



PATIENT

Dumper Staffone

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

8.6 Pounds

INTERPRETED BY

Dr. Amanda Olsen

IMAGING PERFORMED BY

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

HOSPITAL NAME

Limestone VH

REFERRING VET

Dr. Amanda Olsen

INVOICE

38010

DATE

5/26/22

PRESENTING CLINICAL SIGNS

Presented 1 week ago for weight loss despite good to increased appetite and increased thirst. Previous history (2019) of elevated ALT/AST/Tbili and ultrasound (performed elsewhere, images not available) changes consistent with presumptive IBD and cholangiohepatitis. At that time, clinical sign's resolved and BW improved on pred and ursodiol, both of which have been discontinued for the past year. Current BW shows return of elevated ALT/AST/Tbili. Tbili significantly elevated over where it had been previously. Restarted pred and ursodiol last week and owner has noted no improvement since. Ultrasound to confirm return of presumptive IBD/cholangiohepatitis and rule out any new disease (biliary mucocele, neoplasia, etc...). Patient also has a history of chronic URI. Abnormal PE/Chem/CBC/UA Results: AST 163, ALT 450, Tbili 3.6, Chol 269, PLT 132 w/ adequate estimate, Neut 11097, USG 1.030, trace protein, Bili 2+, UPC 0.1 T4 normal at 1.8, freeT4 slightly high at 54.5

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 (4.36 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 (4.41 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 subjectively normal in size, 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 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 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 ducts are normal/not visible.



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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 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. Jejunum wall measured 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.

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

- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Moderate gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver appears large and heterogeneous with no focal lesions, and there is some mild debris in the gallbladder, but no significant bile duct dilation or evidence of an obstruction. These findings could be consistent with cholangiohepatitis, but other differentials such as round cell neoplasia, infectious disease, etc. are also possible. In these situations, I would consider:

- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc..
- Recommend thyroid evaluation (this has already been done)
- If not already done consider pre and post prandial bile acids to evaluate liver function. This is not necessary in this case due to the elevation in bilirubin reported.



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- Consider fine needle aspirate if round cell neoplasia is on your differential list (25 g needle, normal coags)

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- If cytology is not helpful and there is no response to therapy, consider liver biopsy with samples obtained for histopathology and culture.

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- If triaditis is suspected, consider therapy for cholangiohepatitis (fluids, antibiotics, +/- ursodiol, +/- steroids), testing for pancreatitis and evaluation for IBD (GI panel to Texas A&M GI lab). The pancreas is hypoechoic and prominent, so testing for concurrent pancreatitis and IBD is strongly recommended.

- Consider a feeding tube if patient is not eating for a prolonged period of time

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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)

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