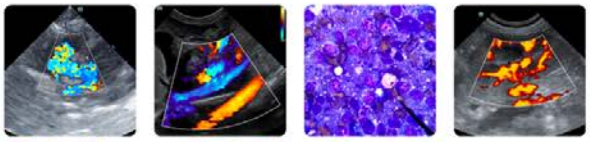

PATIENT

Smeagol Lewis

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12.5 Years

WEIGHT

12.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Emily Kirk

HOSPITAL NAME

Shiloh Animal Hospital

REFERRING VET

Dr. Alesha Diniz

INVOICE

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PRESENTING CLINICAL SIGNS

Inappetence, jaundice, elevated bilirubin and ALT, slightly low RBC (but hematocrit and hemoglobin fine). No pain on abdominal palpation. Some vomiting, no diarrhea.

Abnormal PE/Chem/CBC/UA Results: RBC 5.89 (L), MCV 54.3 (H), MCH 17.7 (H), Monocytes 0.74 (H), Eosinophils 0.06 (L), MPV 23.3 (H) Glucose 174 (H). BUN 14 (L), Chloride109 (L), Globulin 5.2 (H), ALT 318 (H), Bilirubin - Total 4.1 (H) Full labs attached

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 (4.4 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 (4.31 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 “plump” measuring 0.65 cm. 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 right adrenal gland is “plump” measuring 0.64 cm. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

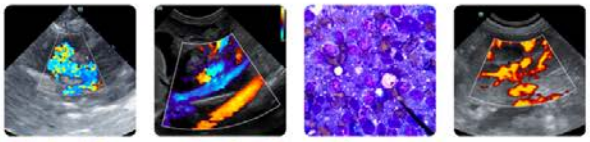
Spleen

The spleen is subjectively normal in size (1.07 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a small hyperechoic lesion in the parenchyma measuring 0.38 cm, most consistent with a benign myelolipoma-like lesion. Continued monitoring is warranted.

Liver

The liver is large in size, and normal in 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 gall bladder is large. The gallbladder wall is hyperechoic and thickened, measuring at 0.30 cm. The cystic and common bile duct are thickened, dilated and tortuous. The proximal cystic duct measures at 0.47 cm. The common bile duct is visualized at the level of the duodenal papilla, appearing thickened and



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dilated, measuring 0.39 cm and 0.57 cm at the level of the duodenal papilla. There is questionable mucus versus tissue within the duct at the level of the duodenal papilla.

Gastrointestinal

The stomach contains minimal luminal contents. 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 uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.37 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. The duodenal papilla is prominent and slightly hyperechoic, measuring 0.55 cm x 0.89 cm. The distal common bile duct is dilated at this level. There is a suspected mucus plug at the level of the duodenal papilla, but abnormal tissue/a mass effect cannot be ruled out.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with non-formed fecal material and gas shadowing distally. There ascending colon wall is prominent and hyperechoic, measuring at 0.23 cm with a prominent submucosal layer. Wall layering is intact.

Pancreas

The right limb of the pancreas is prominent and mildly 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. No significant lymphadenopathy noted. The omentum is slightly hyperechoic in the cranial abdomen.

PRIMARY FINDINGS

- Slightly prominent, mottled right limb of the pancreas – Findings are most consistent with chronic pancreatic remodeling +/- mild chronic pancreatitis.
- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Large, thick-walled gallbladder with a dilated, tortuous, thick-walled bile duct and an enlarged duodenal papilla/mucus plug at the level of the duodenal papilla – Possible differentials for the thickening would include infectious (cholecystitis), inflammation, or neoplastic infiltration.

SECONDARY FINDINGS

- Bilaterally "plump" adrenal glands – The adrenal glands are both large with no significant structural abnormalities. This is most likely a benign-age related change. This can be caused by chronic stress/concurrent illness etc… If signs of cushings disease are present (diabetes, thin skin etc..) pituitary dependent cushings could be considered but is much less likely.

