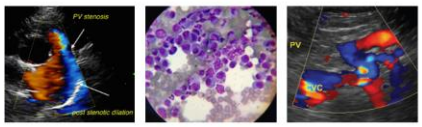
IMAGING PERFORMED BY
svsimaging.net 309-737-3070



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Bart Whittington

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

11

WEIGHT

10lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Whittington

INVOICE

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DATE

11/28/2022

PRESENTING CLINICAL SIGNS

Bart has been vomiting at least once a month for the last 6 months. In the past 30 days, he would vomit 4-6 times in a day about 2-3 times a week. After vomiting he would be given fluids and cerenia and then would be ok for about 5 days and then start to vomit again. He became inappetant about 4 days ago but then would intermittently eat and then vomit again. He seems to have an appetite but can't hold the food down. Before this ultrasound today at 12:30 pm, he hasn't eaten since 8 am yesterday morning 11/27/22. If he did eat something it would have been a very small amount.

Abnormal PE/Chem/CBC/UA Results: The skin of Bart's entire body appears hyperemic (pink to red) including his ears as well. Normal temp of 101.5F, Bloodwork is normal except for Creatinine of 1.7 which we already know he is in early stage 2 kidney disease. Only values that are mildly elevated include: TP: 8.1 (6-8), Glucose 184 (70-130), glob 5 (2.8-4.8). He did test mildly high for hyperthyroidism and a free t4 showed mildly elevated values as well so we were treating with methimazole for the last 2 weeks which didnt seem to help the vomiting.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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 were noted.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. The left kidney measured 4.0 cm in length. The right kidney measured 3.4 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

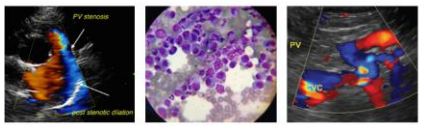
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.36 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.28 cm width.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

Liver

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. Several to multiple variably sized non-homogeneous to cystic intraparenchymal macro nodules to small masses were present, an example measuring 3.5 cm in diameter. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with minor



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focal congealed echogenic debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate retained anechoic fluid with no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.26 cm in width.

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. The duodenum measured 0.26 cm in width. The jejunum measured 0.20 cm in width.

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

Pancreas

The pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

No omental masses or peritoneal effusion was present.

Focal, minor prominent mesenteric lymph nodes not consistent with inflammatory/neoplastic lymphatic criteria were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of a lymph node measured 0.63 cm.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic interstitial nephrosis renal pattern
- Prominent mild irregular to hypoechoic pancreas-suggestive of chronic active pancreatitis
- Structurally normal GI tract with gastric hypomotility
- Several variably sized non-homogeneous cystic intraparenchymal hepatic macronodules/small masses-suggestive of benign cystic biliary adenomas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary cause of the intermittent vomiting may be chronic active pancreatitis with secondary mild upper GI inflammation and associated gastric hypomotility. The potential for structurally insignificant inflammatory bowel which may present sonographically normal cannot be definitively excluded. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Three view chest radiographs are recommended if not done to assess for occult thoracic pathology.

Empirically, a canned limited antigen or hydrolyzed diet trial with smaller more frequent feedings, gastric protectant protocol and therapy for chronic active pancreatitis pending additional diagnostics would be reasonable. Sonographic monitoring of the pancreas, GI tract and benign hepatic macronodule/small masses for evidence of progression if persistent clinical signs is suggested.

