



PATIENT PRESENTING CLINICAL SIGNS

Miestro Ross patient has been vomiting and having diarrhea and has been losing weight over the last 2 months. Abnormal PE/Chem/CBC/UA Results: increased ALT, ALP, AST and Bili. Increased Spec FPL.

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 Years

WEIGHT

Unknown

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Companion Pet Clinic

REFERRING VET

Dr. Finney

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36854

DATE

4/12/22

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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, likely consistent with mild cellular debris, protein or crystals. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.5 cm. The right kidney measured 4.3 cm.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

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

The left adrenal gland was mildly prominent in size, measuring 0.50 cm in diameter. This is likely a patient variant and not overtly consistent with left adrenal neoplasia.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The spleen measured 0.76 cm. 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 mildly enlarged with mild uniform increased hepatic parenchyma echogenicity exhibiting mild coarse echotexture. No evidence of hepatic masses or nodules. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. Mild luminal sediment noted. The cystic biliary duct and proximal to mid common bile duct exhibited mild tortuous dilation, containing anechoic content, not overtly extending to the level of the duodenal papilla. CBD dilation measured up to 0.50 cm.

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 primarily maintained 1:3 muscularis/mucosa ratio with segmental propensity for subtly prominent muscularis layer, yet without evidence of mural



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Miestro Ross

hypertrophy and loss of intestinal wall layering. No intestinal masses noted. Jejunum wall measured 0.23 cm. 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.

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Pancreas

The **pancreas** was normal in size with areas of mild capsule asymmetry and mild hypoechoic to non-homogeneous parenchyma compared to adjacent omentum with pancreatic duct dilation.

BREED

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Free Abdomen

Focal mild subjectively benign or reactive pancreaticoduodenal lymphadenopathy noted.

SEX

Neutered Male

No free fluid.

AGE

11 Years

- Hepatopathy
- Non-distended gallbladder with mild luminal debris
- Mild to moderate dilated proximal common bile duct without overt obstructive criteria
- Chronic active pancreatitis
- Suspect inflammatory enteropathy

WEIGHT

Unknown

ULTRASONOGRAPHIC FINDINGS

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

INTERPRETED BY

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

Overall, the hepatobiliary presentation is suggestive of cholangitis/cholangiohepatitis. Potential for vacuolar hepatopathy, infiltrative neoplasia (less likely), or other hepatopathy possible. Ultrasound guided FNA of the liver could be considered for screening cytology, assuming normal clotting status and using 25-gauge needle. Overt evidence of post-hepatic obstruction (i.e., calculi, mucus, or duodenal papillae pathology) was not visualized. Strong potential for triad disease in this patient.

IMAGING PERFORMED BY

Jenna Walsh, CVT

Further assessment may include GI panel to include PLI, TLI, cobalamin and folate. Sonographic reassessment of the gallbladder and common bile duct suggested if progressive evidence of cholestasis. Empirically, some or all of the following protocol could be considered.

Triaditis/Pancreatitis protocol

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Part or all of this protocol may be considered based on your clinical impression of the patient:

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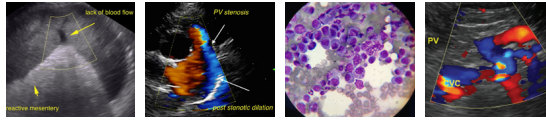
Recommend pain management when anorexic with **Buprenorphine** (0.01-0.02 mg/kg IM or SC), clinical trial of **Zithromax** (50 mg sid/cat x 10 days, 3 weeks if bartonella +), **Prednisolone** (0.5-2 mg/kg tapering over 1 week to minimal effective dose), and **B12 injections** if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet** (*Hydrolyzed diets have been shown to be more effective in dietary intolerance case management compared to hypoallergenic diets*) or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes a persistent issue then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. One diet does not work for all patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.

