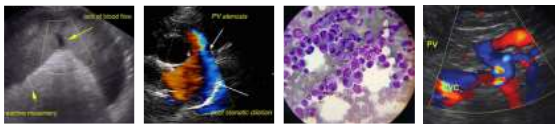




**PATIENT**

Jasper Park

**SPECIES**

Feline

**BREED**

DSH

**SEX**

MN

**AGE**

12 years

**WEIGHT**

10.63 lbs.

**INTERPRETED BY**

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

**IMAGING PERFORMED BY**

Jenna Walsh, CVT

**HOSPITAL NAME**

Companion Pet Clinic

**REFERRING VET**

Dr. Kryukova

**INVOICE**

13091

**DATE**

1/18/22

## PRESENTING CLINICAL SIGNS

Not Eating very well for 5 weeks. Pet is icterus
Abnormal PE/Chem/CBC/UA Results: Current Medications Prednisolone 3mg/ml 0.6 mls BID

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.8 cm in length. The right kidney measured 3.9 cm in length.

### *Adrenal Glands*

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.34 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.37 cm width.

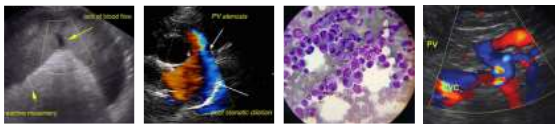
### *Spleen*

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

### *Liver/ Gallbladder*

The liver presented normal size. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with mild gallbladder debris. The gallbladder walls were sonographically unremarkable without evidence of inflammatory changes.

The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction. The common bile duct measured 0.2 cm diameter. The degree of proximal common bile duct dilation was not consistent with post hepatic obstruction.





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### *Gastrointestinal*

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. The duodenum wall width measured 0.34 cm. The jejunum wall width measured 0.35 cm.

Normal visible colon wall layers were present with apparent formed feces in lumen.

### *Pancreas*

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

### *Free Abdomen*

Multiple, jejunocolic and hepatic lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 3.4 cm x 1.3 cm. No effusion was noted.

## ULTRASONOGRAPHIC FINDINGS

### *Primary Findings*

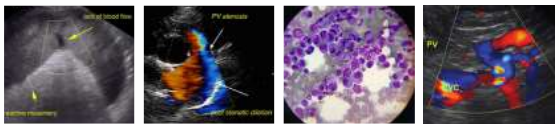
- Enteropathy exhibiting intact yet altered wall layering
- Hepatopathy exhibiting generalized hyperechoic parenchyma
- Associated jejunocolic and hepatic lymphadenopathy
- Heterogeneous pancreas
- Mild gallbladder debris with mild nonobstructive proximal common bile duct dilation

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the small intestine is compatible with infiltrative enteropathy. Inflammatory infiltrative enteropathy / IBD with potential for neoplastic infiltrative enteropathy with round cells such as lymphoma or other are possible. Concurrent lymphoid hyperplasia, reactive lymphadenitis, owing to intestinal inflammation or early neoplastic abdominal lymphadenopathy are possible.

The liver may indicate chronic hepatic parenchymal or hepatobiliary inflammation i.e., cholangiohepatitis, vacuolar hepatic changes, lipidosis, while the possibility of hepatic round cell neoplasia cannot be excluded.

Assuming normal clotting status, lymph node and hepatic parenchymal FNA using a 25-gauge needle is warranted for screening cytology. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.





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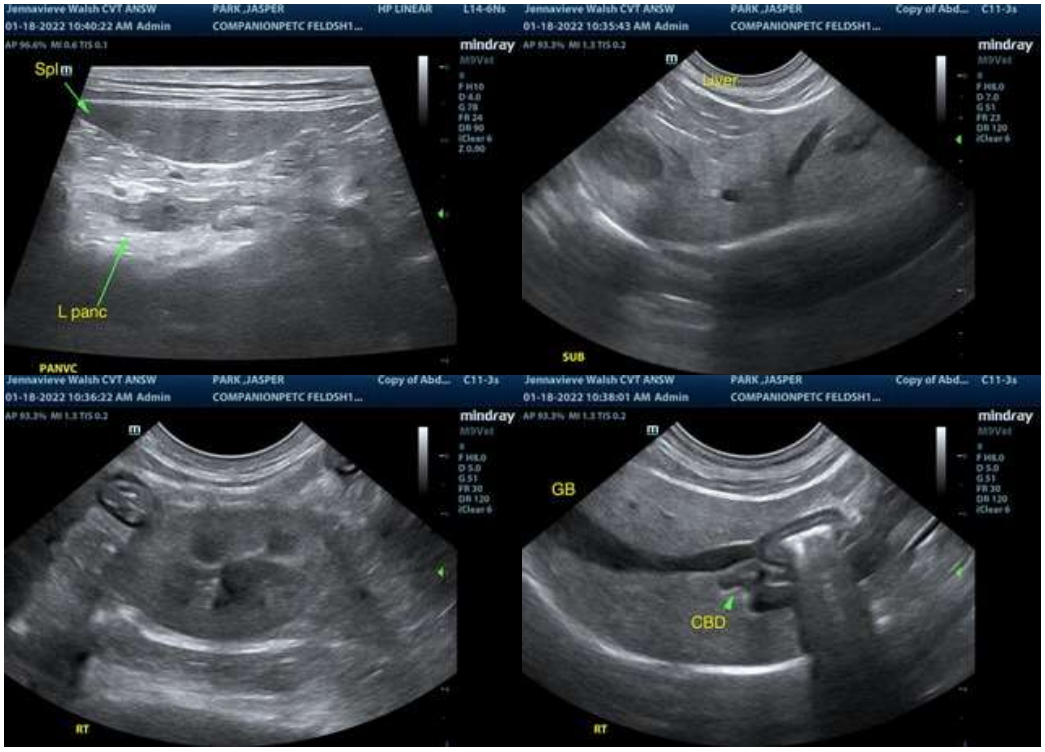
The potential for chronic Triad Disease may be possible in this patient in addition to current prednisolone. Some or all of the following protocol with as-needed gastrointestinal support could be considered.