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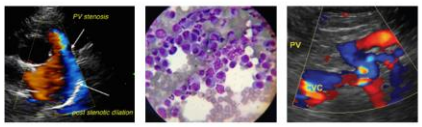

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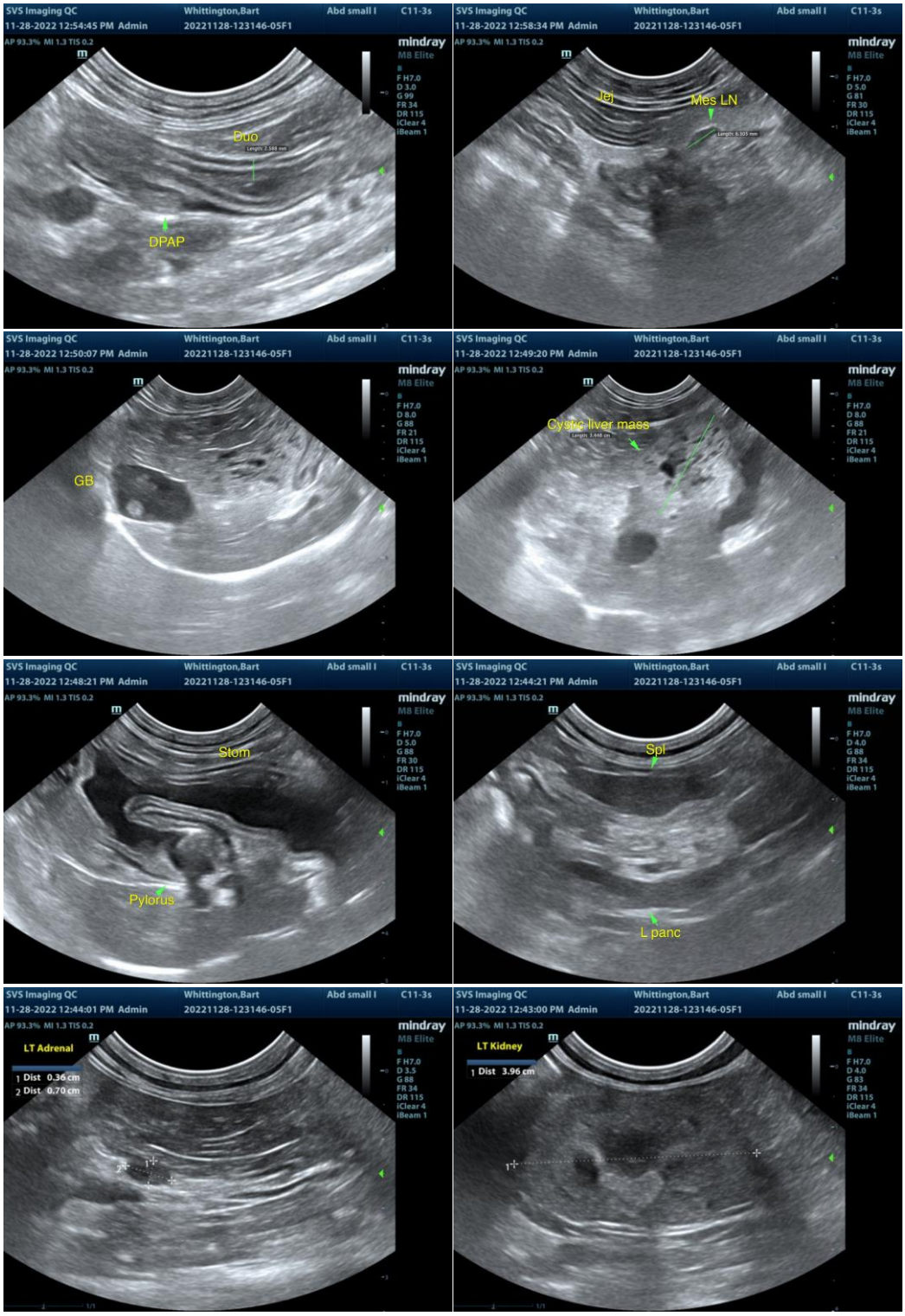
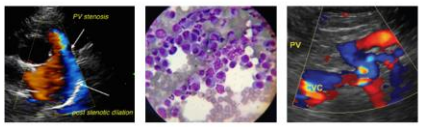


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance please contact me.

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