

PATIENT PRESENTING CLINICAL SIGNS

Mason Dzomic Inappetence, vomiting, elevated liver values Renal K+
 ALP 357, ALT not read, GGT 32, TBili 3.7, Globulin 6.1, Potassium 2.9

SPECIES

Feline

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

BREED

DSH

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 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.

SEX

MN

No evidence of pathology in the area of the aortic trifurcation.

AGE

9 years

A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomodullary symmetry and definition expected for the age of the patient. Multiple, variably sized cortical infarctions were present in both kidneys, more prominent in the left kidney. No evidence of pelvic dilation was present. The left kidney was mild subnormal in size owing to prominent cranial cortical Infarction. The left kidney measured 2.9 cm in length. The potential for mild compensatory hypertrophy associated with the right kidney is noted. The right kidney measured 4.8 cm in length.

WEIGHT

14.5

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.43 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.47 cm width.

INTERPRETED BY

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 (Canine and Feline)

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. The spleen measured 0.95 cm width at the level of the hilus.

IMAGING PERFORMED BY

Rebekah Jakum, CVT
 ARDMS/RVT

HOSPITAL NAME

Stanglein VC

Liver/ Gallbladder

REFERRING VET

Dr. Rothrock

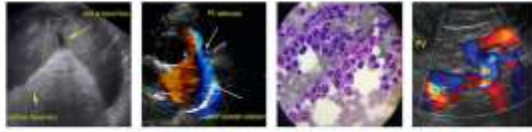
The liver exhibited subjective mild generalized enlargement with a maintained symmetrical capsule contour and uniform hepatic parenchyma. No overt masses or nodules were noted. Lobar to generalized mild to moderate biliary tree dilation was present. The common bile duct exhibited mild distention with mildly echogenic to thickened potential mild edematous gallbladder walls. Anechoic content was primarily present in the gallbladder with mild nondependent particulate debris extending into the mildly dilated cystic biliary duct and proximal common bile duct. The proximal common bile duct measured 0.34 cm width. Segmental, significant to marked mid to distal common bile duct dilation was noted measuring 1.6 cm diameter extending caudally into the area of the duodenal papilla. Primarily anechoic content was noted within the distended common bile duct without overt

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3/8/22



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evidence of calculi or mucoduct. Subjective potential for mild prominent duodenal papilla was present measuring 0.58 cm in diameter.

Gastrointestinal

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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 gastric body wall width measured 0.25 cm.

BREED

DSH

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 wall width measured 0.24 cm.

SEX

MN

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

Pancreas

AGE

9 years

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. Regional peripancreatic reactive mesentery was noted around the pancreas base and proximal right pancreatic limb. No overt evidence of neoplasia.

Free Abdomen

WEIGHT

14.5

No free fluid or lymphadenopathy was present.

ULTRASONOGRAPHIC FINDINGS

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- Cholangitis / cholangiohepatitis pattern with lobar to generalized biliary tree dilation, generalized to segmental, significant common bile duct dilation extending into area of the duodenal papilla
- Bilateral chronic renal changes with multifocal cortical infarctions
- Subjective concurrent chronic active pancreatitis with regional peripancreatic reactive mesentery
- Overtly normal gastrointestinal tract

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Although a definitive cause of post hepatic obstruction i.e., calculi, mucus, or neoplastic criteria was not definitively evident, concern for chronic post-hepatic obstruction in this patient is warranted exhibited by generalized segmentally significant common bile duct dilation measuring >0.5 cm width, as well as concurrent lobar biliary tree dilation. Given these findings, exploratory laparotomy for gross inspection of the common bile duct, areas of the duodenal papilla, potential for common bile redirection technique, bile culture and sensitivity, +/- hepatic parenchymal biopsies for histopathology, as well as tissue culture and sensitivity is warranted. A coagulation panel is recommended prior to surgical considerations.

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Empirically, aggressive cholangiohepatitis / chronic active pancreatitis therapy with as-needed gastrointestinal support with close monitoring for evidence of progressive hepatic enzyme elevations or evidence of cholestasis would be a more conservative approach. Baseline renal staging Including urine culture and sensitivity and UPC level, as well as screening blood pressure, is recommended.

