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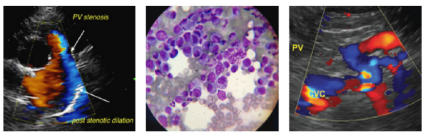

SonoPath
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PATIENT

Maycee Curry 268079

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10 Years

WEIGHT

6.7 kg

INTERPRETED BY

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC – Dr. Bianco

INVOICE

37087

DATE

4/22/22

PRESENTING CLINICAL SIGNS

Maycee presented to the WVRC-Emergency Service on 4/21/2022 for evaluation of continued vomiting despite receiving anti-nausea medication. Owner reports that Maycee has always been a chronic, intermittent vomiter, who typically would vomit about 3x a month. However, right now she is vomiting more often than that. Owner reports that this past Friday (4/15/22) she was not eating and was vomiting. She did have a BM at that time. By Monday (4/18/22), owner reports that Maybee was only passing small, dry bowel movements and was still vomiting. Owner elected to take her to her primary care vet, who performed x rays and bloodwork (not available for review at the time of exam), and gave her a Cerenia injection and prescribed Clavamox TGH. Owner also reports that by Wednesday (4/20/22), she seemed worse again, so owner took her to FVARC where she was given SQ fluids, cerenia, and discharged with cerenia and gabapentin. Owner reports that she has been giving these things but Maycee continues to vomit, so she would like to pursue an abdominal ultrasound as the next step.
Abnormal PE/Chem/CBC/UA Results: CBC: all values WNL. Chem: ALT 148, AST 62, all other values WNL. PCV/TP 30% and 7.6g/dL, serum clear.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is well distended with anechoic contents. The wall is smooth and regular. No abnormalities are noted with the trigone or proximal urethra, and there is no evidence of sediment, cystoliths, polyps or a mass.

Kidneys

The **left** kidney measures 3.93 cm (3.80-4.40 cm). The capsule is smooth. Hyperechoic regions are observed within the cortex, which may be suggestive of inflammation or ischemia. The spleen remains hyperechoic to the cortex. A mild loss of the normal definition of the cortico-medullary junction is present. A thin hyperechoic line is observed within the medulla traversing parallel to the corticomedullary junction. Mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. An accumulation of intrapelvic fat is noted. The surrounding mesentery is mildly hyperechoic.

The **right** kidney measures 4.30 cm (3.80-4.40 cm). Findings are similar to the left kidney.

Aortic bifurcation/trifurcation

No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.34 cm in diameter. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

The **right** adrenal gland measures 0.34 cm in diameter. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Spleen

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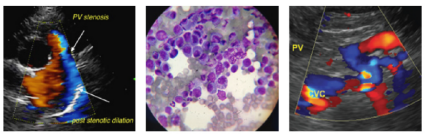

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Mild splenomegaly (12.1 mm (normal = 10 mm)), however, no abnormalities are observed with its overall architecture, echotexture, or echogenicity, and the capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

Liver

There are no obvious signs of hepatomegaly and its borders are smooth and sharp. The liver's echotexture is homogeneous, but mildly hyperechoic, i.e., it is isoechoic to very mildly hyperechoic to the falciform fat. No abnormalities are observed with the hepatic vessels visualized.

The gallbladder wall is within normal limits in thickness and echogenicity. There is no evidence of echogenic material within the GB or edema surrounding it. Although the cystic duct is not overtly dilated, it is mildly tortuous. The common bile duct is not identified due to the large amount of gas in the stomach. An obvious obstruction is not visualized.

Gastrointestinal

The gastric wall is within normal limits in thickness and the wall layers are well defined. No obvious abnormalities are observed with its peristalsis.

The small intestinal wall thickness, including the duodenum, is within normal limits. The jejunum measures up to 0.22 cm (WNL). Although the definition of the wall layers is preserved, the submucosa and the muscularis are more prominent than usual and fogging of the mucosa is present. No abnormalities are observed with the ileo-cecal-colic junction. Abnormally dilated loops of bowel are not observed.

Ingesta and gas are present in the transverse colon.

The colonic wall is not thickened and mural detail is considered normal.

There are no obvious signs of a mass, foreign body or an obstruction in the gastrointestinal tract.

Pancreas

No overt abnormalities are observed with the parenchymal echogenicity or echotexture of either limb. There is no evidence of hyperechogenicity of the surrounding mesentery, i.e., signs of active pancreatitis are not present, nor is there evidence of neoplasia.

Other

Lymph nodes

No abnormalities are observed

Abdominal effusion is not visualized.

ULTRASONOGRAPHIC FINDINGS

- Cholecystitis cannot be excluded despite the absence of classical sonographic signs.
- Cholestasis, cholangitis/cholangiohepatitis, including a suppurative form, may be the cause of hepatic changes observed.
- Hepatic lipidosis due to hyporexia is likely contributing to the diffuse hyperechogenicity of the liver.

