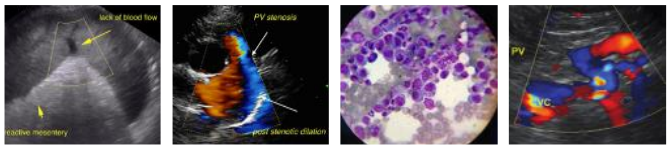

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1-800-838-4268 info@sonopath.com

PATIENT
Ninja Korfman

SPECIES
Feline

BREED
DSH

SEX
Female

AGE
15 Years

WEIGHT
14.7 Pounds

INTERPRETED BY
Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY
Dr. Laurel Logas

HOSPITAL NAME
Bradenton VH

REFERRING VET
Dr. Laurel Logas

INVOICE
37350

DATE
5/3/22

PRESENTING CLINICAL SIGNS

P was presented for not eating for two days, no known U/D. No vomiting, but did have diarrhea as of this AM.
Abnormal PE/Chem/CBC/UA Results: NEU%-38.0, LYM%-8.7, WBC-4.36, LYM-0.38, MONO-0.05, HGB-16.5, MCHC-36.4, PHOSHORUS-2.3, GLUCOSE-217

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 4.04 cm (3.80-4.40 cm). The capsule is smooth. The cortex is mildly hyperechoic and a mild to moderate loss of the normal definition of the cortico-medullary junction is present. Mild mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths. The pelvis measures 1.65 mm. The surrounding mesentery is isoechoic to the cortex, i.e., it may be mildly hyperechoic.

The **right** kidney measures 4.34 cm (3.80-4.40 cm). The capsule is smooth. The cortex is mildly hyperechoic and a mild to moderate loss of the normal definition of the cortico-medullary junction is present. Very small mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. The pelvis measures 0.59 cm. A normal accumulation of intrapelvic fat is noted. The surrounding mesentery is mildly hyperechoic.

Aortic bifurcation/trifurcation

No abnormalities observed.

Adrenal Glands

The **left** adrenal gland is not visualized.

The **right** adrenal gland measures 0.31 cm at the cranial pole and 0.32 cm at the caudal pole. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

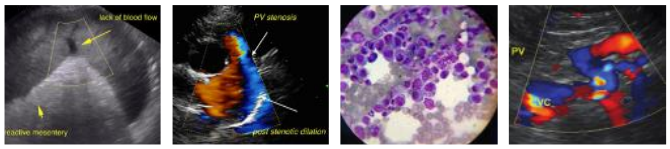
Spleen

Mild splenomegaly is observed; 13.2 mm (normal = 10 mm). it is within normal limits in echotexture, and echogenicity. The capsule is smooth. A hypoechoic nodule is noted toward the tail. It measures in 3.9 mm in diameter x 4.61 mm in length. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

Liver

There are no obvious signs of hepatomegaly. The borders are smooth to mildly rounded. The liver is mildly to moderately heterogeneous, with a coarse and granular echotexture. It is diffusely hyperechoic, i.e., it is mildly hyperechoic to the falciform fat.

A hyperechoic mass effect is present in the region of the left pancreas. It has irregular contours and measures approximately 1.5 cm in diameter x 2.4 cm in length. An anechoic to hypoechoic nodule is present within the mass effect. The latter measures 0.33 cm in diameter x 0.53 cm in length. The



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mass effect appears to be associated with the liver. No obvious 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. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction.

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.

One loop of small intestine is at the high end of the normal reference range at 0.29 cm. Other than the one loop of small intestine that is at the high end of the normal reference range, the small intestines, including the duodenum, is within normal limits and the definition of the wall layers is preserved. Abnormally dilated loops of bowel are not observed.

No abnormalities are observed with the ileo-cecal-colic junction.

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

Pancreas

No overt abnormalities are observed with the echogenicity or echotexture of the parenchyma. There is no evidence of hyperechogenicity of the surrounding mesentery, i.e., signs of active pancreatitis are not present.

