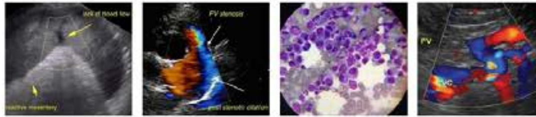


PATIENT
Charlie Sublette

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
11 Years

WEIGHT
13.3 Pounds

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

IMAGING PERFORMED BY
Loetitia Saint-Jacques, LVT

HOSPITAL NAME
MountainView AH

REFERRING VET
Dr. Ashlie Brown

INVOICE
44763

DATE
8/17/23

PRESENTING CLINICAL SIGNS

Patient presented for a periodontal treatment. Pre-op blood work showed an ALT of 769 with hyperglobulinemia. No vomiting or diarrhea noted. Owner did notice some blood in litter box. Was taken to other DVM who did urinalysis and indicated hematuria could be from cystocentesis or from inflammation in the bladder. PE unremarkable.

Abnormal PE/Chem/CBC/UA Results: ALT 769 TP 9.4 Globulin 6.5

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 (4.14 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 (4.59 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 0.35 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 0.39 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.

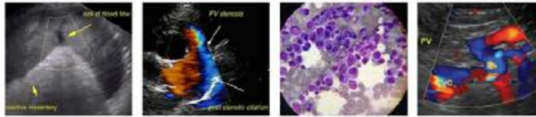
Spleen

The spleen is subjectively normal in size (1.0 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. No focal nodules or cystic lesions are observed.

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. Additionally, there is a dependent hyperechoic foci most consistent with a small cholelith measuring 0.61 cm x 0.34 cm. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains mild fluid. 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 measures 0.23 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. Prominent pancreatic duct noted at 0.24 cm on the right limb. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes. A cranial abdominal lymph node measures 0.73 cm. A mesenteric lymph node measures 0.62 cm. The omentum is of normal echogenicity.

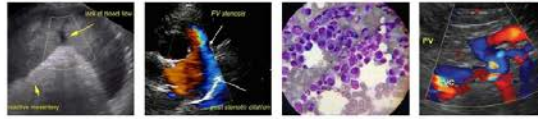
ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled pancreas with prominent pancreatic duct – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Focal hyperechoic shadowing material visualized within the gallbladder lumen – Findings are most consistent with a cholelith. No evidence of an obstructive process is visualized.
- Occasional mildly prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the liver to explain the elevation in ALT reported. There is a small stone visualized within the gallbladder, but the gallbladder wall does not appear thickened, and there is no evidence of an obstruction at this time. Consider the following for further evaluation:

- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc.
- Recommend thyroid evaluation (if not already done)
- Consider screening for toxoplasmosis



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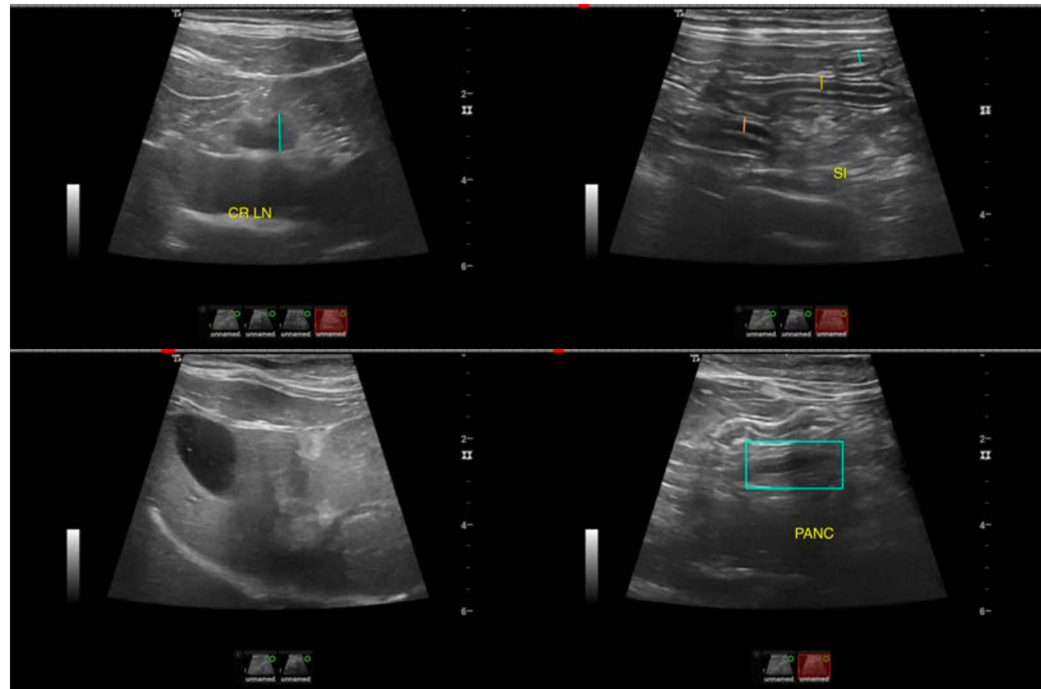
- If not already done consider pre and post prandial bile acids to evaluate liver function
- Consider Fine needle aspirate if round cell neoplasia is on your differential list (25 g needle, normal coags)
- Consider liver biopsy with samples obtained for histopathology and culture
- If triaditis is suspected consider therapy for cholangiohepatitis, testing for pancreatitis and evaluation for IBD (GI panel to Texas A&M GI lab)
- Consider a feeding tube if patient is not eating for a prolonged period of time

