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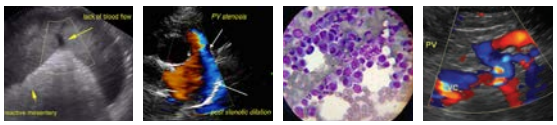


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

George Simms

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

16 Years

WEIGHT

8.8 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. Yomada

INVOICE

33221

DATE

12/3/21

PRESENTING CLINICAL SIGNS

Hx: George was presented to TVH this morning after he completely stopped eating about 4 days ago. O called 3 days ago to try and get an appointment, but then P escaped the house and hasn't been back until this morning when O was finally able to bring him in. O says that over the past 6 months at least, George has stopped eating his regular Fancy Feast cat food and has been living on Temptations treats only. Now he won't even eat those. P has a history of poor appetite on and off for the past couple of years, which he's been seen for with Dr. Johnson. Labwork was run both in April 2020 and April 2021 and only showed mild elevation in amylase, slightly low K+ on most recent panel. O was Rxed miratazointment to use but no other meds. On one instance P was constipated and treated as outpatient. O hasn't seen P defecate in several days either. PE: P is weak and emaciated, markedly jaundiced, ataxic. Estimate at least 10% dehydrated (very tacky MMs, no skin turgor, eyes sunken, abdomen doughy). BCS: 2. T: 96.8, HR: 220, RR: 30. Doughy abdomen, small walnut sized structure in cranial abdomen which feels encapsulated; unsure if fecal ball or mass. Kidneys palpate small bilaterally
Abnormal PE/Chem/CBC/UA Results: CBC - Low-normal Hct at 27.6% with elevated MCHC 37.9 (suspect when well hydrated P may be mildly anemic), stress leukogram (WBC 14.68k, neutrophilia 14.09k, lymphopenia 0.21k), normal thrombogram (plt 248k) Comprehensive Plus - MARKED bilirubinemia (Tbili 16.0, GGT 68), moderate elevations in hepatic values (ALT 341, ALKP 162, AST 244), marked hypercholesterolemia >450, mild azotemia (BUN 56.8, Creat 1.9), hyperproteinemia (TP 8.2), hypermagnesemia 3.5 Lytes - Slightly low chloride 106, low-normal potassium 3.4 T4 - Unable to run; TVH out of T4/SDMA slides. Will save serum and run when able UA - Unable to obtain. P urinated a large amount in carrier on the way here.

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. Mild non-dependent, 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.

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 4.3 cm. The right kidney measured 4.4 cm.

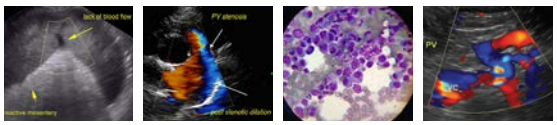
The area of the aortic trifurcation was free of pathology.

Adrenal Glands

No overt pathology in the area of the left and right adrenal gland.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The spleen was normal in size, measuring 0.63 cm in width. 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



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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. 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 exhibited generalized mild distention. Subtly prominent yet isoechoic gallbladder walls were present with primarily anechoic content. Mild non-dependent particulate luminal debris was present in the gallbladder. The proximal common bile duct exhibited mild tortuous distention, measuring 0.3 cm diameter. No overt evidence of ductal mucus or calculi.

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.

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

Pancreas

The left limb, right limb, and base of 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 inflammation. No overt evidence of neoplasia. Mild generalized pancreatic duct dilation present.

Free Abdomen

A moderately sized cystic to non-homogeneous mass lesion was noted in the area of the right pancreatic limb, directly adjacent to and dorsal to the descending duodenum. This cystic mass lesion measured approximately 2.8 cm x 1.8 cm with a cystic component noted in the mass measuring approximately 2.2 cm in diameter. The cystic component contains anechoic fluid with subjective mild cellular component. Subtle evidence of regional reactive mesentery was present. No evidence of free fluid or overt lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Acute cholangitis/cholangiohepatitis pattern with non-obstructive proximal common bile duct dilation
- Mild active to chronic active pancreatitis
- Cystic mass lesion in area of the right pancreas and duodenum – pancreatic, duodenal or biliary origin possible. Benign cyst, abscess, cystic or necrotic granuloma, neoplasia, or other possible.
- Bilateral chronic interstitial nephrosis renal pattern
- Mild particulate urinary bladder sediment – likely mild cellular or crystalline debris.

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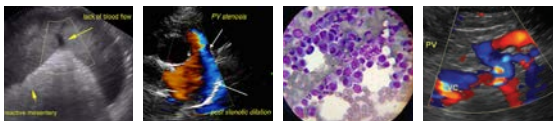

