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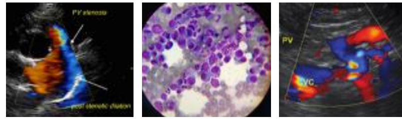

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**DATE**
9/16/22

**PATIENT**
Oliver Parsons

**SPECIES**
Feline

**BREED**
DSH

**SEX**
Neutered Male

**AGE**
9/15/15

**WEIGHT**
10 Pounds

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

**HOSPITAL NAME**
Animal Emergency Hospital

**REFERRING VET**
Dr. Roper

**INVOICE**
17319

## PRESENTING CLINICAL SIGNS

History: 2 weeks ago P went to rDVM for a ear infection. P started ear medication. P did not eat for a week. Last week P started fluids but did not get a lot in because he ripped it out. P has been eating all week but has been eating differently. P has lost 2lb in two weeks. Tbili 2.3->4.1 increased, ALT decreased 3162->298. P only eats dry food and dry chicken. O believed 2 weeks ago ate toothpick and vomited. Indoor only FeLV/FIV vaccinated.

Current Medications: None listed.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

## 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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.45 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 (4.38 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 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. The spleen measured 0.81 cm in width at the level of the hilus.

### *Liver*
The liver is subjectively large in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. No focal nodules or cystic lesions are observed

The gall bladder appears bilobed. There is a moderate to large amount of intraluminal debris visualized within both gallbladder lumens. The gallbladder wall is prominent and mildly thickened, measuring 0.19 cm

with mild subjectively hyperechoic surrounding hepatic tissue. The cystic duct appears tortuous and dilated, measuring at 0.36 cm and it can be followed to just beyond the liver. No obvious obstructions are visualized.

### ***Gastrointestinal***

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36 cm 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. The duodenum measured as normal (between 0.13-0.38 cm in wall thickness) and the jejunum measured as normal (0.14 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***

There is scant free abdominal fluid. No lymphadenopathy is present. The omentum is generally of normal echogenicity.

### ***Other***

A brief view of the heart was submitted. No pericardial effusion was seen.

## ULTRASONOGRAPHIC FINDINGS

- Bilobed gallbladder with moderate to large gallbladder sludge, a mildly thickened wall and dilated/tortuous cystic and bile duct. These findings are most consistent with cholecystitis.

- Large heterogeneous liver. Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.

- Scant free abdominal fluid.

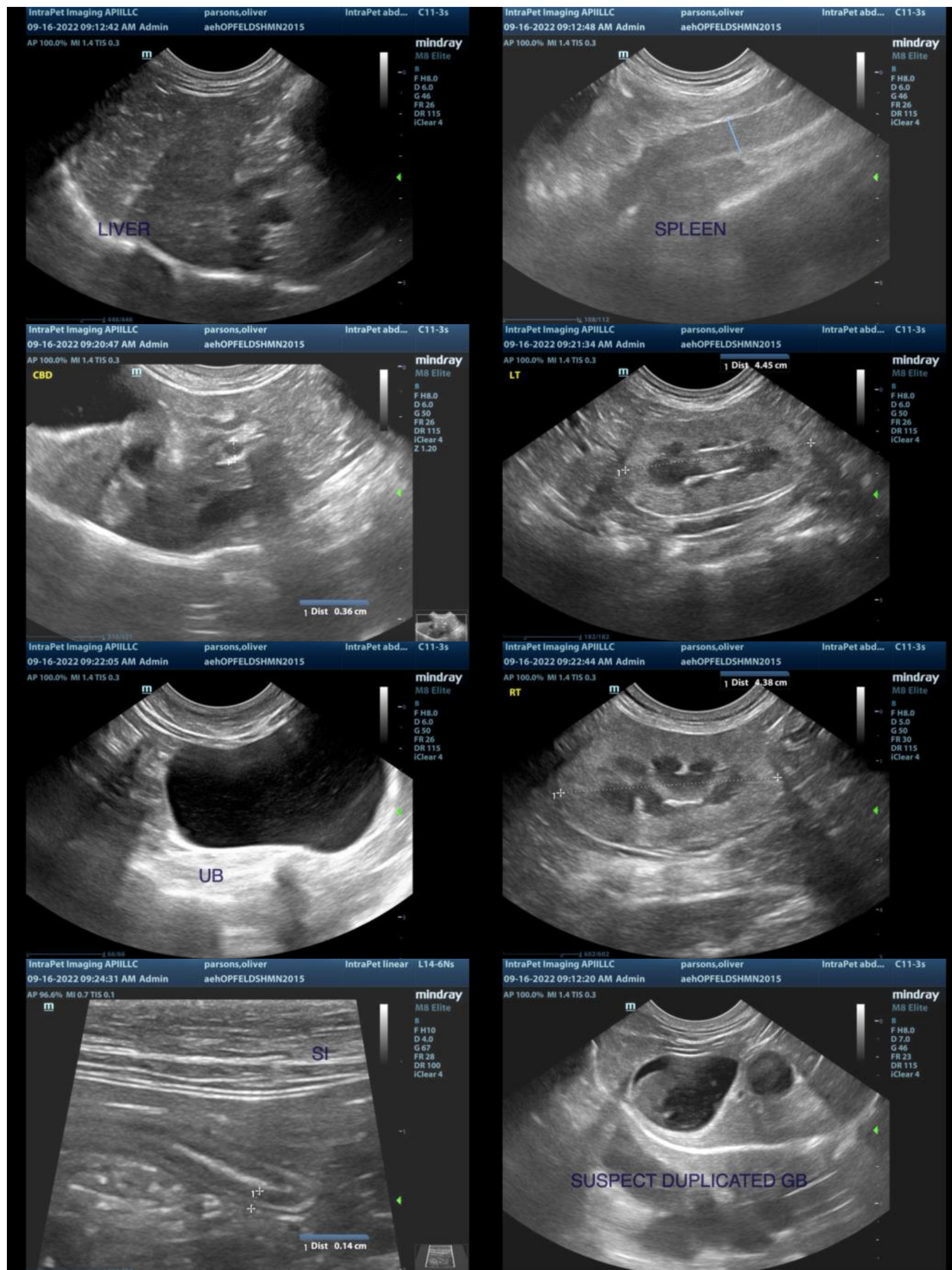
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

