

**PATIENT**

Gatsby Duran 275247

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years

WEIGHT

5 kg

INTERPRETED BYLisa Carioto, DVM,
DVSc, Diplomate
ACVIM**IMAGING PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC – Dr. Bianco

INVOICE

39772

DATE

7/22/22

PRESENTING CLINICAL SIGNS

Weight loss over several months. Historical hyperthyroidism. Came in for straining to urinate. Urinary obstruction revealed. Also constipated.

Abnormal PE/Chem/CBC/UA Results: BUN 67 (H), all else WNL at this time (including T4).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Patient was given butorphanol prior to the scan

Urinary System

The **urinary bladder** is minimally distended due to the presence of a urinary catheter. The catheter extends to and is in contact with the apical wall. Wall thickness cannot be evaluated as it is poorly distended. Its very mild irregularity may also be associated with poor distention of the urinary bladder. The lumen of the trigone and proximal urethra is filled by the urinary catheter. Three, small hyperechoic structures, that do not cause an acoustic shadow, are noted along the dependent wall.

Kidneys

The **left kidney** measures 4.41 cm (3.80-4.40 cm), very mildly increased in size. The capsule is mildly irregular. The cortex is moderately to severely hyperechoic, i.e., it is significantly hyperechoic to the spleen. A moderate loss of the normal definition of the cortico-medullary junction is present. A small number of mineralizations of the pelvis is noted, without evidence of nephroliths or pyelectasia. An accumulation of intrapelvic fat is noted. The surrounding mesentery is not hyperechoic.

The **right kidney** measures 3.50 cm (3.80-4.40 cm), mildly decreased in size. The kidney is mildly "rounded". The capsule is smooth. The cortex is hyperechoic, in addition to a moderate decrease in corticomedullary definition. A small number of mineralizations of the pelvis is noted, without evidence of nephroliths or pyelectasia. An accumulation of intrapelvic fat is noted. The surrounding mesentery is mildly to moderately hyperechoic.

Aortic bifurcation/trifurcation No abnormalities observed.

Adrenal Glands

The **left adrenal gland** measures 0.31 cm at the cranial pole, 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.

The **right adrenal gland** measures 0.38 cm. 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

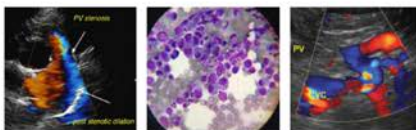
The spleen is mildly increased in size. It has a diffusely mottled or reticulated echotexture with a smooth capsule. Subjectively, it may be mildly hypoechoic compared to normal. A well-defined hyperechoic area, (0.79 cm in diameter), is noted toward the tail along the periphery. No obvious abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

Liver

Mild hepatomegaly is suspected, however, this is better characterized at the time of the ultrasound or radiographically. The liver's borders are smooth and vary between sharp to very mildly rounded. The

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overall echotexture is homogeneous other than a few hypoechoic nodules scattered throughout the parenchyma. It is within normal limits in echogenicity

Examples: 0.48 cm in diameter x 0.67 cm in length. A second hypoechoic nodule, measuring 0.32 cm in diameter x 0.63 cm in length, is noted subcapsularly. It does not disrupt the integrity of the capsule. Target-like lesions are not observed. No obvious abnormalities are noted with the hepatic vessels.

The **gallbladder** (GB) is mildly dilated, which is consistent with a fasting patient. The GB wall is within normal limits in thickness and echogenicity. A trivial amount of echogenic material is present within the GB, however, a moderate amount is present within the cystic duct, which is mildly to moderately dilated. The cystic duct is not tortuous. No abnormalities are noted with the common bile duct, 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.

The small intestinal wall thickness, including the duodenum, is within normal limits and the definition of the wall layers is preserved. Abnormally dilated loops of bowel are not observed.

Transverse colon: Ingesta and gas are present

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

Pancreas

The **left limb** is mildly enlarged and moderately hypoechoic, with slightly irregular contours. Multiple anechoic to hypoechoic nodules, most consistent with cysts, are observed. They are concentrated in one region of the pancreas. The surrounding mesenteric fat is moderately hyperechoic. Overt signs of neoplasia are not noted.

