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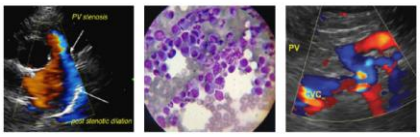

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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PATIENT

Mr. Tubby Rooks

SPECIES

Feline

BREED

DMH

SEX

MN

AGE

8 years

WEIGHT

13.4 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging KC

REFERRING VET

Dr. John Lyle

INVOICE

13668

DATE

4/14/22

PRESENTING CLINICAL SIGNS

4/11: Taken to emergency hospital. Had been losing weight over past couple weeks. Unknown eating/drinking/urinating, defecating habits. Vomited yellow that day and noticed skin was yellow. Used to weight 17-19 lbs. Indoor only. Transferred to rDVM. Has been receiving SQ fluids and force feedings (not eating on his own). Also taking Ursodiol, amoxicillin. Got a Cerenia injection 4/12. Seems to have perked up a bit since first coming in, but abdomen but abdomen appears more distended since yesterday.
Abnormal PE/Chem/CBC/UA Results: Exam: Icteric, lethargic, nasal congestion, dehydrated. Abdomen doughy and reactive. BCS 6/9. 4/11: PCV 35%, GLU 156, Lactate 4 (0-2.5). Increased liver values.

ALT 169, ALP 163, TBili 7.2, BUN 13, Creatinine 0.9, Glucose 176, Triglyceride 180

Unremarkable CBC

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder exhibited mild distention yet normal tone. The visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Moderate to marked, nondependent to swirling, echogenic to hyperechoic 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.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.2 cm in length. The right kidney measured 4.5 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.51 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.38 cm width.

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 1.0 cm width at the level of the hilus.

Liver/ Gallbladder

The liver presented exhibited generalized enlargement. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver

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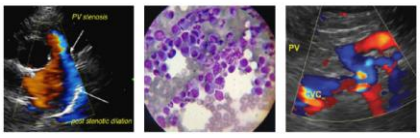

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parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with mildly prominent to echogenic gallbladder walls. Anechoic content was present. Potential for bilobed gallbladder is possible yet not definitive. If present, this is a normal patient variant and not considered pathological. The common bile duct was normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Potential mild retained anechoic fluid and luminal gas was present in the stomach. The gastric body wall width measured 0.27 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. The jejunum wall width measured 0.17 cm.

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

Pancreas

The pancreas was indistinctly visualized yet subjectively exhibited subtle prominent size with subtle capsule asymmetry. Mildly nonhomogeneous to hypoechoic parenchyma was present.

Free Abdomen

An Increased amount of omental fat exhibiting uniform mild increased omental echogenicity was present. Mild volume subjective anechoic peritoneal free fluid was present. No evidence of omental lymphadenopathy or masses was noted.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy exhibiting generalized mild parenchyma hyperechogenicity
- Suspect low-grade to mild pancreatitis
- Sonographically unremarkable gastrointestinal tract, potential mild gastric stasis
- Generalized reactive mesentery and mild volume peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the liver was nonspecific with considerations including hepatitis / cholangiohepatitis, vacuolar hepatic changes, and lipidosis, while the possibility of round cell hepatic neoplasia such as lymphoma cannot be excluded. Assuming normal clotting status and with vitamin K pretreatment, ultrasound-guided FNA of the liver using a 25-gauge needle is warranted for cytology.

A GI panel to include PLI/TLI/Cobalamin/Folate, given the weight loss, is warranted and would be indicated if lipidosis is confirmed. Concurrent peritoneal fluid analysis, cytology +/- culture and sensitivity (if evidence of inflammatory cells), is also recommended. Empirically, therapy for cholangiohepatitis, lipidosis, and suspect low-grade pancreatitis with as-needed gastrointestinal support, monitoring of clinical response and potential recheck sonogram if persistent clinical signs, progressive / persistent hepatic enzyme elevations and/or peritoneal free fluid would be reasonable.

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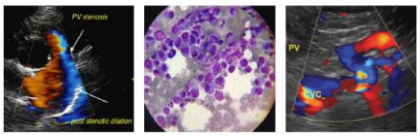