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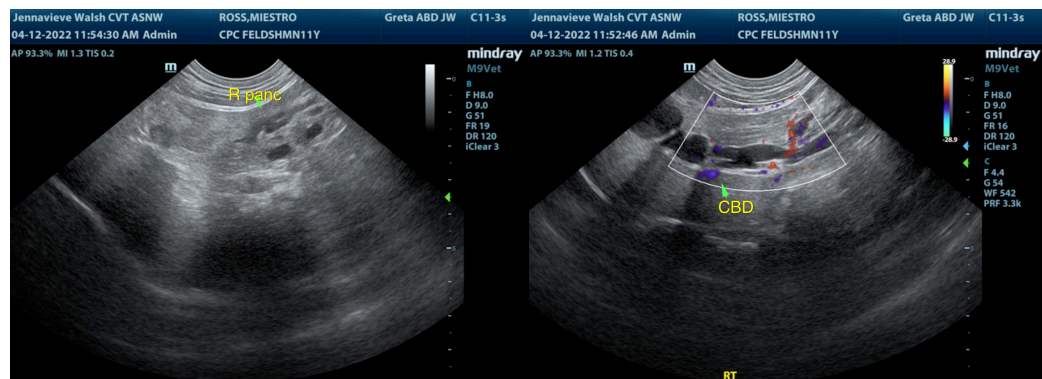
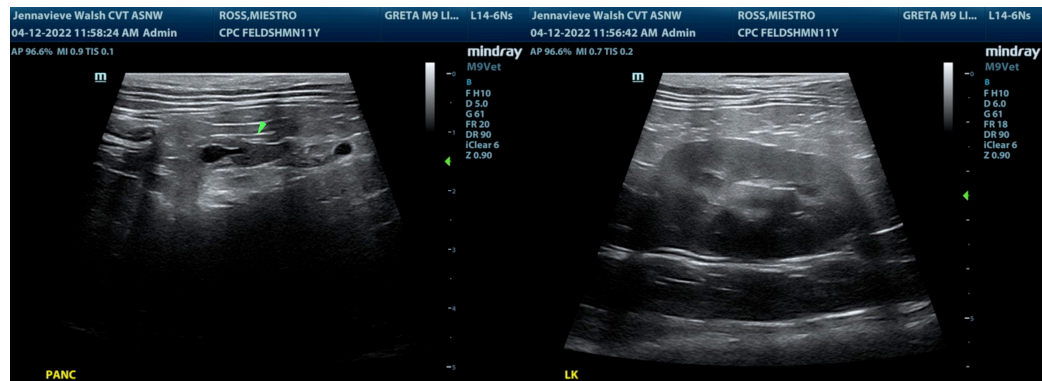
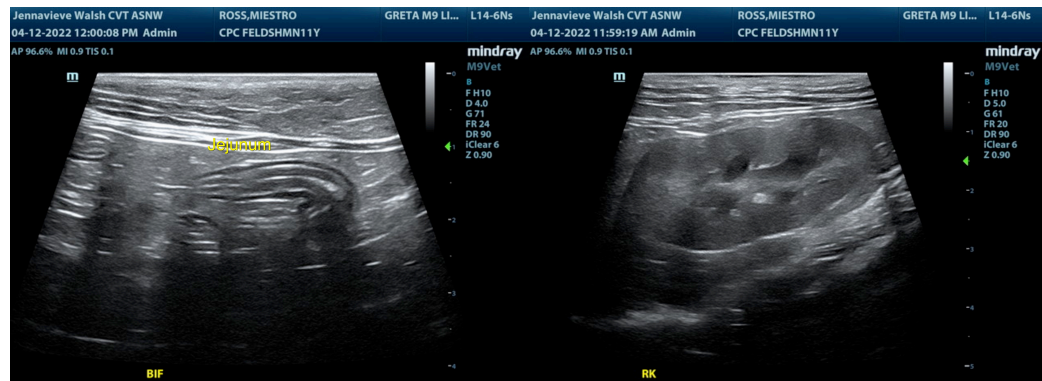
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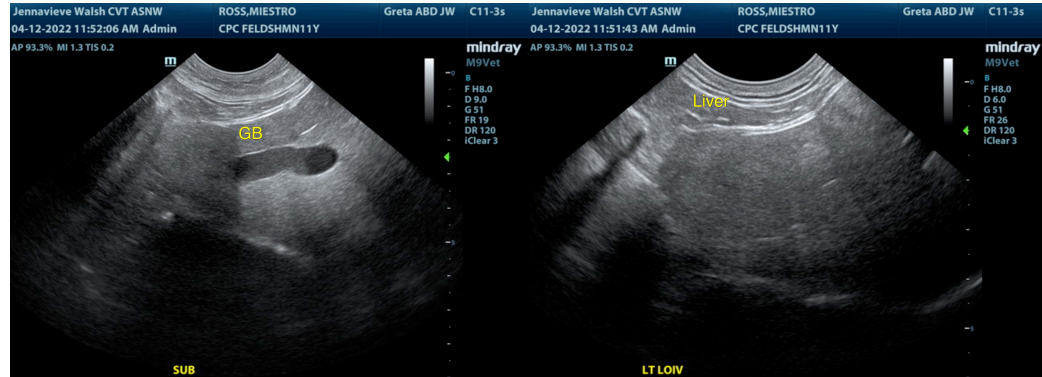
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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