The right limb of the pancreas is mildly hypoechoic with a hyperechoic “capsule”. The surrounding parenchyma is very mildly hyperechoic. Mild pancreatitis cannot be excluded.

Other

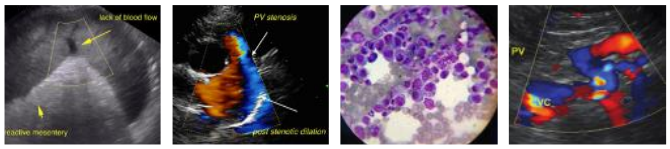
Lymph nodes

No abnormalities are observed

Abdominal effusion is not visualized.

ULTRASONOGRAPHIC FINDINGS

- A component of the hepatic changes are most likely secondary to a vacuolar hepatopathy and hepatic lipidosis. However, cholestasis, and cholangitis/cholangiohepatitis cannot be excluded. The mass effect noted in the left cranial quadrant appears to be a hepatic lobe. A benign adenoma may be present; an adenocarcinoma is also possible, but is not as likely. A fine needle aspirate or tissue biopsy is required to achieve a diagnosis.
- Differential diagnoses for the hypoechoic splenic nodule include nodular or lymphoid hyperplasia and extramedullary hematopoiesis. Neoplasia, such as lymphoma, mast cell or other round cell tumour, is considered unlikely.
- The right limb of the pancreas is mildly hypoechoic with a hyperechoic “capsule”. The surrounding parenchyma is very mildly hyperechoic. Mild pancreatitis cannot be excluded.
- Inflammatory bowel disease cannot be excluded despite the lack of severe intestinal changes or abnormalities noted on today’s abdominal ultrasound.



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- The renal changes observed are suggestive of chronic age-related degeneration, however, pyelonephritis cannot be excluded based on the mild hyperechogenicity of the surrounding mesentery.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture and sensitivity are recommended to exclude pyelonephritis.

A TLI, vitamin B12, and folate should be considered as cats suffering from IBD and/or pancreatitis may suffer from cobalamin deficiencies and exocrine pancreatic insufficiency, despite normal stools. If the test is cost prohibitive, supplementation with vitamin B12 is suggested. The TLI should be performed if weight loss persists.

Analgesia for visceral pain, such as buprenorphine, is suggested, as well as supportive care, such as subcutaneous fluids or a few days' of intravenous fluids.

Deworming with a broad spectrum dewormer is suggested, even if Ninja does not go outdoors, but lives with other pets that do.

A veterinary prescription brand hypoallergenic diet, whether hydrolyzed or novel protein, is suggested. 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.

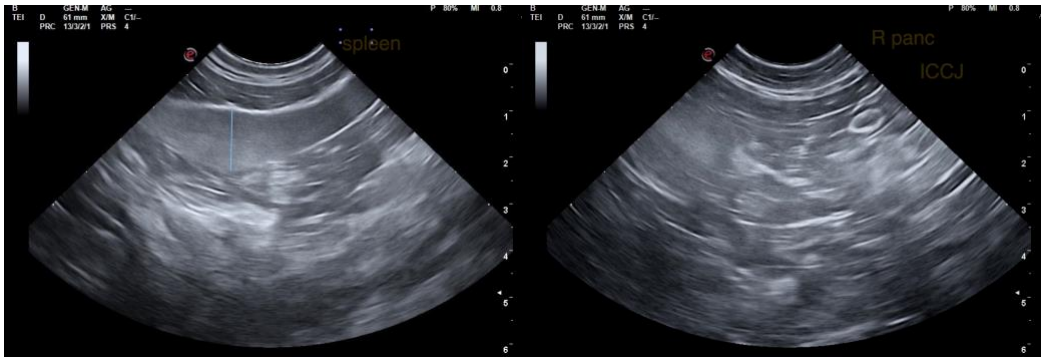
Small, frequent meals are recommended.

A 10-14 day trial with famotidine or omeprazole may be considered.

A fine needle aspirate or tissue biopsy of the possible liver "mass effect" or abnormal lobe is required to achieve a diagnosis.

An evaluation of Ninja's arterial blood pressure is strongly recommended, ideally in the presence of the client to minimize the effects of stress.

