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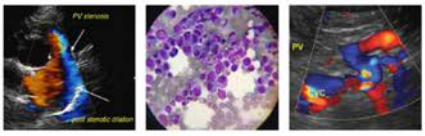

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Buddy Barriger

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

10 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

40167

DATE

8/4/22

PRESENTING CLINICAL SIGNS

Weight loss, used to be about 18lbs 2018, hyporexia, no vomiting.
Abnormal PE/Chem/CBC/UA Results: Presented to ER 5-24-22: ALT (GPT) 1299 H ALP 73 BUN 33.4 H Creatinine 2.12 H Ultrasound: "Liver Focused: Multiple mixed echogenicity masses/ nodules throughout the liver varying in size from 5.2cm to 2cm. Gall bladder normal shape and size. No free abdominal fluid noted." Recheck blood work 06-17-22 : CBC: Monocytes 600 H Chem: SDMA 21 H (16) Creat 2.5 H (2.2) BUN 35 (44) (was 33.4 at ER) ALT 1,195 H (306) AST 163 H (58) ALP 60 H (53) Tbil 0.2 III/VI heart murmur Moderate dehydration

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 (4.21 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 (3.83 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, irregular, and diffusely cystic. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. The majority of the hepatic parenchyma is diffusely cystic with a “swiss cheese” like appearance. These cystic lesions vary in size from approximately 0.5-5.2 cm. There is a large, hypoechoic, slightly echogenic cystic structure measuring 5.8 cm visualized that appears to contain hyperechoic debris. I suspect this is a very large, focal hepatic cyst, but a mass or abscess cannot be ruled out.

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

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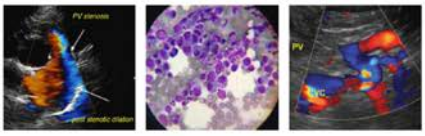

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Gastrointestinal

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 0.31 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 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.

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

- Large, irregular, heterogeneous and diffusely cystic liver with minimal normal parenchyma visualized. Many of these lesions have the typical characteristics of hepatic cysts/cystadenomas. The largest cystic lesion appears to have slightly more echogenic fluid and more of a mass effect.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The majority of the liver appears significantly cystic with lesions most consistent with cystadenomas or benign hepatic cysts. These tend to behave relatively benign, but can cause issues due to space occupation, and I suspect there is enough cystic tissue here to be damaging the hepatocytes and causing the ALT elevation. Additionally, there is a very large cyst measuring 5.8 cm that is more distinct and rounded with more echogenic fluid within, which could represent an infected cyst or more of a mass lesion.

Options are somewhat limited. A contrast CT scan would be very helpful to get a global view of the liver and try and determine if there is any benefit to surgical intervention. Additionally, you could consider trying to drain the large focal lesion and submit the fluid for fluid analysis and cytology. In my experience, these tend to refill relatively quickly, but it could provide some relief by relieving some of the pressure. If a percutaneous drainage is attempted, recommend trying to pass the needle through some more solid tissue to act as a cork and try to prevent leakage of the cystic fluid, as this would be a risk for this case.

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

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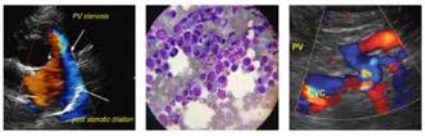

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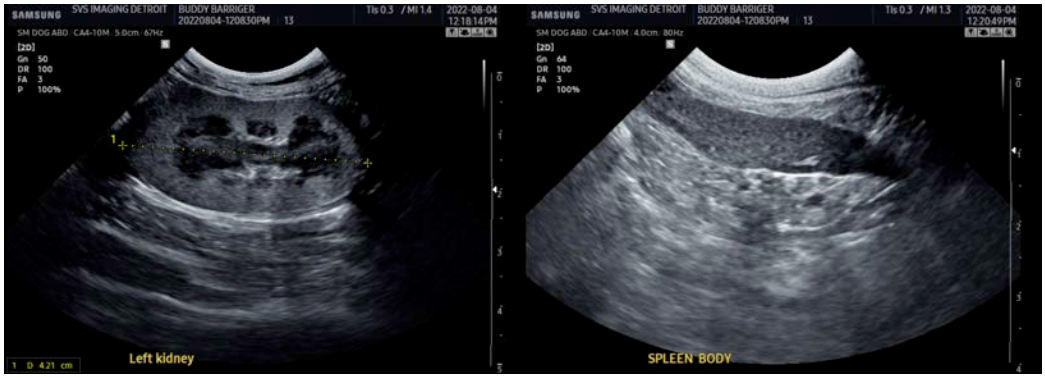

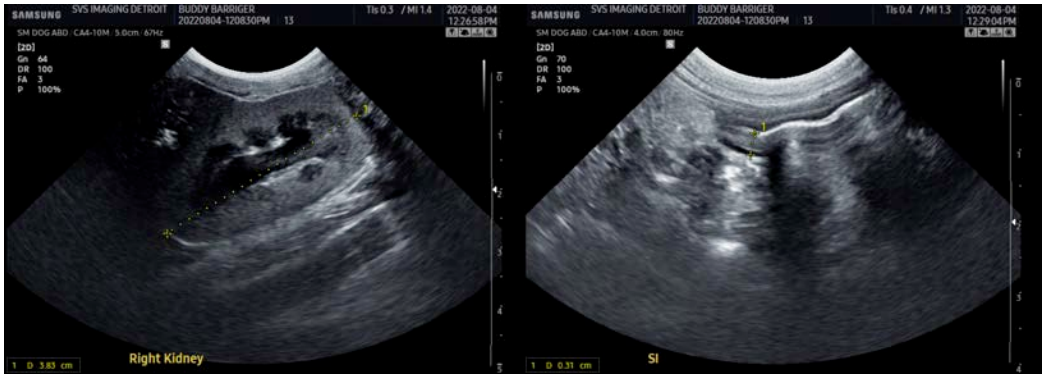

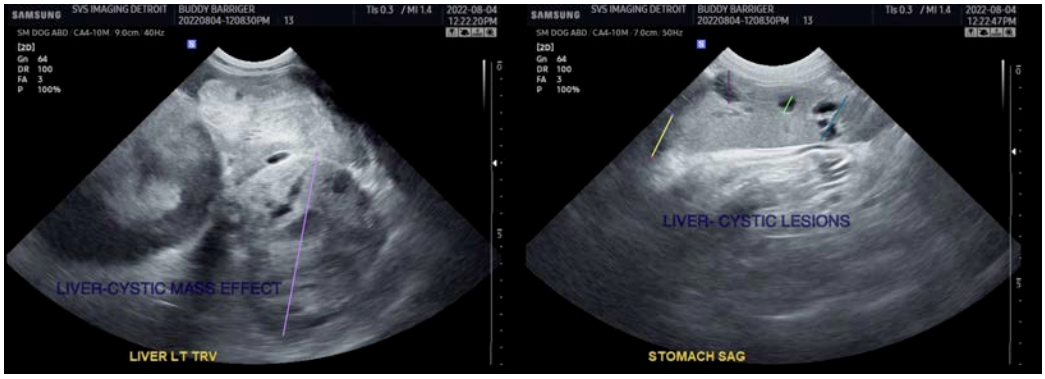

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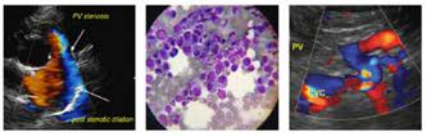

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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