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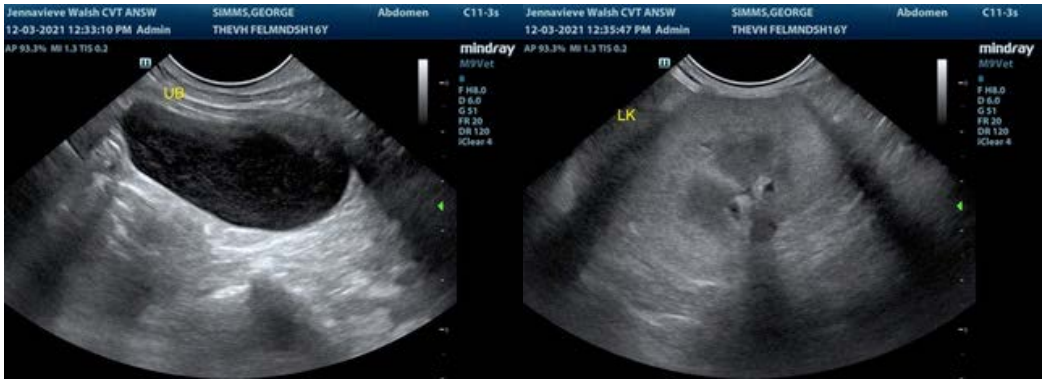
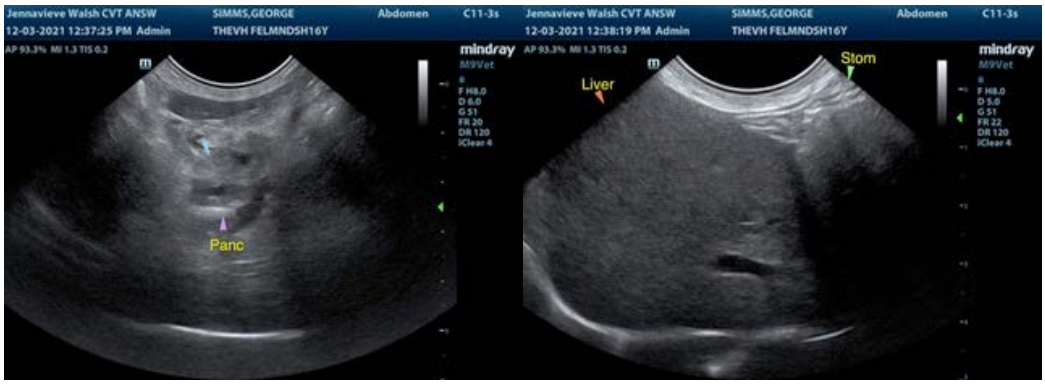
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

The cystic mass lesion in the area of the right pancreatic limb and duodenum did not overtly appear to be obstructive to bile flow given the lack of significant common bile duct distention. However, potential for emerging obstruction cannot be definitively excluded. Rather, the presentation of the liver and gallbladder is most consistent with acute hepatobiliary inflammation. Minor potential for occult hepatic neoplasia, though thought less likely.

Assuming normal clotting status, ultrasound guided FNA of the liver as well as potential FNA of the cystic mass lesion with collection of fluid for analysis +/- culture and sensitivity could be considered. Empirically, aggressive therapy for acute cholangiohepatitis and pancreatitis would be appropriate. GI panel to include PLI, TLI, cobalamin and folate as well as 3-view chest radiographs to rule out occult pathology as a contributing cause of weight loss would be warranted.





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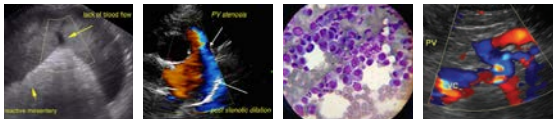

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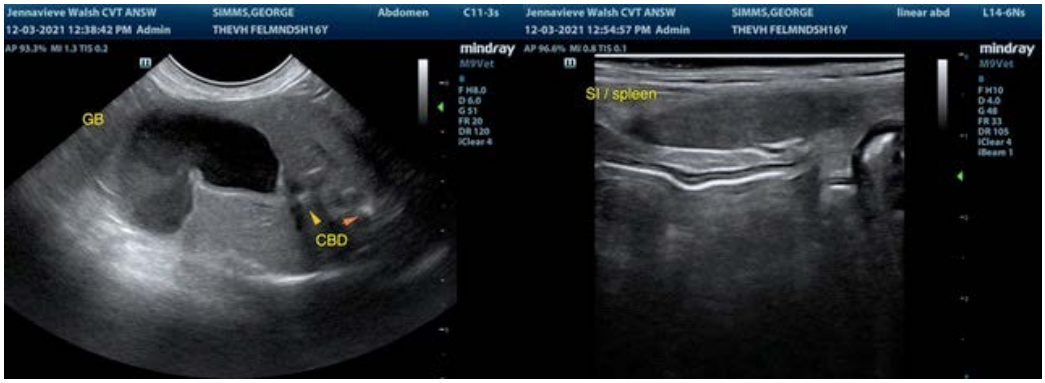

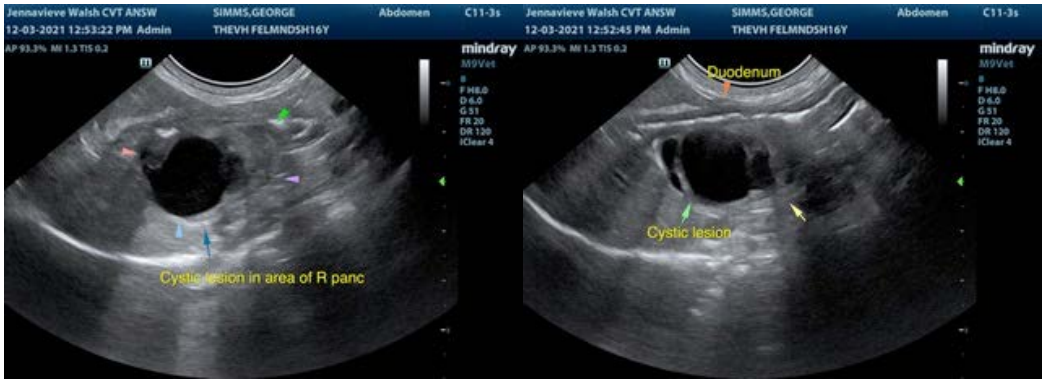

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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