Other**Lymph nodes**

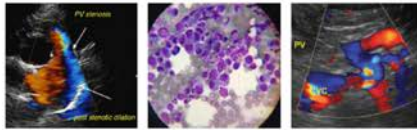
No evidence of lymphadenomegaly
An isoechoic, right medial iliac lymph node, is visualized
An isoechoic mesenteric lymph node is noted (0.29 cm in diameter x 1.48 cm in length).

Abdominal effusion

A scant amount of anechoic fluid is visualized in the cranial abdomen, adjacent to the gallbladder and ventral to the liver.

ULTRASONOGRAPHIC FINDINGS

- **Pancreas:** Active pancreatitis is suspected, in addition to multiple, benign, pancreatic cysts in the left limb.
- **Spleen:** A single regenerative nodule is suspected at the tail. The latter may also represent a combination of fat, fibrosis and mineralization. The mild splenomegaly and mottled echotexture may be consistent with splenitis, extramedullary hematopoiesis or reactive hyperplasia. Neoplasia, such as lymphoma, or other round cell tumour, cannot be excluded.

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- **Kidneys:** Age-related degeneration and glomerulonephrosis are likely playing a role in the changes observed, however, some of the abnormalities are suggestive of pyelonephritis.
- **Urinary bladder:** Sediment in the lumen of the urinary bladder, and mineralizations, which may have caused a partial obstruction. An underlying urinary tract infection and pyelonephritis should not be excluded based on the renal abnormalities observed.
- **Liver:** Benign, age-related nodular hyperplasia and hepatic lipidosis are likely. One cannot rule out cholestasis and cholangitis/cholangiohepatitis (+/- secondary to pancreatitis). An infection due to ascending bacteria from the GI tract is also possible.
- **Gallbladder:** Gallbladder sludge and possible cholecystitis (+/- a suppurative component), without evidence of an obstruction. Obtaining a history regarding signs of gastroesophageal reflux disease (GERD), from the client is suggested.
- **Ascites:** Extravasation due to increased vascular permeability and vasculitis associated may be implicated.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinalysis and culture and sensitivity to exclude pyelonephritis

Enrofloxacin (less than 5 mg/kg PO once a day based on ideal body weight) pending culture results.

Fine needle aspirates of the spleen to exclude neoplasia, as well as FNAs of the liver, with culture of the liver and bile, pending coagulation profile results. Vitamin K (0.5 mg/kg SQ) is suggested 30-45 minutes prior to the procedure, even if PT/PTT within normal limits.

Pending the above results or, if the former are not pursued, the following are suggested:

Analgesia for visceral pain, such as buprenorphine (0.005-0.01 mg/kg sublingually every 8-12 hours) for a minimum of 7-10 days. Continue for 3-4 weeks if an improvement is noted; the dose and frequency may be weaned to the minimum effective dose during that time.

+/- gabapentin

Supportive care (+/- IV fluids vs SQ fluids, maropitant, mirtazapine, etc.)

Obtaining a history regarding signs of gastroesophageal reflux disease (GERD), from the client

If signs of GERD present, 10-14 day trial with famotidine or omeprazole (0.7-1 mg/kg PO q12h).

Small, frequent meals of a palatable diet, ideally with a neutral pH and canned food (increase water consumption due to urinary issues).

Constipation likely due to dehydration, although underlying IBD possible (despite absence of sonographic abnormalities. If constipation persists, psyllium or PEG 3350 (Restoralax) may be added to food.

+/- Spec fPL, serum cobalamin, and folate, to confirm pancreatitis and assess for underlying malabsorption and dysbiosis. If not possible, consider administration of cobalamin supplementation and assess response to therapy.

Cholangitis/cholangiohepatitis and cholecystitis and secondary ascending bacterial infections are possible differential diagnoses. Although indiscriminate use of antibiotics is not normally recommended, one could begin treatment with a broad-spectrum antibiotic and assess clinical response.