Cholestasis, cholangitis/cholangiohepatitis cannot be excluded. Secondary ascending bacterial infections may also occur. If further diagnostics are not pursued, another option is the following; although indiscriminate use of antibiotics is not normally recommended, one could start treatment with a broad-spectrum antibiotic. Although not ideal, an injection of cefovecin (Convenia) may be tried, i.e., 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.



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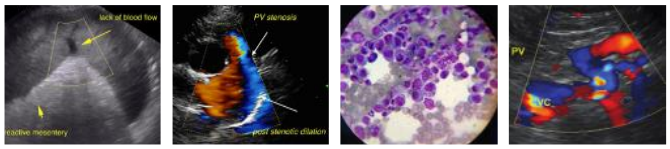

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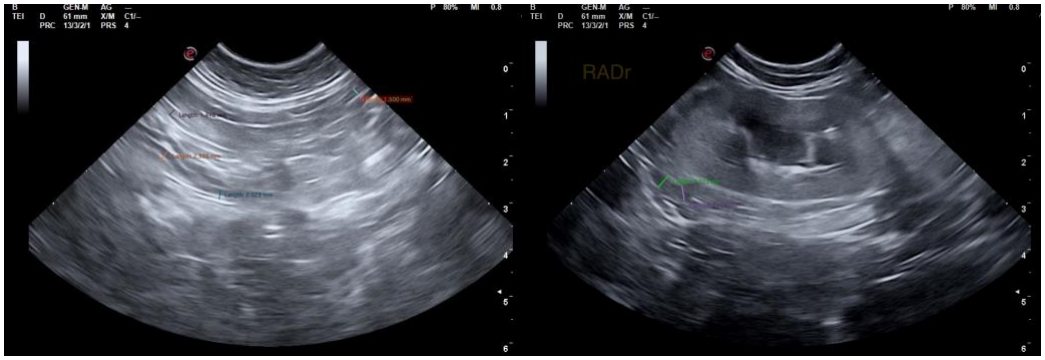