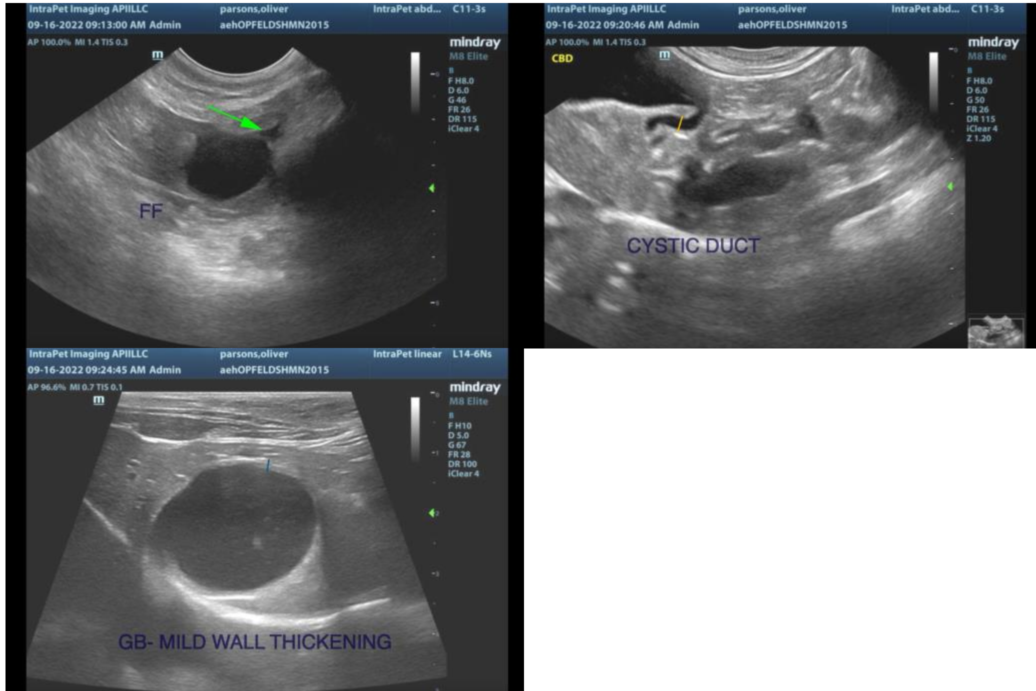
There are two gallbladder lumens visualized, which appear to have a moderate to large amount of debris, a mildly thickened wall and a thickened tortuous cystic and common bile duct. No obvious point of obstruction is visualized.  This is concerning for cholecystitis given the bilirubin elevation reported. I recommend treatment for cholecystitis with ursodiol, antibiotics and supportive care (fluids, antiemetics, etc.). Additionally, I recommend probiotic therapy whenever using antibiotics. I recommend repeat imaging of the gallbladder in approximately 48 hours or sooner if the patient is not feeling better.

The liver is large and somewhat heterogeneous. If coagulation parameters permit, consider a fine needle

aspirate of the liver in an effort to rule out round cell neoplasia.

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






**The information and recommendations provided are based on the images presented by the referring veterinarian. 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.

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