILE DUCT/INTRALUMINAL MATERIAL





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