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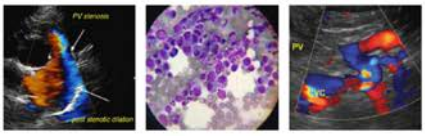

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Clinical Sonography & Telecytology
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PATIENT

Lola Hough

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

15 Years

WEIGHT

8.14 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Cat Care of Rochester Hills

INVOICE

40329

DATE

8/11/22

PRESENTING CLINICAL SIGNS

Continued weight loss over past year (9.84 lbs on 10-4-21, now is 8.14), very occasional vomiting, decreased appetite, occasional UFIE (on-off, not new), occasional constipation

Abnormal PE/Chem/CBC/UA Results: *** Increased ALP (114), ALT (735), AST (247), have always been normal in past), all other results wnl. *** Very mild lymphopenia FPL is wnl, rest of bloodwork is wnl MSU Thyroid panel w/interpretation run on 3-14-22 = no evidence of hyperthyroidism Currently on cobalequin 3x/week, benefiber 1/4 tsp SID (for hairballs), Zyrtec 5 mg SID (for allergies, barbering), Cat lax prn (for hairballs, firm stool) Hx of moderate dental disease Started on Denamarin this week 1 tab PO SID x30 days. PE is wnl, occasional otitis, abdomen feels mildly doughy, no heart murmur. **Please see attached labs and radiograph.

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 (3.64 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 (3.74 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 left adrenal gland is normal in size measuring 0.38 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 (0.89 cm in width at the level of the hilus), 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 distinct 0.52 cm hyperechoic nodule visualized within the parenchyma, most consistent with a myelolipoma.

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. There is a 1.81 cm irregular cystic structure visualized within the parenchyma. Additionally, there are numerous small, ill-defined, hypoechoic nodules (2-4?). One nodule measures 0.59 cm.

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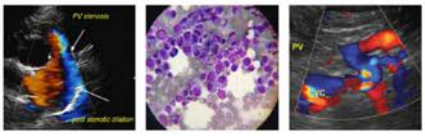

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The bile duct is visualized and appears slightly dilated and prominent at 0.32 cm.

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. Duodenum wall measured 0.32 cm. Jejunum wall measured 0.20 cm. Visualized peristalsis appears appropriate. There is a section of small intestine that appears mildly dilated and fluid filled. No obvious lesions visualized associated with this section of bowel.

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.

PRIMARY FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mildly heterogeneous liver with an irregular cystic structure and occasional ill-defined, subtle hypoechoic nodules – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy. Cystic structures such as these most typically are benign lesions. The hypoechoic nodules are ill-defined and could represent a benign or neoplastic process.
- Mildly dilated/tortuous 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).
- Area of moderately fluid dilated small intestine – No lesion is visualized associated with this section of bowel. Consider possible focal ileus(?).

SECONDARY FINDINGS

- Small, hyperechoic nodule visualized within the spleen – most consistent with a benign myelolipoma. Recommend continued monitoring.

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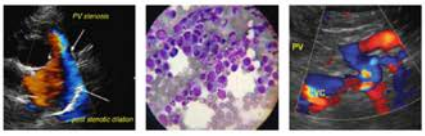

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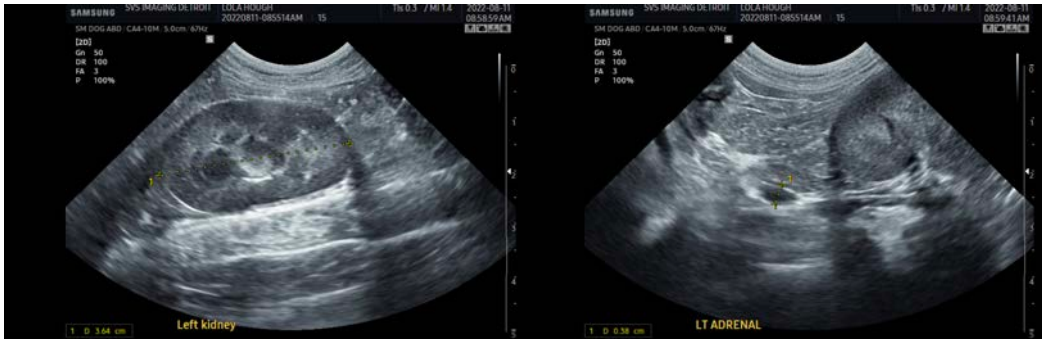
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No large focal lesions are visualized associated with the urinary bladder, bowel or liver. The liver is heterogeneous and there are some ill-defined nodules. The bile duct is somewhat dilated with no obvious obstruction. Consider the following:

- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc..
- Recommend thyroid evaluation (if not already done)
- If not already done consider pre and post prandial bile acids to evaluate liver function
- Consider fine needle aspirate if round cell neoplasia is on your differential list (25 g needle, normal coags)
- If cytology is not helpful and there is no response to therapy, consider liver biopsy with samples obtained for histopathology and culture.
- 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)
- Consider starting Ursodiol therapy due to the bile duct dilation visualized.

Most of the GI tract appears relatively normal. There is no obvious bowel wall thickening, mass lesions, etc. There is a section of bowel that appears somewhat fluid dilated, possibly consistent with focal ileus. You could consider a short trial on anti-nausea/prokinetic medication such as Metoclopramide with close monitoring, as foreign material cannot be 100% ruled out. Additionally, you could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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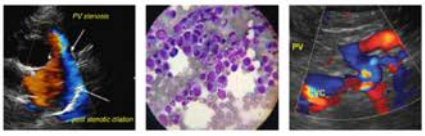

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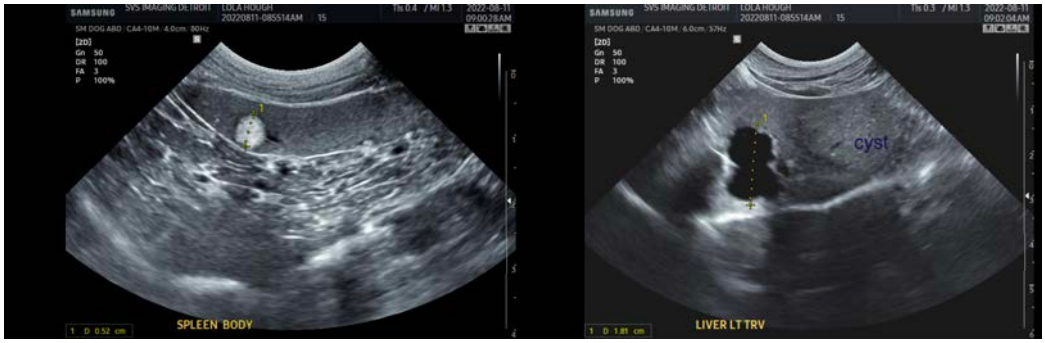

