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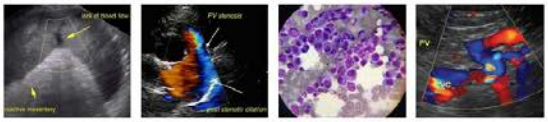

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Sierra Bosch

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6 Years

WEIGHT

15.16 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Desert Hills AH

REFERRING VET

Dr. Michelle Caldwell

INVOICE

41589

DATE

9/22/22

PRESENTING CLINICAL SIGNS

Chief Concern/Provisional Diagnosis: Elevated liver values History / Physical Findings: P presented 8/11/22 for an annual exam. Noted 0.5# weight loss and decreased appetite for about 1 week. No vomiting or diarrhea. Decreased energy. Labs performed and showed minimal elevation in ALT (112), rest wnl. Discussed possible causes of elevated ALT with O and given GI signs recommend abdominal rads and maldigestion profile - which was normal. Rad report below Diet- Hill's i/d- P re-presented on 9/22 for a bloated abdomen but noted 1.5# weight gain but appetite is still off and on. P had vomited twice a couple weeks prior but none since. Recheck labs showed ALT of 138 and Abdominal US was then done (today's images).

Abnormal PE/Chem/CBC/UA Results: 8/11/22: ALT 112, 9/22/22 ALT 138 (10-100) RADS: The abdomen is unremarkable. The cause of the poor appetite and weight loss is undetermined by today's images. Differentials may include underlying gastroenteritis or pancreatitis. Underlying intestinal disease like inflammatory bowel disease may also be considered. No clear evidence of a gastric or intestinal foreign body is seen nor is there indication of an intestinal obstructive pattern

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 is borderline large and irregular (likely due to previous infarcts) 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 or hydroureter. Renal vasculature is normal.

The right kidney is borderline large (4.3 cm) and irregular (likely due to previous infarcts) 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 or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.41 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 0.33 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 (0.74 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.

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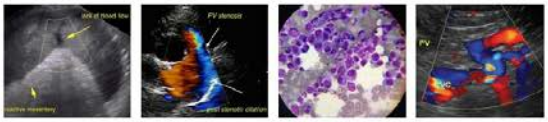

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Liver

The liver is large with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

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 cystic and common bile ducts are normal/not visible.

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 measures 0.20 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. There are occasional visible but not significantly enlarged lymph nodes. One mesenteric lymph node measures 0.37 cm. The pancreaticoduodenal lymph node measures 0.37 cm. The omentum is of generally normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Borderline large, irregular kidneys – These changes could be partially due to previous infarcts. The solitary renal lesion identified is ill defined and hyperechoic, this could be consistent with a previous renal infarct and can be an indicator of current or previous renal disease.

- Large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.

- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting. Incidental gall bladder debris is less common in cats.

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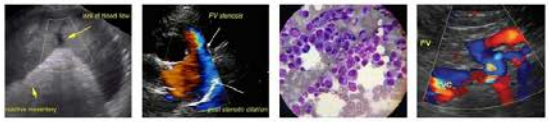

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

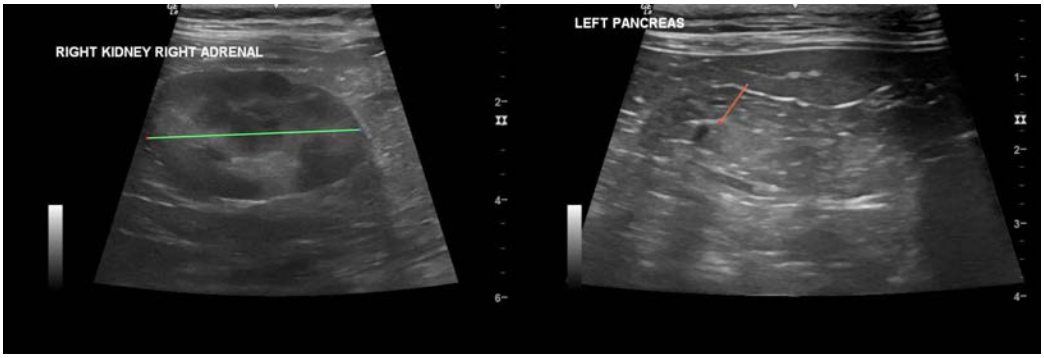
The lesions observed on today's scan are relatively mild. Unfortunately, the severity of the lesions observed in the liver do not always correlate with the amount of disease present. No focal lesions were observed and the gallbladder changes are relatively mild. Consider these recommendations for further evaluation of a possible hepatopathy:

- 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)
- 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

It is also possible that the changes in the liver are secondary to the weight loss and some other primary problem that is not clearly evident at this time.

The significance of the renal changes described is uncertain. Consider a blood pressure evaluation, urinalysis and culture to establish a baseline.