The pancreas appears somewhat prominent with a prominent pancreatic duct, but there is minimal reactive surrounding mesentery. These changes are likely consistent with remodeling and previous episodes of pancreatic inflammation. Correlate findings with a quantitative fPLI level.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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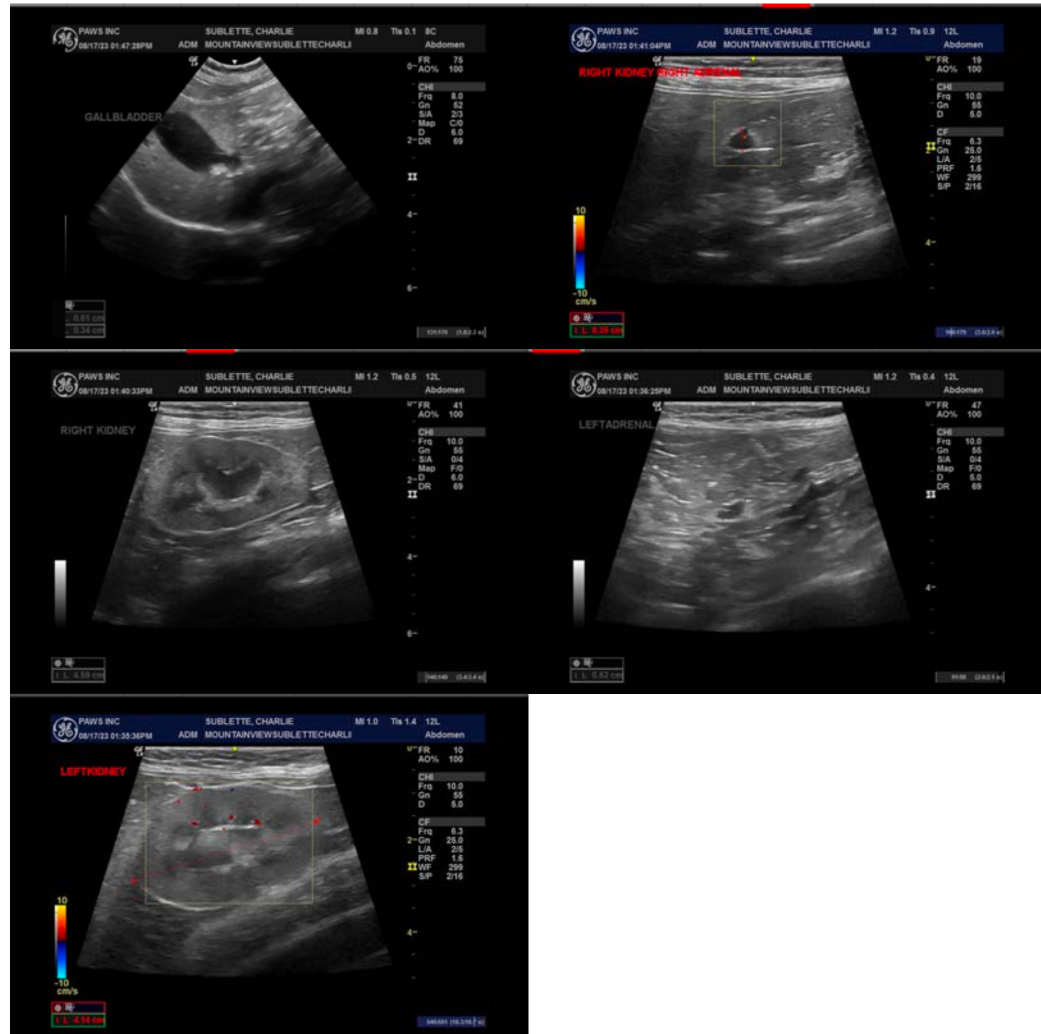

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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