Recommend pain management when anorexic with **Buprenorphine** (0.01-0.02 mg/kg IM or SC), clinical trial of **Zithromax** (50 mg sid/cat x 10 days, 3 weeks if bartonella +), **Prednisolone** (0.5-2 mg/kg tapering over 1 week to minimal effective dose), and **B12 injections** if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet (***Hydrolyzed diets have been shown to be more effective in dietary intolerance case management compared to hypoallergenic diets***)** or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes a persistent issue then biopsies, ideally full-thickness Intestinal biopsies, +/- hepatopancreatic biopsies would be warranted, and/or recheck sonogram to assess for more emerging disease.



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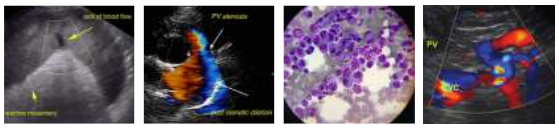

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AnimalSoundsNW.com 541-357-9423

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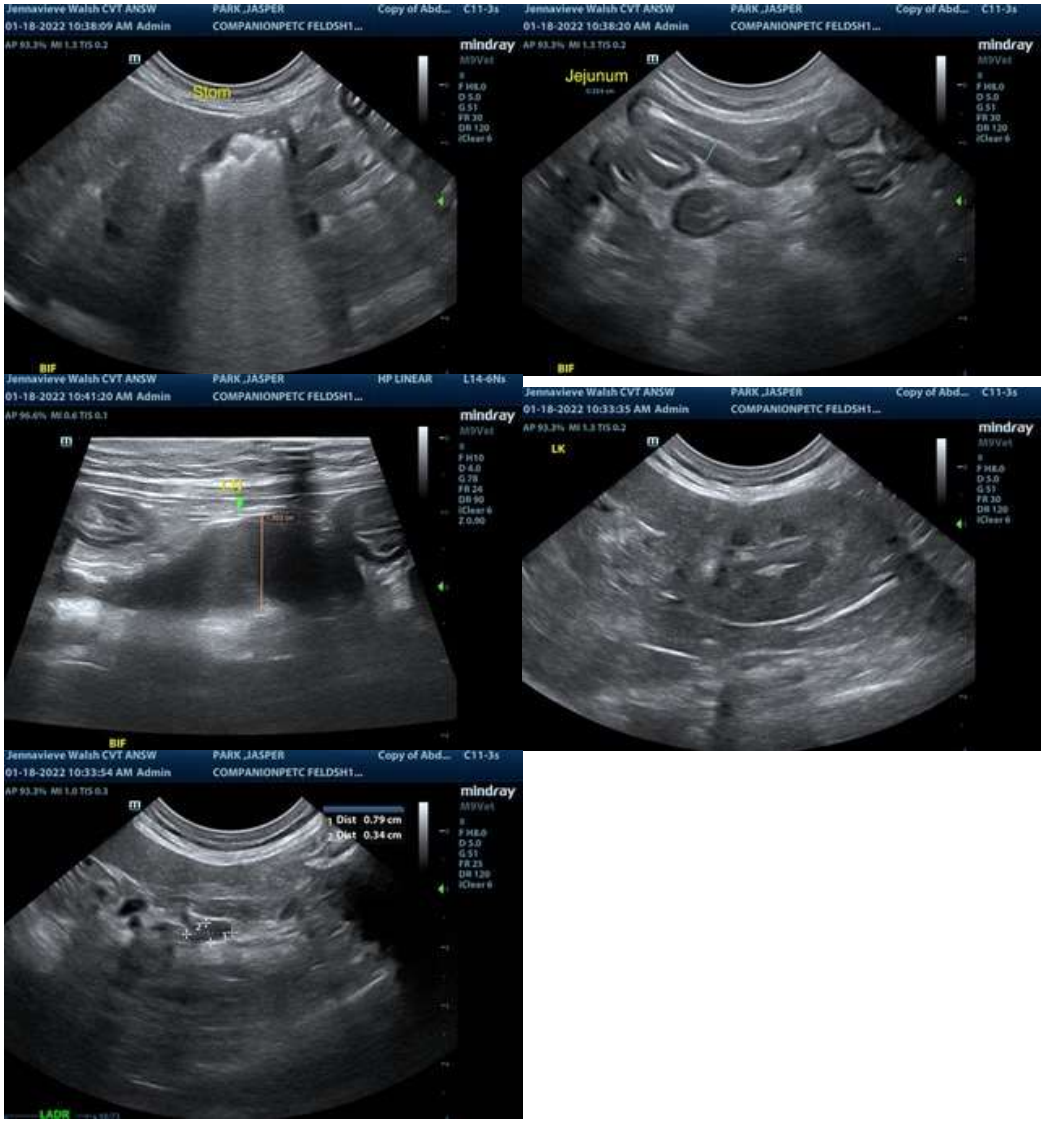


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)**
**info@SonoPath.com**