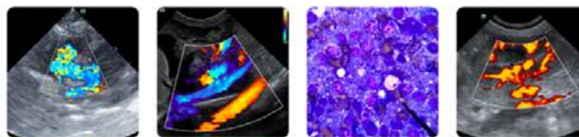

PATIENT

Cleo Febus

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

4 Years

WEIGHT

12

INTERPRETED BY

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

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Javier Rodriguez

INVOICE

72017

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PRESENTING CLINICAL SIGNS

Pt presented as a referral for an abdominal u/s to evaluate signs of anorexia that started 4 days ago, decreased urine and jaundice. Currently taking Famotidine, Cerenia, and Metronidazole. Supporting with RC Recovery canned food. Vaccines up to date.

Abnormal PE/Chem/CBC/UA Results: PE: Icterus felv / fiv - negative Radiographs and Bloodwork attached as supporting documents.

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 (3.97 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 (4.15 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 0.33 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 0.36 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.

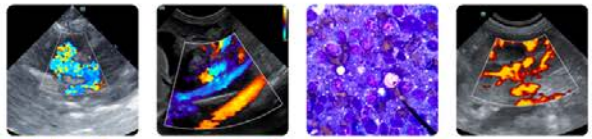
Spleen

The spleen is subjectively normal in size (0.98 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 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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.



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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. Duodenum wall measures 0.22 cm. Jejunum wall measures 0.18 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 visible/mildly mottled in the right limb. 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 fluid near the spleen. There are occasional small, prominent mesenteric lymph nodes. An example measures 0.49 cm. Additionally there is a cluster of lymph nodes near the ileocecal junction measuring 0.26 cm, 0.42 cm, and 0.31 cm, with reactive mesentery in the region.

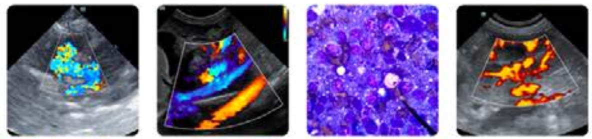
ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with mild pancreatic remodeling.
- Hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Mild reactive lymphadenopathy, particularly at the ileocecal junction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the liver to explain the elevation in bilirubin reported. The gallbladder appears normal. The bile duct is not clearly visualized, which makes significant dilation less likely. Findings at this time are supportive of a primary hepatopathy. Consider the following:

- Provided coagulation parameters are normal, consider a fine needle aspirate of the liver for cytologic evaluation. This would help to differentiate hepatic lipidosis from round cell neoplasia.
- If clinically appropriate, you could consider screening for toxoplasmosis.
- A biopsy of the liver with samples for histopathology and culture would likely be necessary for a definitive diagnosis. If there is no response to therapy and/or if lipidosis is not suspected, this may be necessary. Prior to this consider empirical treatment for acute liver injury with a course of Ursodiol, Denamarin, and antibiotics and supportive care. A feeding tube may need to be



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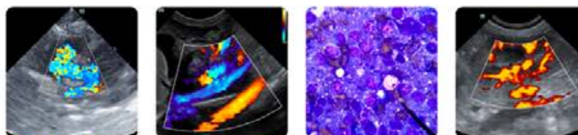
considered.

No definitive bowel lesions or pancreatic lesions are observed, but the pancreas is visible, and the small intestine occasionally appears somewhat "ropey". If a chronic enteropathy is suspected, you could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further investigate.

If the patient appears to be getting worse despite therapy, you could consider repeat imaging, looking for the progression of today's lesions and the development of new lesions.



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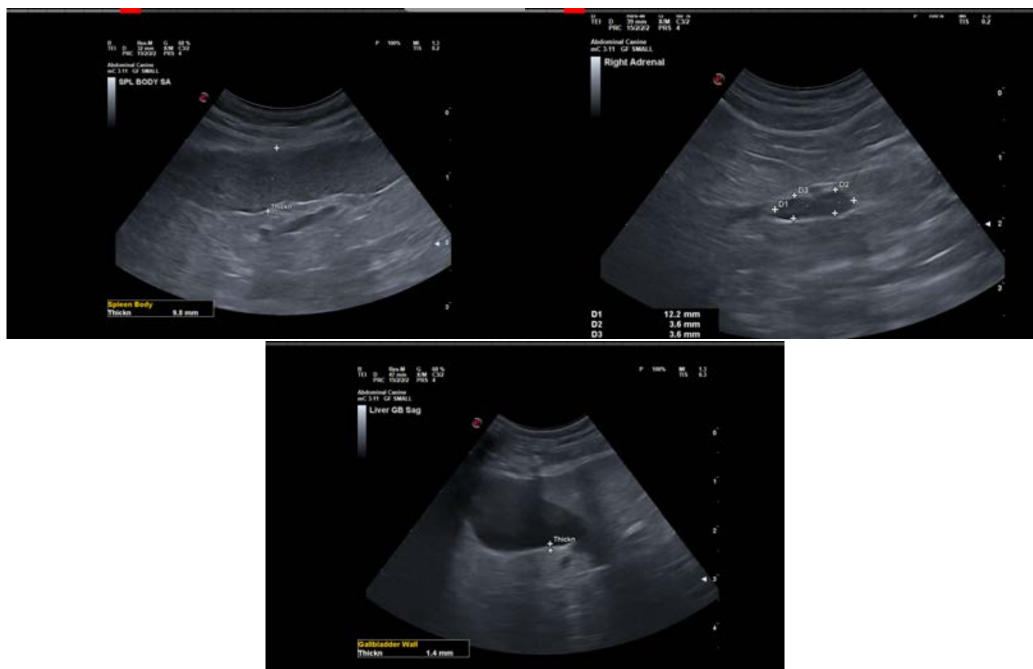

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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