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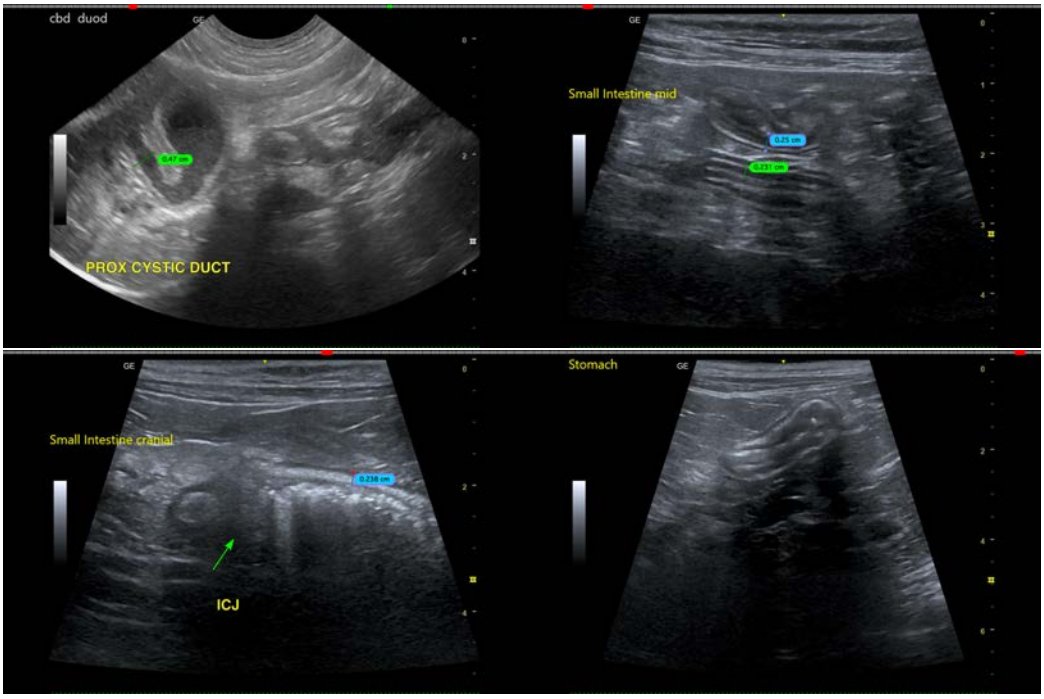
- Hyperechoic lesion in the spleen – This has an appearance most consistent with a benign lesion such as a myelolipoma. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is large and heterogeneous. Additionally, the gallbladder is distended with a hyperechoic, thick wall and a dilated/tortuous bile duct with thick walls. These findings are concerning for possible cholecystitis, although infiltrative neoplasia can also have this appearance. The bile duct remains dilated to the level of the duodenal papilla, which is somewhat prominent, possibly consistent with a mucus plug at this level, although a poorly defined mass effect cannot be ruled out. Recommend aggressive treatment for cholecystitis with a course of Ursodiol, Denamarin, antibiotics, and continued monitoring of the gallbladder. If sampling of the bile is possible, you could consider submission for cytology and cultures. Additionally, a fine needle aspirate of the liver itself is strongly recommended (provided coagulation parameters are normal) to look for any evidence of underlying round cell neoplasia, which could be contributing.

If there is no response to this treatment and liver values continue to rise, further evaluation with a contrast CT scan or possibly surgical explore could be considered. Additionally, a short course of anti-inflammatory steroids could be considered provided round cell neoplasia is ruled out with cytology.

The pancreas is slightly prominent in the right limb, and some sections of small intestine exhibit a slightly prominent muscularis layer. This could be consistent with mild Triaditis, which could be contributing to the symptoms described.



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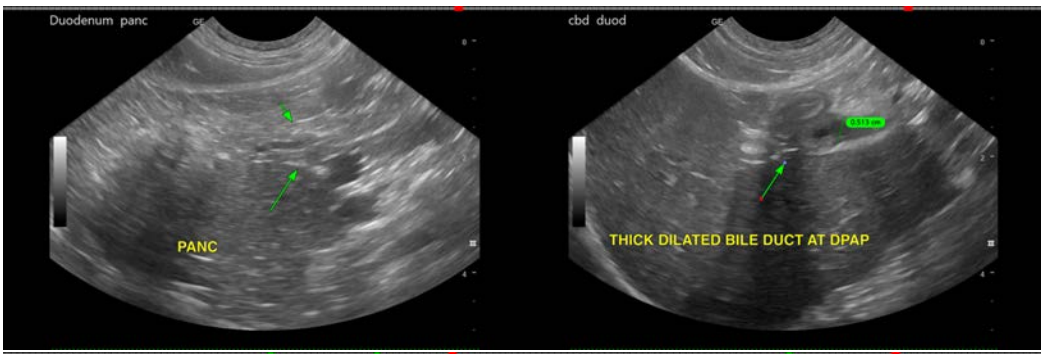