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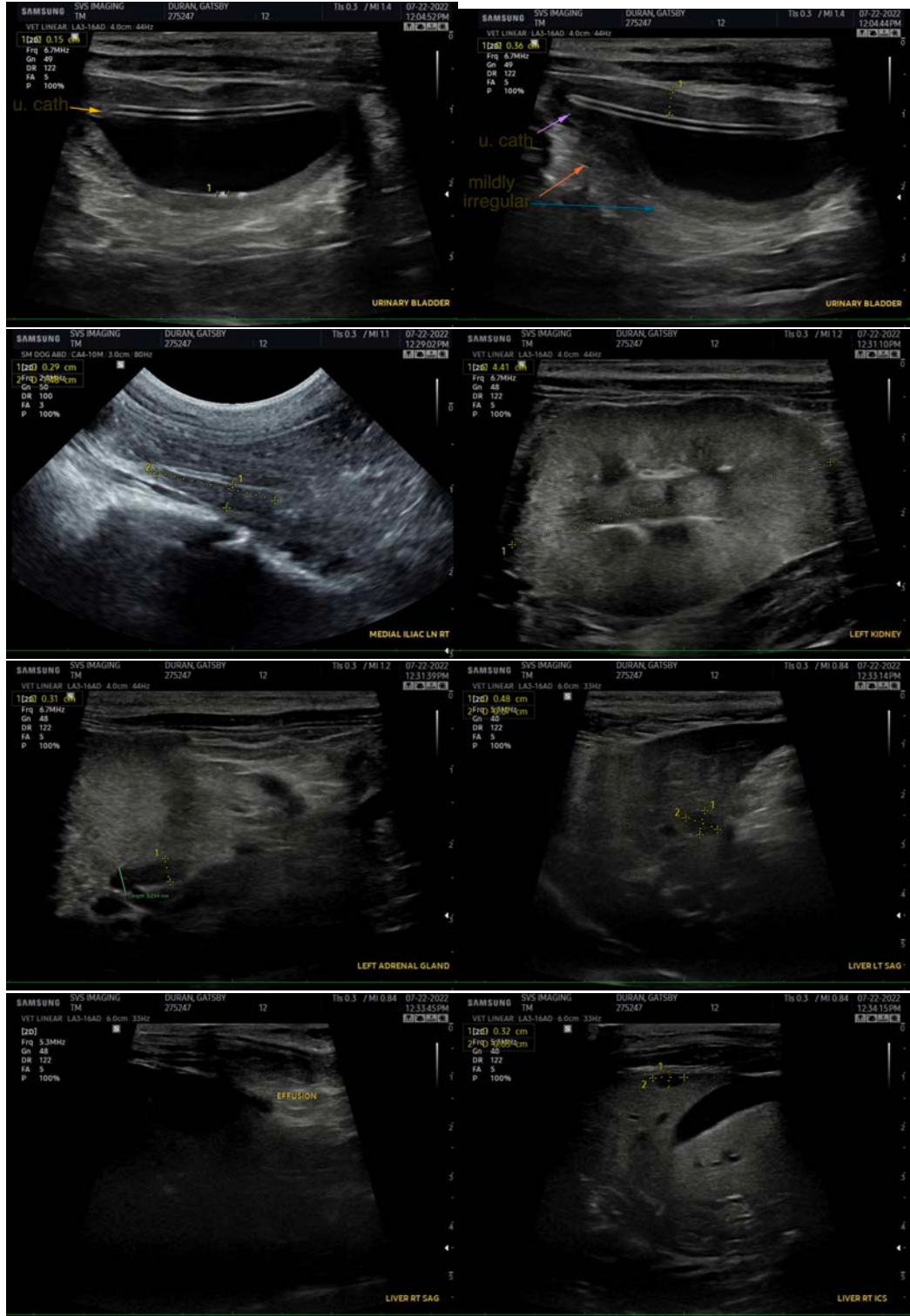
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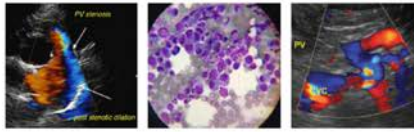
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*If a response is observed, continue antibiotics for a total of 4 to 6 weeks.



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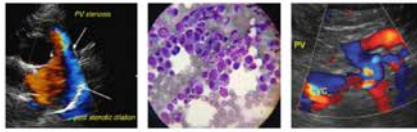
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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