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



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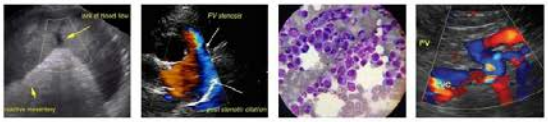

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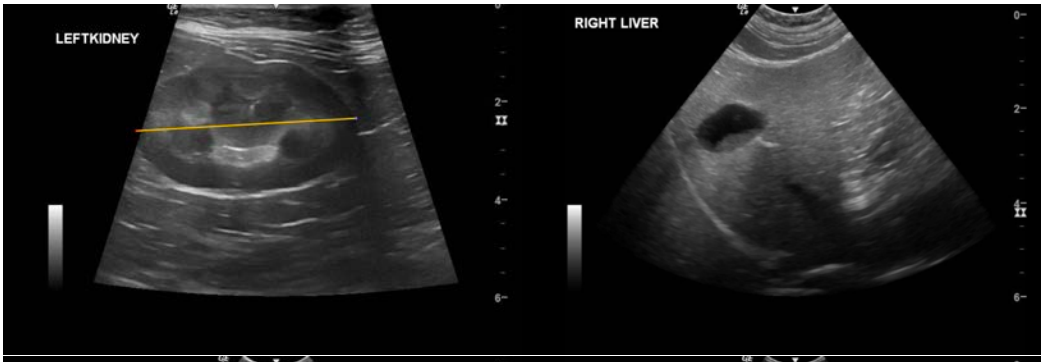

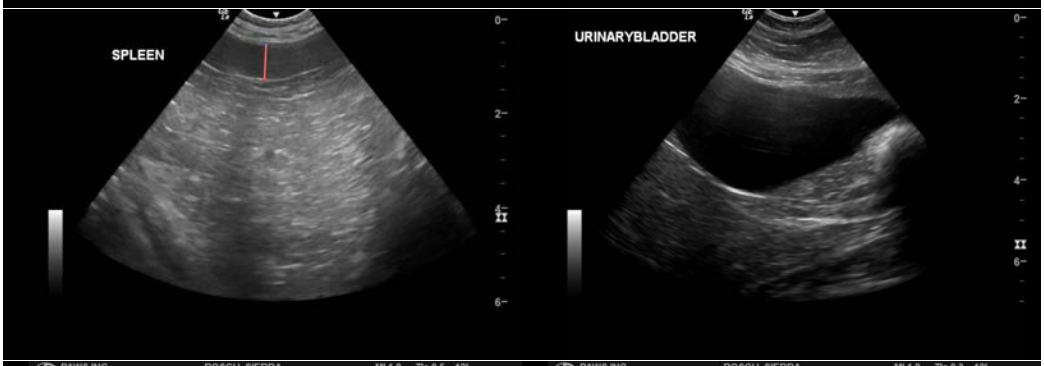

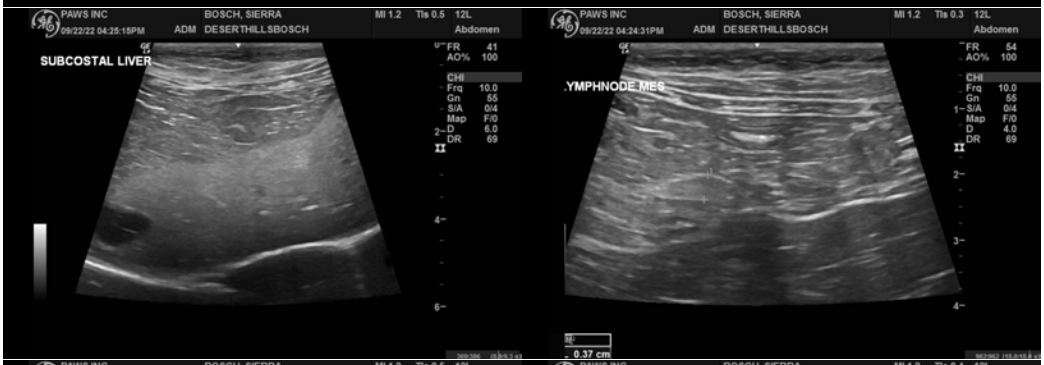

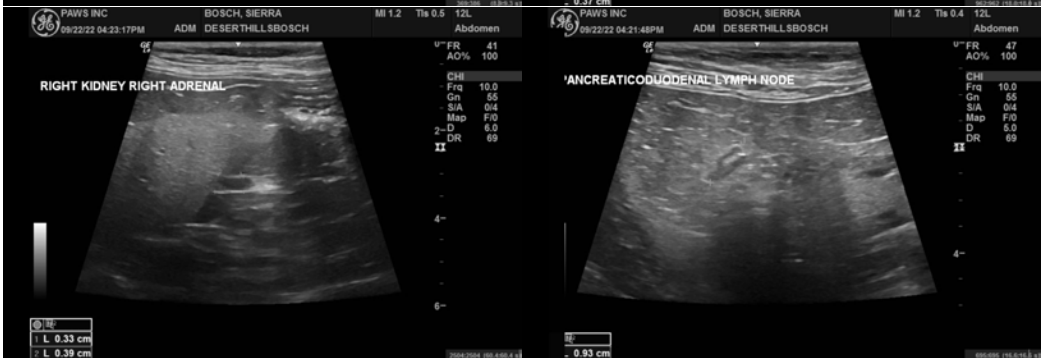

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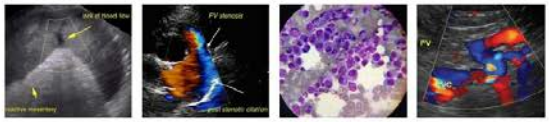

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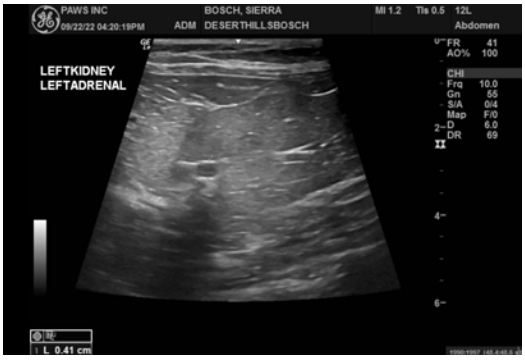

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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