

PATIENT PRESENTING CLINICAL SIGNS

Buddy Steinmetz

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years

WEIGHT

8.5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

The Veterinary
Hospital

REFERRING VET

Dr. Johnson & Berman

INVOICE

33984

DATE

1/5/22

Long hx of vomiting since at least June 2021. P had abdominal ultrasounds with Animal Sounds on 6/16/21 which showed mild active to chronic active pancreatitis, moderate mineralized non-obstructive gallstones and mild age-related kidney changes. P was doing OK on prednisolone and cerenia (originally had run a course of amoxicillin, cerenia, buprenorphine and prednisolone) but since discontinuing pred has developed clinical signs again. On PE, bowel feels thickened but otherwise NSF's Current Medications 2.5mg prednisolone daily, eating RC GI HE diet Radiographic Findings Rads from 8/4/21 - - No major alteration in size or position of gall stones (large stone ventrally with dorsal smaller mineral opacities) - Mineral opacities in stomach consistent with small femurs (most likely rodent remains as Buddy is a fervent hunter) - Otherwise no major changes (Circular metal opacities in skin remain - most likely previous BB gun shot) Primary Question/Differential to Be Answered in This Exam Is there IBD also present with pancreatitis? Is the pancreatitis still active? What is the cause of the vomiting? Are P's gallstones problematic?
Abnormal PE/Chem/CBC/UA Results: 12/28/21 - check Comp Plus Profile: CBC - WNL; Chem - slightly low Ca++, all else WNL

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. Primarily anechoic urine was present in the lumen. Very minor non-dependent to particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were 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 minor loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.3 cm. The right kidney measured 4.6 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.50 cm. The right adrenal gland measured 0.52 cm.

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

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Focal areas of non-obstructive biliary tree mineral were present intermittently. The hepatic and portal vasculature were normal in appearance without signs of congestion. Solitary to multifocal accumulated calculi were present in the gallbladder, measuring approximately 1.2 cm diameter. Concurrent calculi noted within the cystic biliary duct and



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within the proximal to mid common bile duct. Subtle evidence of associated common bile duct dilation distal to the calculi was present, yet not consistent with overt obstruction. Likewise, the non-distended gallbladder was not overtly suggestive of post-hepatic obstruction in correlation with the lab work. Example of calculus within the common bile duct measured 0.7 cm in diameter. Overall, the gallbladder wall appeared to be overtly normal without evidence of obvious inflammatory criteria and without evidence of peripheral gallbladder inflammation.

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. Gastric body wall measured 0.25 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. Duodenum wall measured 0.26 cm. Jejunum wall measured 0.22 cm.

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

Pancreas

The left limb of the pancreas exhibited mild prominent size and symmetrical contour with mild hypoechoic parenchyma compared to adjacent subtly reactive omentum.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Persistent chronic active pancreatitis pattern
- Minor urinary bladder sediment
- Mild age related kidneys – subjectively static.
- Focal minor areas of biliary tree mineralization within the liver
- Subjective mild progressive yet non-obstructive gallbladder and common bile duct calculi
- Overtly normal gastrointestinal tract

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although the degree of mineral within the gallbladder and common bile duct appeared to be increased to mildly progressive compared to the previous ultrasound, the clinical significance of the gallbladder and common bile duct mineral is unclear given the lack of cholestasis or lack of overt hepatobiliary inflammation. This may continue to be an incidental finding, yet should be closely monitored for evidence of increasing cholestasis.

The persistent vomiting may be owing to persistent chronic active pancreatitis, or potentially structurally insignificant inflammatory gastrointestinal process. Empirically, continued therapy for chronic active pancreatitis with as needed gastrointestinal support and monitoring for hepatic enzyme increases or evidence of cholestasis recommended.



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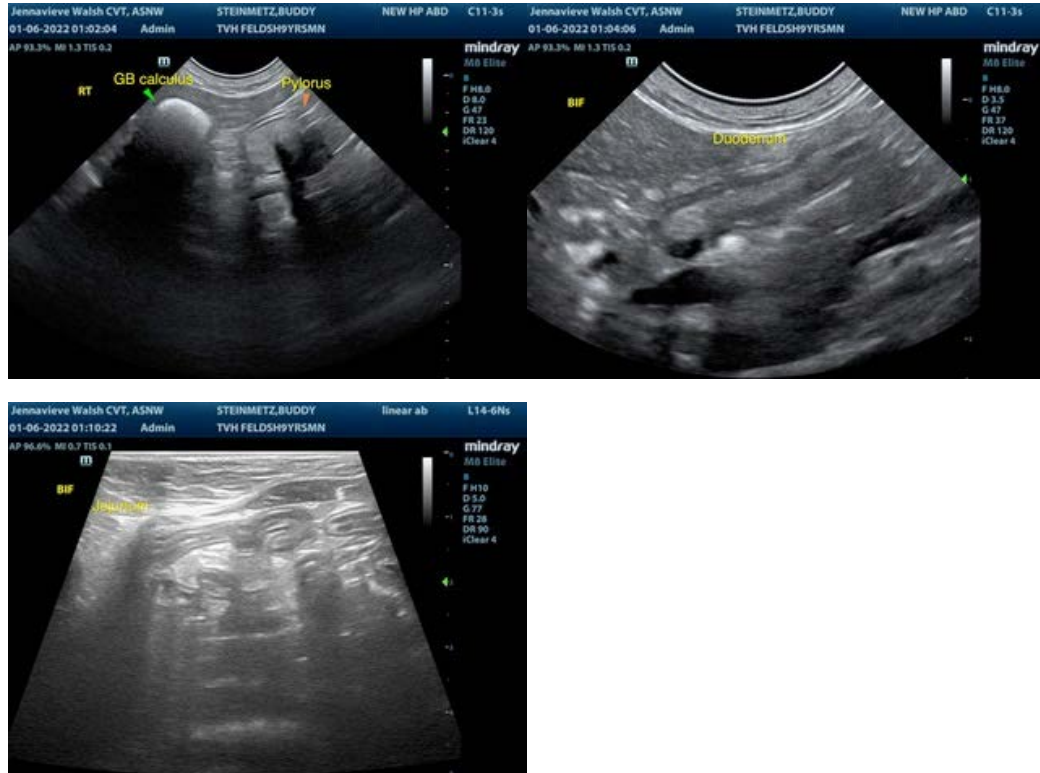
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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