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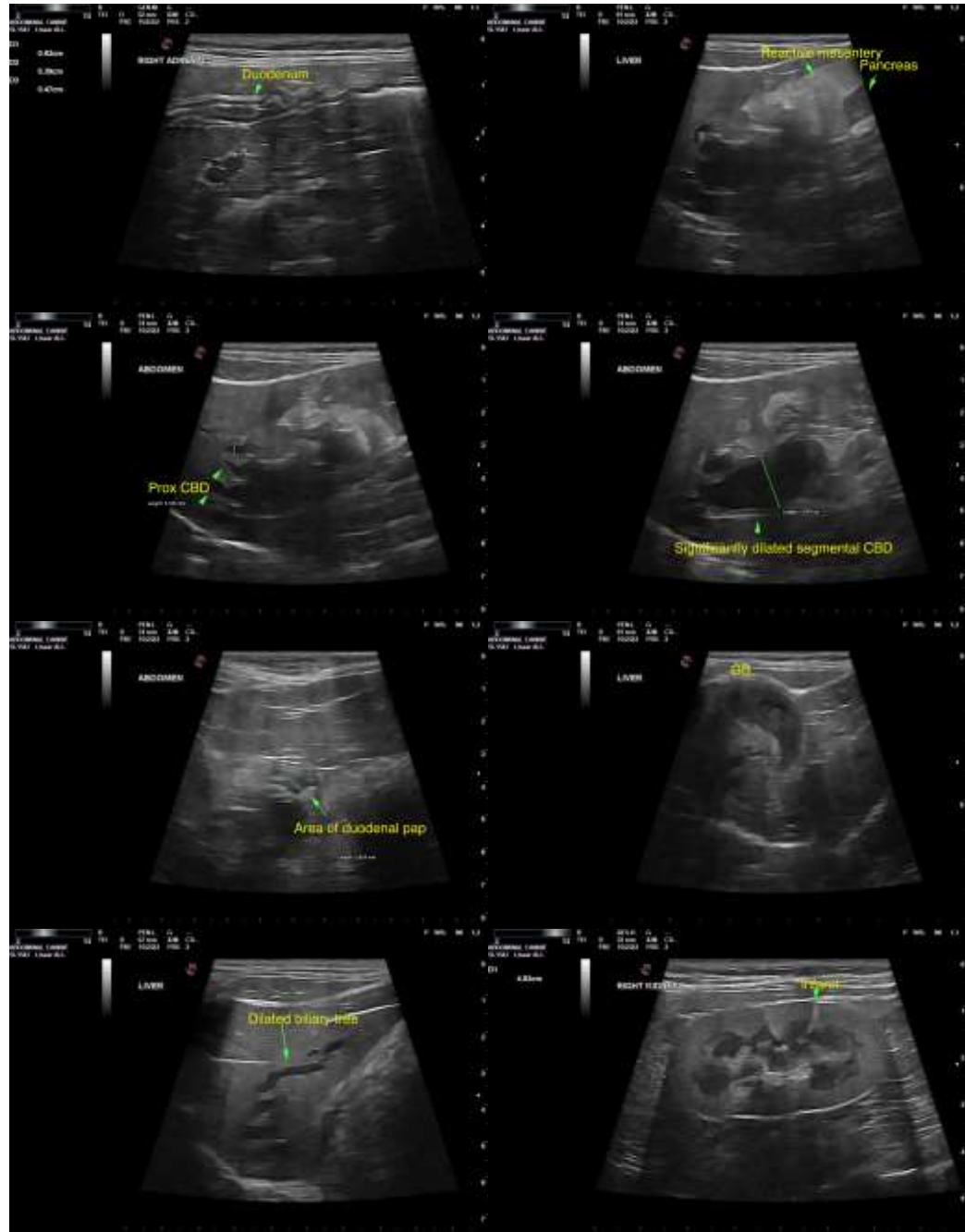
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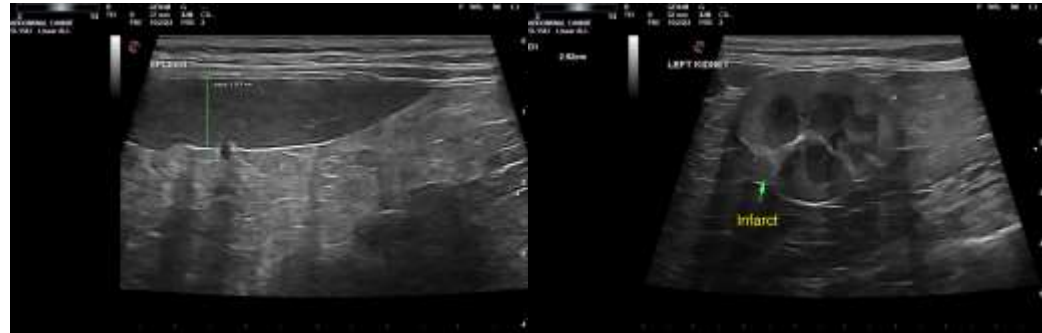
MN

AGE

9 years

WEIGHT

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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 can be of any further assistance, please contact me.

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