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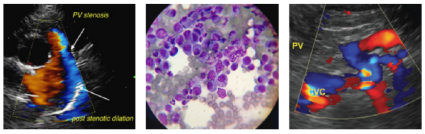

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- Differential diagnoses for splenomegaly include, antigenic stimulation and secondary inflammation (splenitis), as well as immune-mediated induced inflammation. Splenic hyperplasia and extramedullary hematopoiesis may also cause splenomegaly. Neoplasia, such as lymphoma, mast cell tumour, or other round cell tumour, is considered unlikely. A fine needle aspirate would be required to exclude neoplasia with certainty, but is considered unlikely.

- The intestinal abnormalities are subtle and are attributed to inflammation due to vomiting. Underlying causes may include inflammatory bowel disease, as well as cholangitis/cholangiohepatitis, cholecystitis. There are no obvious signs of pancreatitis.

- The perinephric mesentery is mildly hyperechoic, therefore, one cannot rule out pyelonephritis as the cause of Maycee's clinical signs. The other changes observed are subtle and are suggestive of age-related degeneration.

- The thin hyperechoic line observed within the medulla traversing parallel to the corticomedullary junction is a non-specific sign, which is most often idiopathic in nature. However, differential diagnoses may include an area of intraluminal mineral deposits within renal tubules in patients without kidney disease, renal lymphoma or feline infectious peritonitis (FIP). The latter differential diagnoses are considered unlikely, however, an evaluation for proteinuria is suggested once Maycee is feeling better, i.e. once other signs of systemic inflammation have resolved.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture and sensitivity are suggested to exclude possible pyelonephritis. The administration of amoxicillin-clavulanic acid may yield a false negative result.

Analgesia for visceral pain, such as buprenorphine, is suggested, as well as supportive care, such as maropitant once a day for 4-5 days, subcutaneous fluids (administered at home, if possible), as well as a 10-14 day trial with famotidine or omeprazole may be considered.

Cholestasis, cholangitis/cholangiohepatitis cannot be excluded, despite the absence of abnormalities with the gallbladder and bile ducts. Secondary ascending bacterial infections are common. Although indiscriminate use of antibiotics is not normally recommended, one could start treatment with a broad-spectrum antibiotic (see below) and reassess liver enzyme activities, including a GGT, in a few weeks. If an improvement is not observed, a decision to pursue further diagnostics, for example, a FNA of the liver, may be pursued.

To avoid oral antibiotics due to Maycee's anorexia, an injection of cefovecin (Convenia) may be tried (not ideal, but it avoids the GI tract). Discussion with the client that this is not necessarily an ideal drug is suggested, however. If an improvement is observed, at least 2 additional doses are recommended 10-12 days apart.

A veterinary prescription brand hypoallergenic diet, whether hydrolyzed or novel protein, may be tried. Multiple diets may be required, including only canned food, as some individuals cannot digest dry. The kibble may be soaked if an all canned diet is cost prohibitive. *However, it is more important that Maycee eat to prevent her from developing weight loss and sarcopenia.*

Small, frequent meals of a diet that is enticing is recommended.

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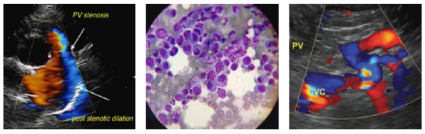