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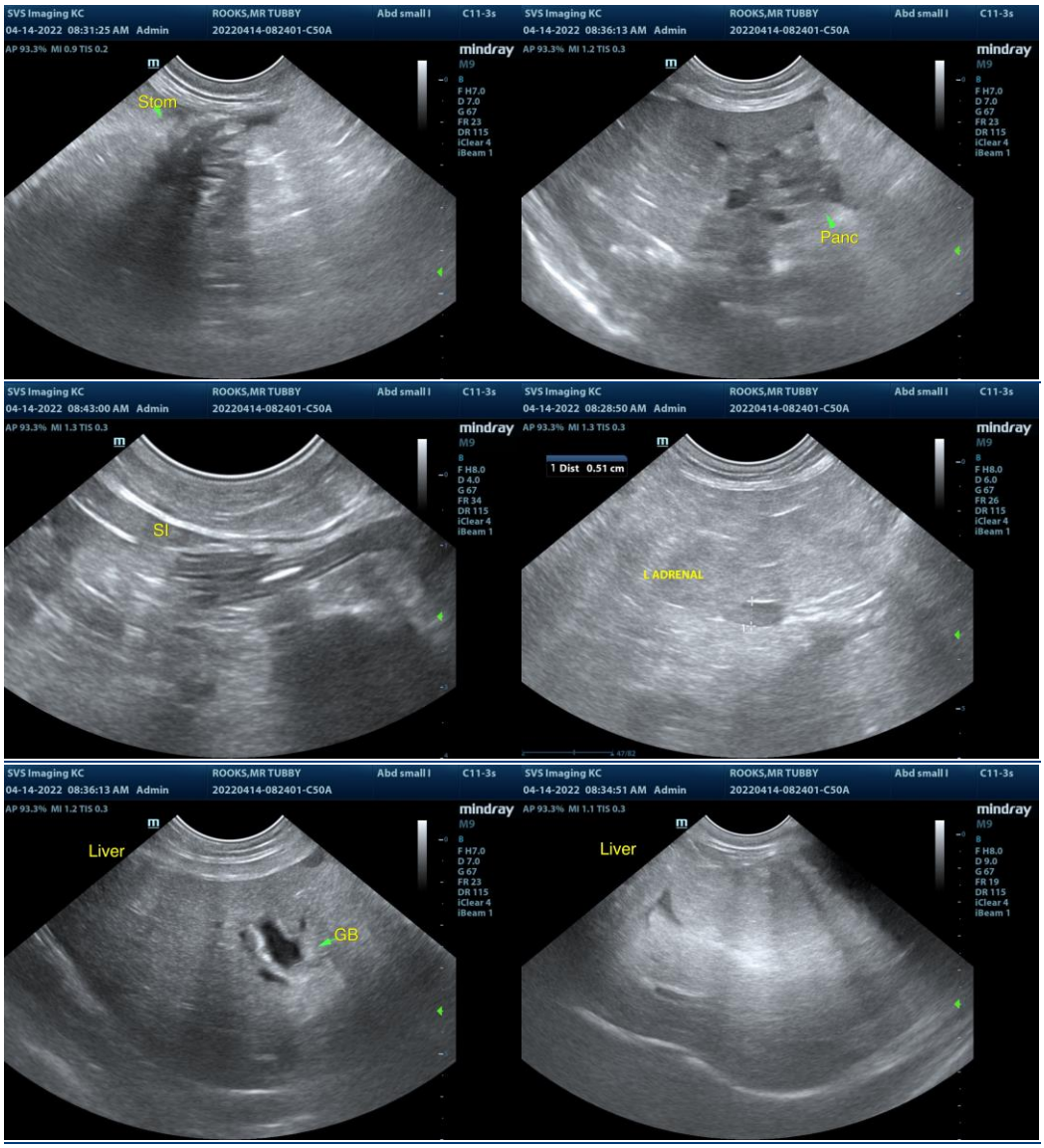

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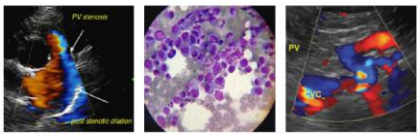

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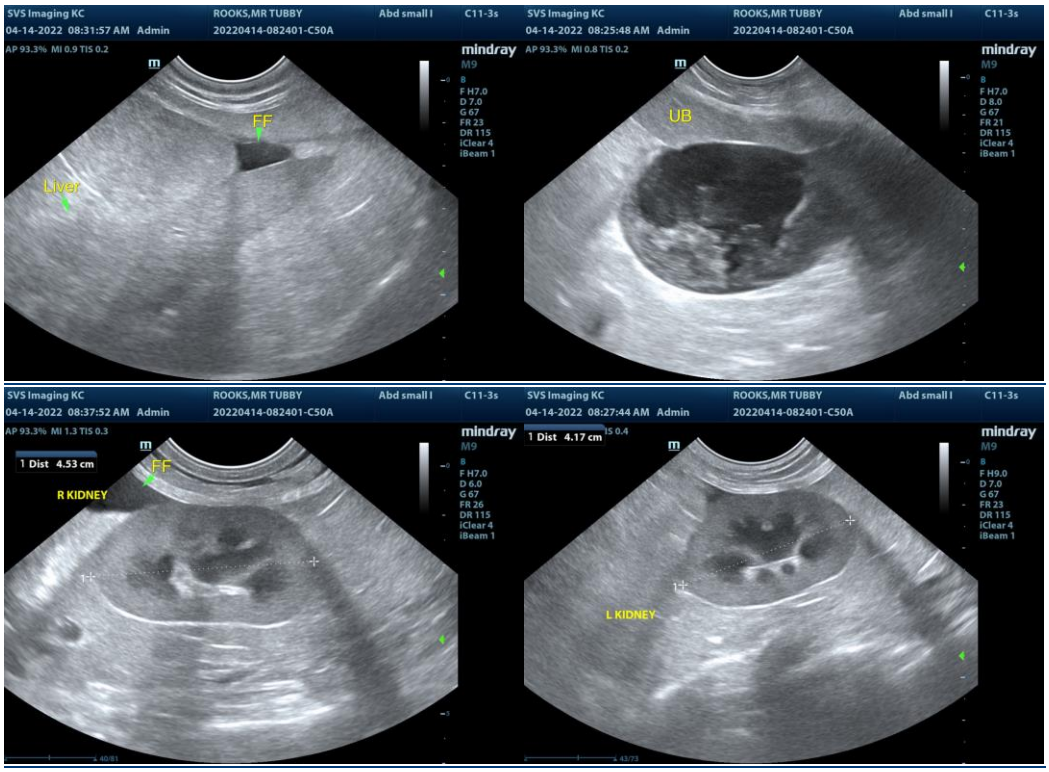

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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