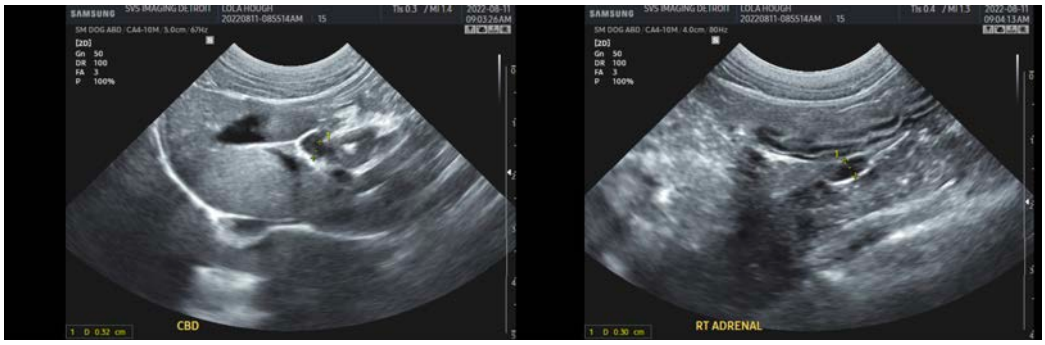

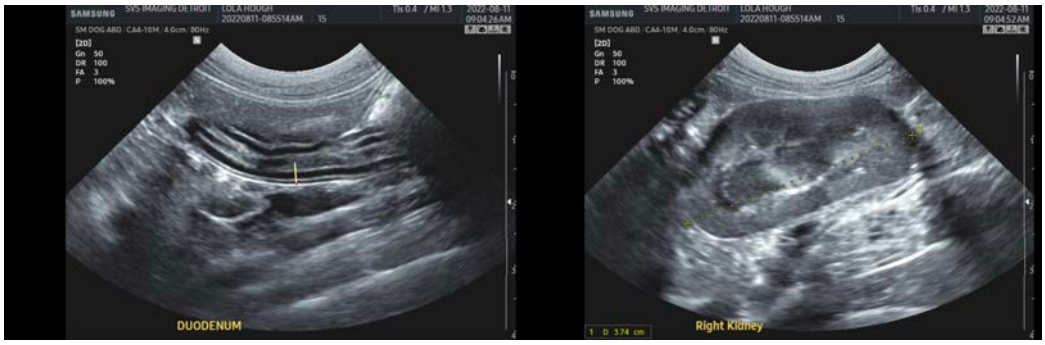

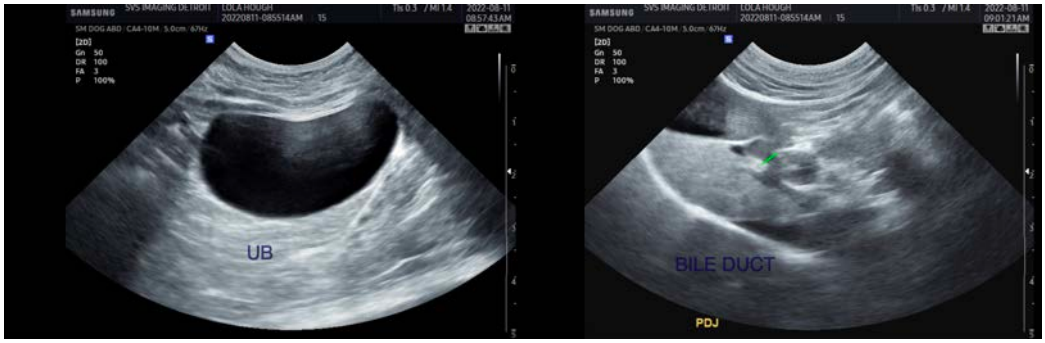

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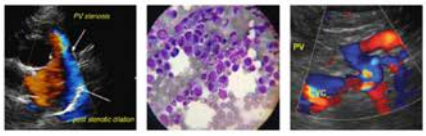

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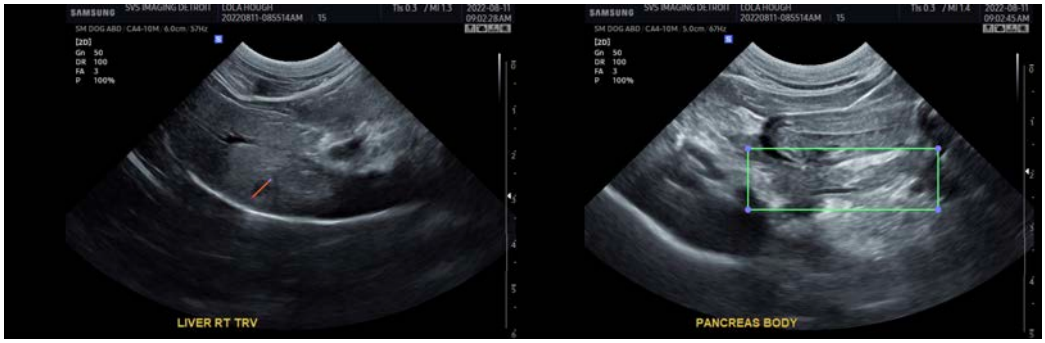

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com