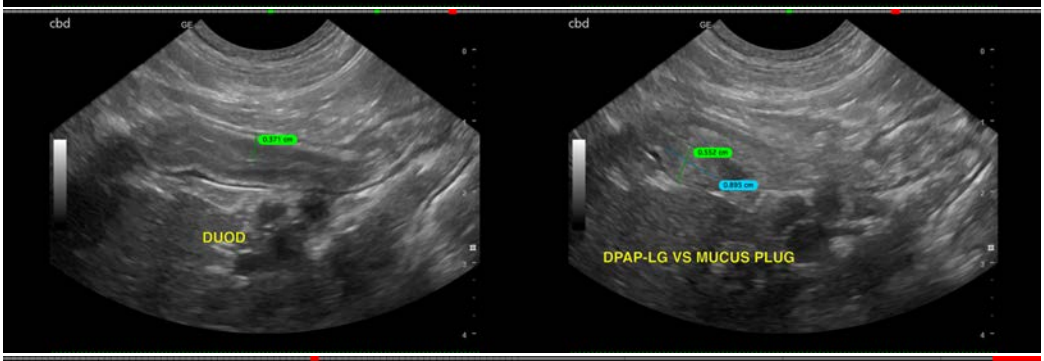

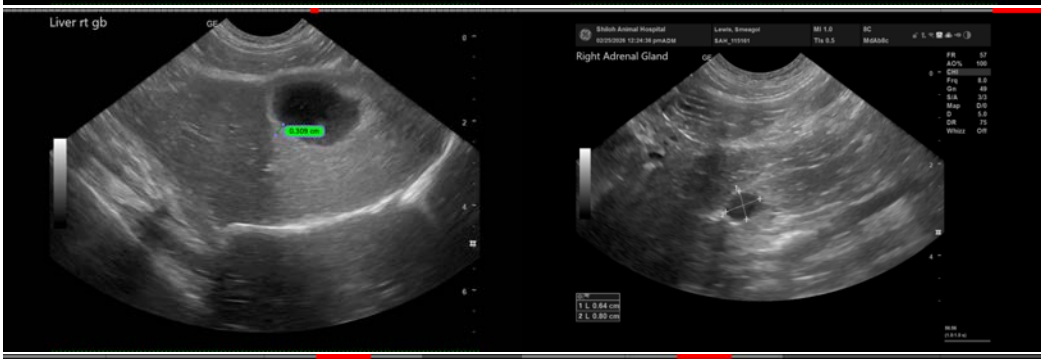

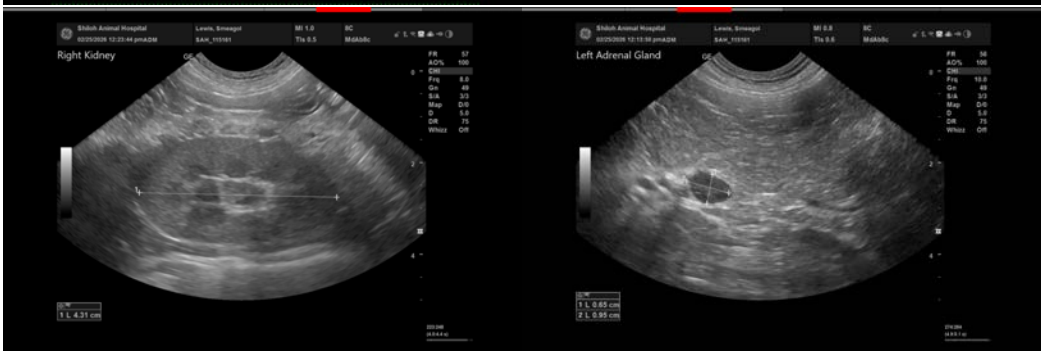

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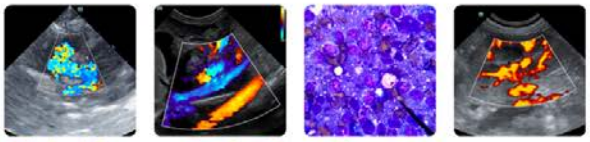

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com