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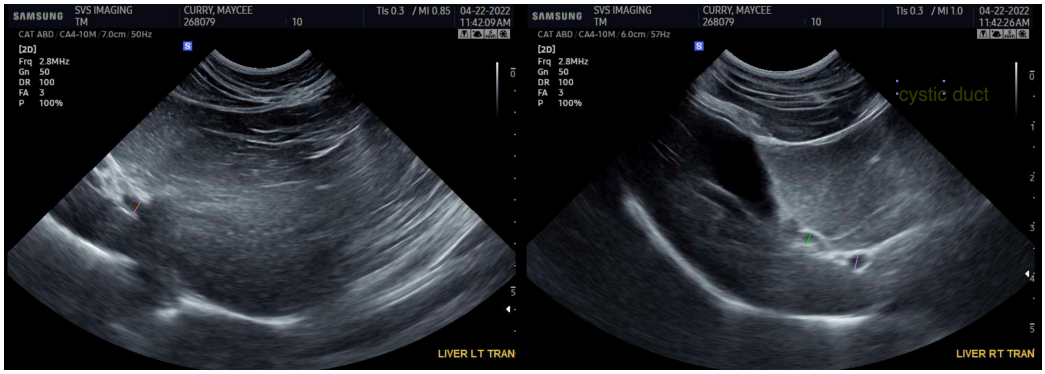
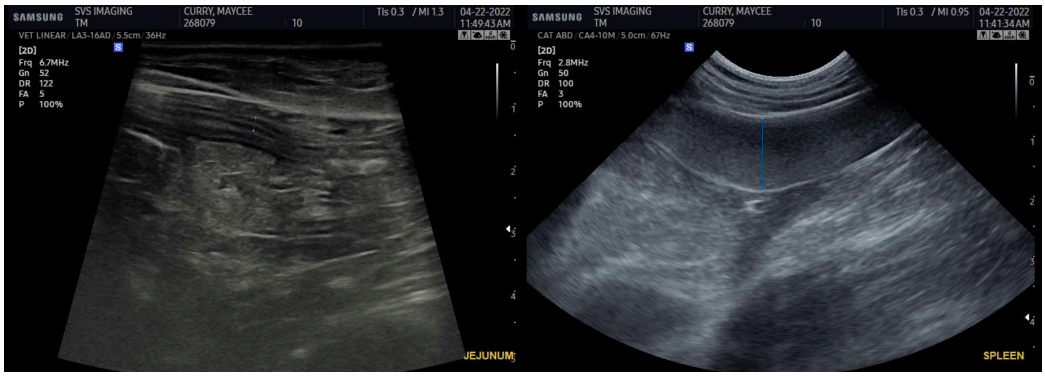
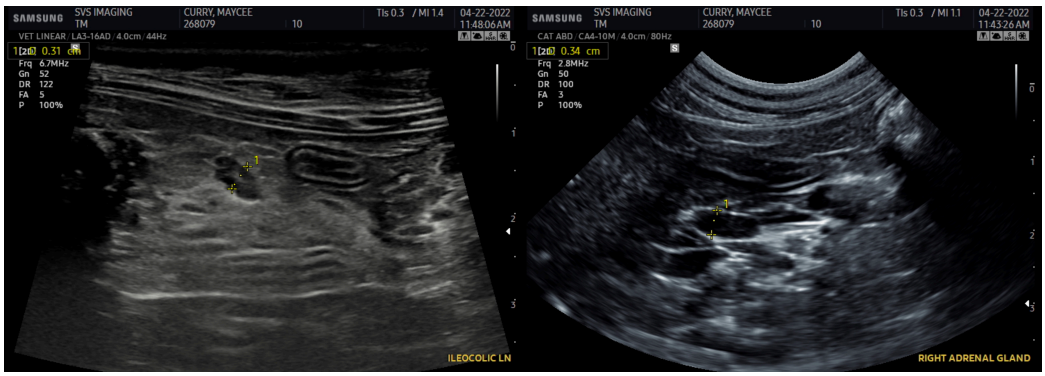
If there is no response to the above, endoscopy and biopsies of the upper and lower GI tract are suggested.

If there is no response within 48 hours, and further diagnostics are not pursued, although not ideal, empirical treatment to treat secondary inflammation caused by the chronic vomiting. For example, a dose of prednisolone may be administered (0.5 mg/kg/day), in addition to a hypoallergenic diet, that is easily digestible, but appetizing to prevent catabolism and sarcopenia.







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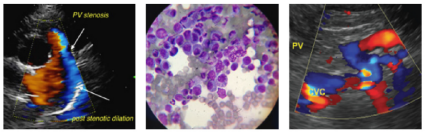

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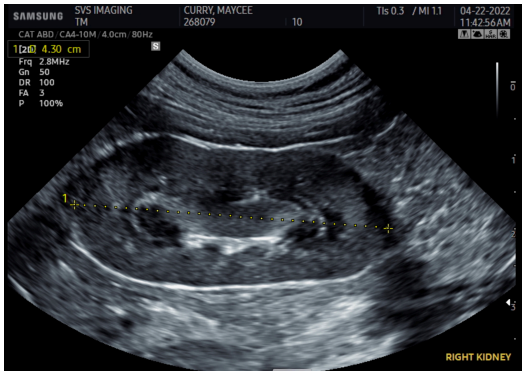

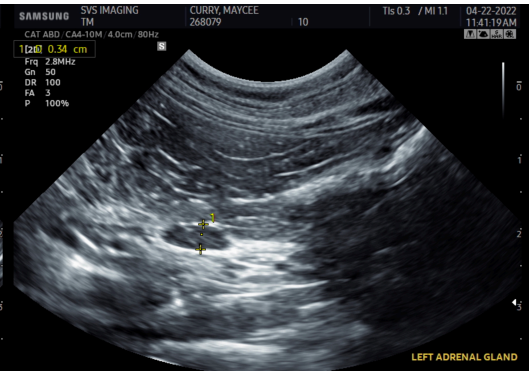

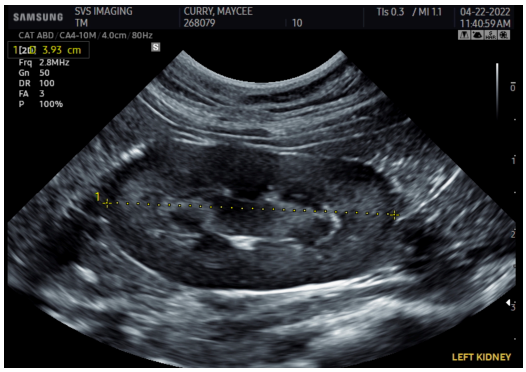

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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