
**PATIENT PRESENTING CLINICAL SIGNS**

KingTutTwo Lang

**SPECIES**

Feline

**BREED**

Tonkinese

**SEX**

Neutered Male

**AGE**

10/1/14

**WEIGHT**

4.3 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

 Loetitia Saint-Jacques,  
 LVT

**HOSPITAL NAME**

Desert Hills AH

**REFERRING VET**

Dr. Michelle Caldwell

**INVOICE**

43130

**DATE**

6/13/23

P has historical ALT elevation starting 3/2022. P has been clinically doing well with no weight loss, pu/pd/pp, vomiting or diarrhea. Most recently, P's ALT was elevated prior to COHAT scheduled for 4/27/23. ALT was 232. COHAT was postponed and thyroid panel was sent out. T4 was 2.5 and ft4ed was elevated at 50.5, TSH <0.03. Internist consult stated that P is hyperthyroid but currently asymptomatic. Discussed other causes of ALT elevation and elected tx with broad spectrum abx for 2 weeks, then recheck, hoping for a reduction. BW results 5/17/23 cbc - hct 50 (29-48), platelets 107,000 (200,000-500,000), clumping noted, adequate platelet estimate Chem - ALT 166, previously 232, 25% reduction in ALT There has been improvement noted and P remains symptomatic at this time Recommend continue 2 additional weeks of clavamox and recheck SA600 to reassess ALT. 6/1 BW results: ALT 198, increased from 166 Per conversation with internist, recommend repeat abdominal US +/- liver biopsy. MEDS: Denamarin 90 mg po sid

**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 (3.33 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 (2.85 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.

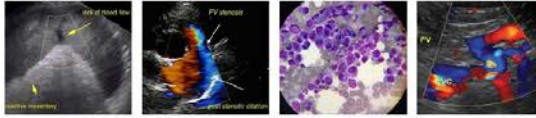
**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.30 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 right adrenal gland is normal in size measuring 0.30 cm at the caudal pole. 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, 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.



**PATIENT** *Liver*

KingTutTwo Lang

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.

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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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***Gastrointestinal***

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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.

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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 measures 0.23 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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***Pancreas***

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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***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.

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**ULTRASONOGRAPHIC FINDINGS**

- No significant lesions visualized

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

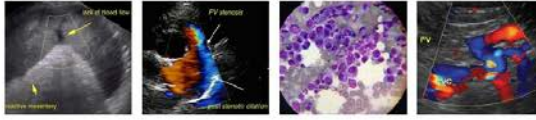
Today's scan is relatively normal for a 9-year-old feline. No focal lesions are visualized associated with the liver to explain the elevation in ALT reported. Consider a liver function test to try and determine if there has been any impact on liver function. If bile acids are elevated, then recommend a biopsy of the liver for histopathology and culture. Additionally consider screening for toxoplasmosis. A fine needle aspirate could be considered if coagulation parameters are normal, primarily to rule out round cell neoplasia, which seems unlikely in this individual.

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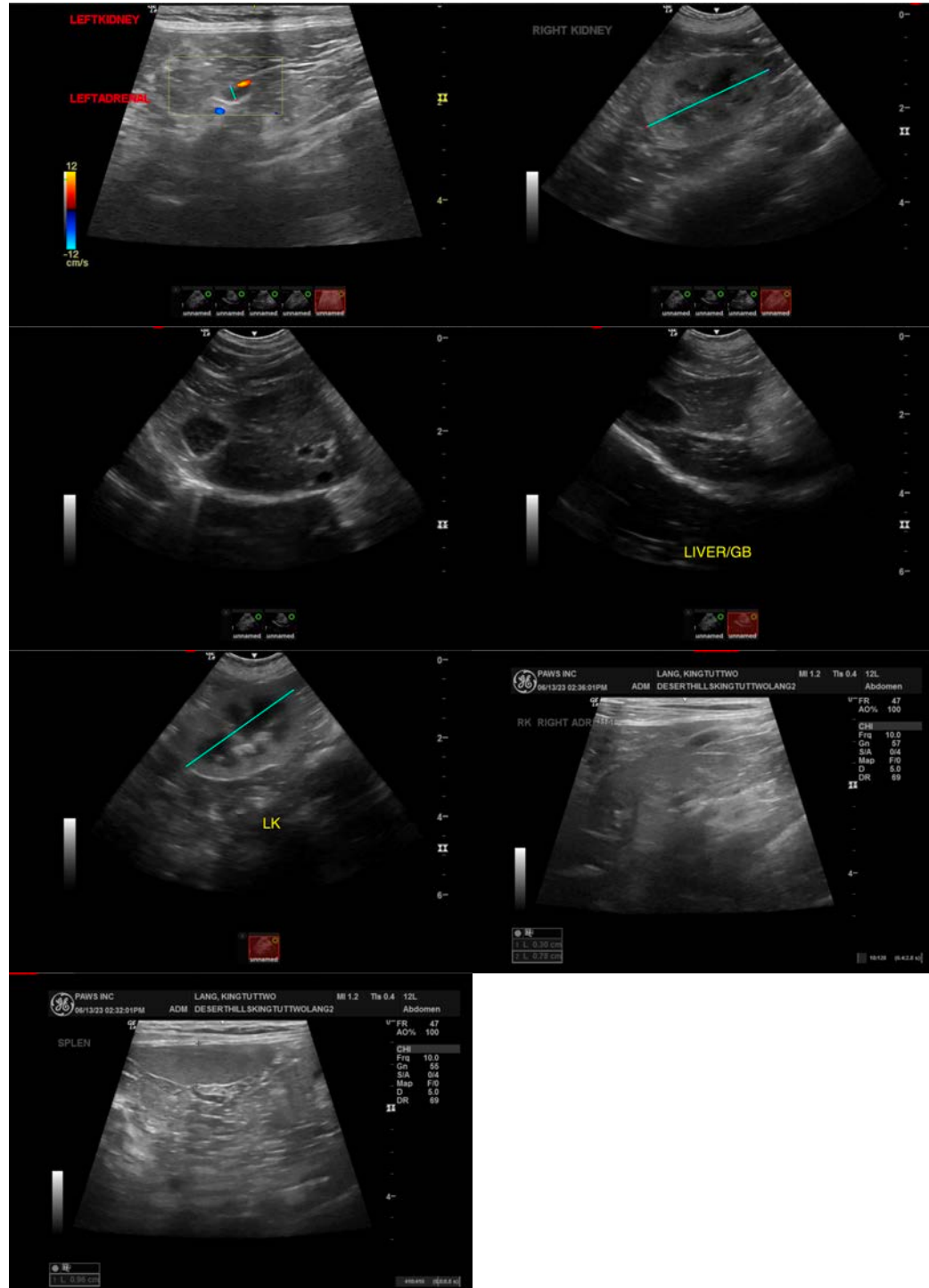
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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Feline

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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info@sonopath.com

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