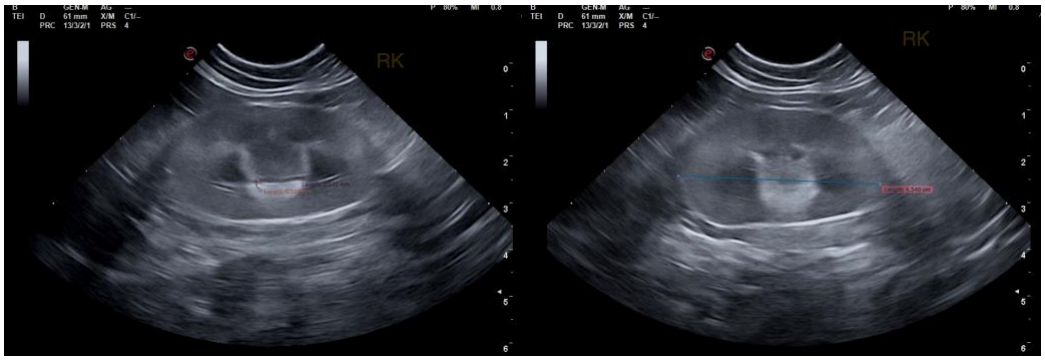

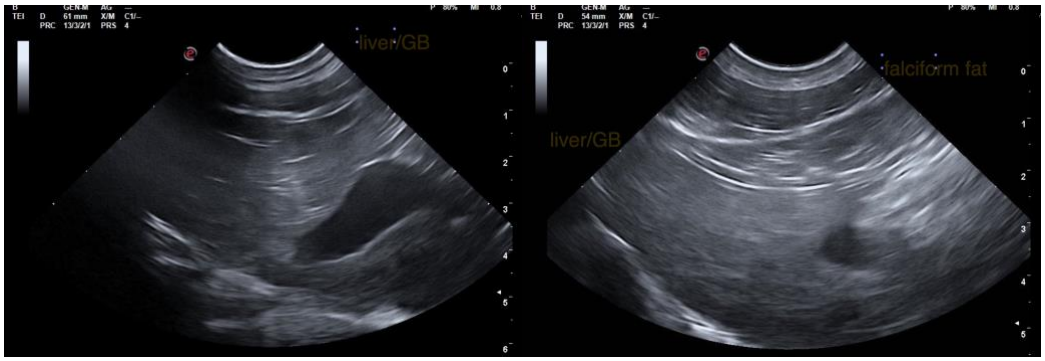

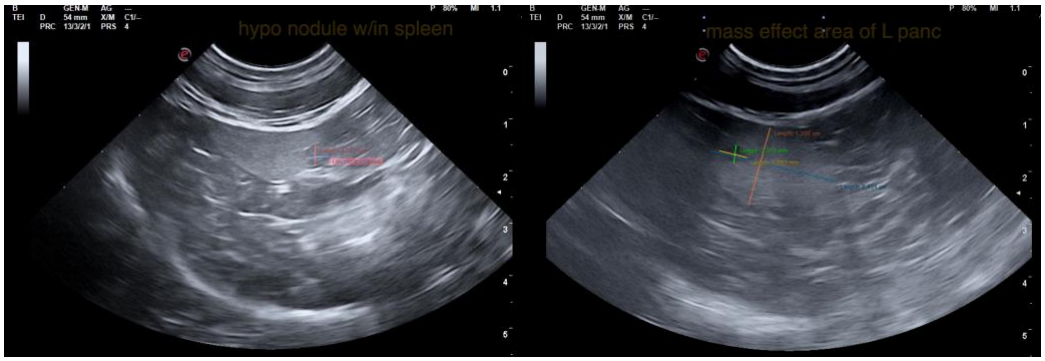

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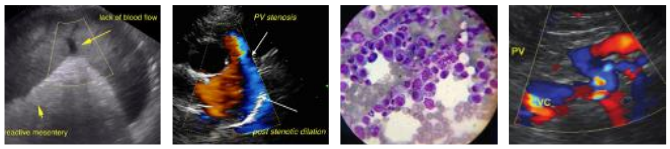

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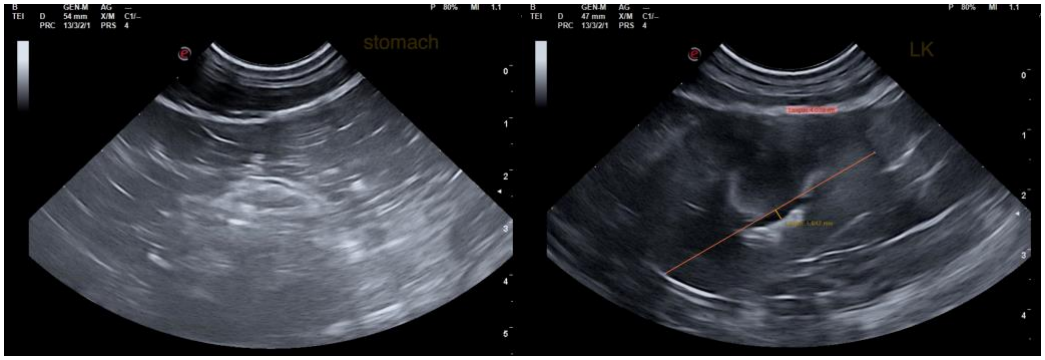

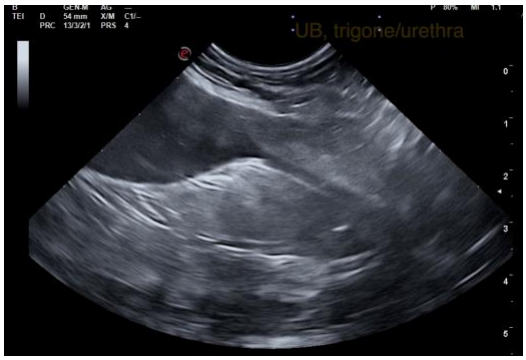

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

Lisa.Carioto@sonopath.com