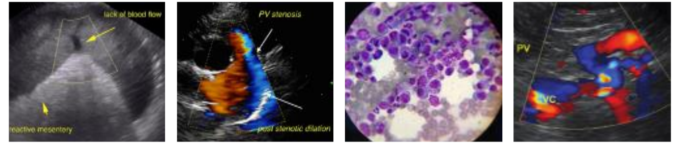
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Yogi Jr. Isaac

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
12 years

WEIGHT
10.9 lbs.

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

IMAGING PERFORMED BY
Alex Emerson DVM

HOSPITAL NAME
Animal Clinic of Casselberry

REFERRING VET
Alex Emerson DVM

INVOICE
16567

DATE
4/11/23

PRESENTING CLINICAL SIGNS

Examined for dry coat and hiding more recently. No known CSVD. Possibly lower appetite Indoor/ outdoor. Mild dehydration otherwise normal PE

Abnormal PE/Chem/CBC/UA Results: ALT 189 ALP 467 Tbili 5.2 BUN 11 Creat, SDMA normal Normal RBC neutrophils 10,600 slight lymphopenia T4 normal HWT neg UA: 1.052 2+ proteinuria, 2+ bilirubinuria

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 minor, hyperechoic nondependent sediment, which may indicate cellular debris / protein, crystalline debris, lipid, or mucus. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of urinary bladder inflammatory or neoplastic criteria was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. Mild uniform increased cortex echogenicity with mildly indistinct to enhanced corticomedullary border demarcation was present in both kidneys. Normal medullary volume was noted with no evidence of pyelectasia. Potential pinpoint dystrophic mineral was noted. The left kidney measured 3.7 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

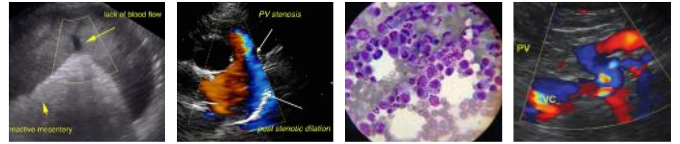
The left or right adrenal glands were not definitively visualized.

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 was moderately enlarged in size with the ventrocaudal liver extending to the level or possibly just distal to the gastric axis. The liver maintained a symmetrical capsule contour with homogeneous parenchyma exhibiting moderate coarse echotexture. Normal hepatic vascular volume was noted. The gallbladder was non-distended in size with mildly echogenic thickened walls containing anechoic content. Mild generalized common bile duct dilation was noted extending from the level of the gallbladder and cystic biliary duct caudally to the level of the duodenal papilla. Anechoic content was present in the common bile duct with potential for minor echogenic debris, consistent with mucus. No visualized common bile duct calculi were noted. Subjective mildly thickened duodenal papilla measuring potentially 0.8 cm x 0.4 cm, was noted. No overt evidence of mineral or calculi was noted at the level of the duodenal papilla.



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Gastrointestinal

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

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 measured 0.27 cm width. The jejunum wall measured 0.25 cm width. The ileocolic wall measured 0.30 cm width.

Subjective possible mildly thickened proximal colon / cecum wall was noted measuring up to 0.5 cm. The remainder of the visualized colon was sonographically unremarkable.

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

A scant pocket of peritoneal free fluid was visualized around the caudal liver margins and adjacent to the gallbladder. No omental masses were noted.

Several, mildly prominent colic 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 0.84 cm diameter.

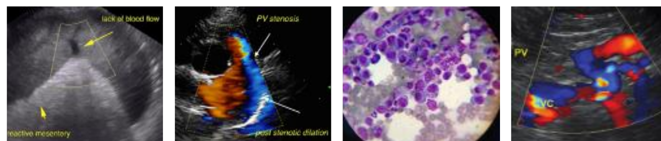
ULTRASONOGRAPHIC FINDINGS

- Cholangitis / cholangiohepatitis hepatobiliary pattern
- Subjective mildly prominent / thickened duodenal papilla
- Sonographically unremarkable stomach and small bowel
- Suspect possible mild thickened proximal colon with mild regional colic lymphadenopathy
- Heterogeneous pancreas - not sonographically consistent with significant / active pancreatitis
- Nonspecific mild chronic renal changes
- Scant pocket of perihepatic free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hepatobiliary presentation is suggestive of inflammatory criteria with potential extension of cholangitis to involve the duodenal papilla. Subjectively, the degree of common bile duct dilation, measuring 0.26 cm diameter, was not overtly consistent with definitive post-hepatic obstruction. However, the possibility of emerging obstruction secondary to duodenal papilla pathology i.e., emerging mass, non-obvious mucus plug, etc., could be possible.

Aggressive empirical therapy for cholangitis / cholangiohepatitis with close monitoring of hepatic response vs. progressive hepatic enzyme elevations and cholestasis would be reasonable. Exploratory



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laparotomy with gross inspection of the common bile duct and area of the duodenal papilla may be indicated. If surgery is elected, gross inspection of the intestinal tract with the possibility of colic biopsies, if thickened colon walls are confirmed, is recommended. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

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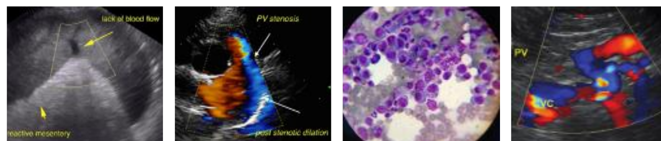

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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