



PATIENT

Auggie Balance

SPECIES

Feline

BREED

British Shorthair

SEX

MN

AGE

11yr

WEIGHT

9.85kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Donna Markland,
DVM

HOSPITAL NAME

Island Mobile Paws
Veterinary Services

REFERRING VET

Harbour City Animal
Hospital

INVOICE

13754ag

DATE

05/09/2023

PRESENTING CLINICAL SIGNS

Presented on May 5th with a history of declining appetite and barely eating since May 2nd. He also has a history of chronic intermittent vomiting. Auggie's normal diet is Purina OM. On PE, Auggie had a painful abdomen. He has a BCS of 9/9. No other significant PE findings were reported. CBC/Chem/T4 showed elevated liver enzymes with no other abnormalities. Spec fPL was also normal. Auggie has been on mirtazapine, buprenorphine, and cerenia since May 5th. His diet was changed to Purina EN.

Abnormal PE/Chem/CBC/UA Results: May 5, 2023: ALT=331 (27-158) AST=148 (16-67) ALP=123 (12-59) Tbili=5.8 (0-5.2) Normal GGT=6 (0-6)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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 were noted.

Mildly prominent kidney size compared to normal feline renal parameters which is suspected to be a patient variant was present. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomodullary symmetry and definition expected for the age of the patient. Focal lateral left kidney cortical infarct was present. No evidence of pelvic dilation was present. The left kidney measured 4.7 cm in length. The right kidney measured 5.0 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

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 1.1 cm in width at the level of the hilus.

Liver/Gallbladder

The liver exhibited potential borderline enlargement with normal structure and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended to mildly subnormal in size with thin walls and primarily anechoic luminal content. The cystic biliary duct extending into the proximal common bile duct exhibited moderate regional dilation with anechoic content and concurrent non-mineralized mucus. The dilated cystic biliary duct/proximal common bile duct measured ~ 2.0 cm in diameter. The mid common bile duct caudal to the dilated section of cystic bile duct/proximal common bile duct adjacent to the portal vein was mildly dilated measuring 0.33 cm and did not appear to extend caudally to the level of the duodenal papilla.



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Gastrointestinal

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate progressive to strongly shadowing ingesta with no signs of ileus, obstruction or foreign material.

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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.

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

Pancreas

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The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

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Free Abdomen

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No omental masses, overt lymphadenopathy or peritoneal effusion was present.

Subtle increased omental echogenicity around the dilated cystic biliary duct/proximal common bile duct was present.

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ULTRASONOGRAPHIC FINDINGS

- Hepatopathy-subjectively benign.
- Non-distended gallbladder, moderate cystic biliary duct/proximal common bile duct with mucus, mildly dilated mid common bile duct at level of the portal vein.
- Sonographically unremarkable GI tract with shadowing gastric ingesta-post prandial presentation, potential for gastric hairball density if history of hairballs.

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Secondary findings

- Bilateral mild chronic renal changes with lateral left kidney infarct.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although non-specific, the hepatobiliary presentation is suggestive of cholangitis/cholangiohepatitis criteria without overt evidence of post hepatic obstruction in conjunction with minor elevated TBIL level at this stage. Potential for segmental cystic biliary duct and proximal common duct bile pooling with mucus. Potential for impinging hepatic cyst on the cystic biliary duct to proximal common duct cannot be definitively excluded yet is thought less likely.

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The possibility of emerging proximal hepatobiliary obstruction is considered less likely given lack of gallbladder distension yet further sonographic monitoring of the gallbladder and common bile duct would likely be ideal based on clinical response to empirical cholangitis/cholangiohepatitis therapy. As needed GI support is recommended.

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Assuming normal clotting status. a hepatic FNA for screening cytology could be considered to identify potential inflammatory cells as well as bile C/S.

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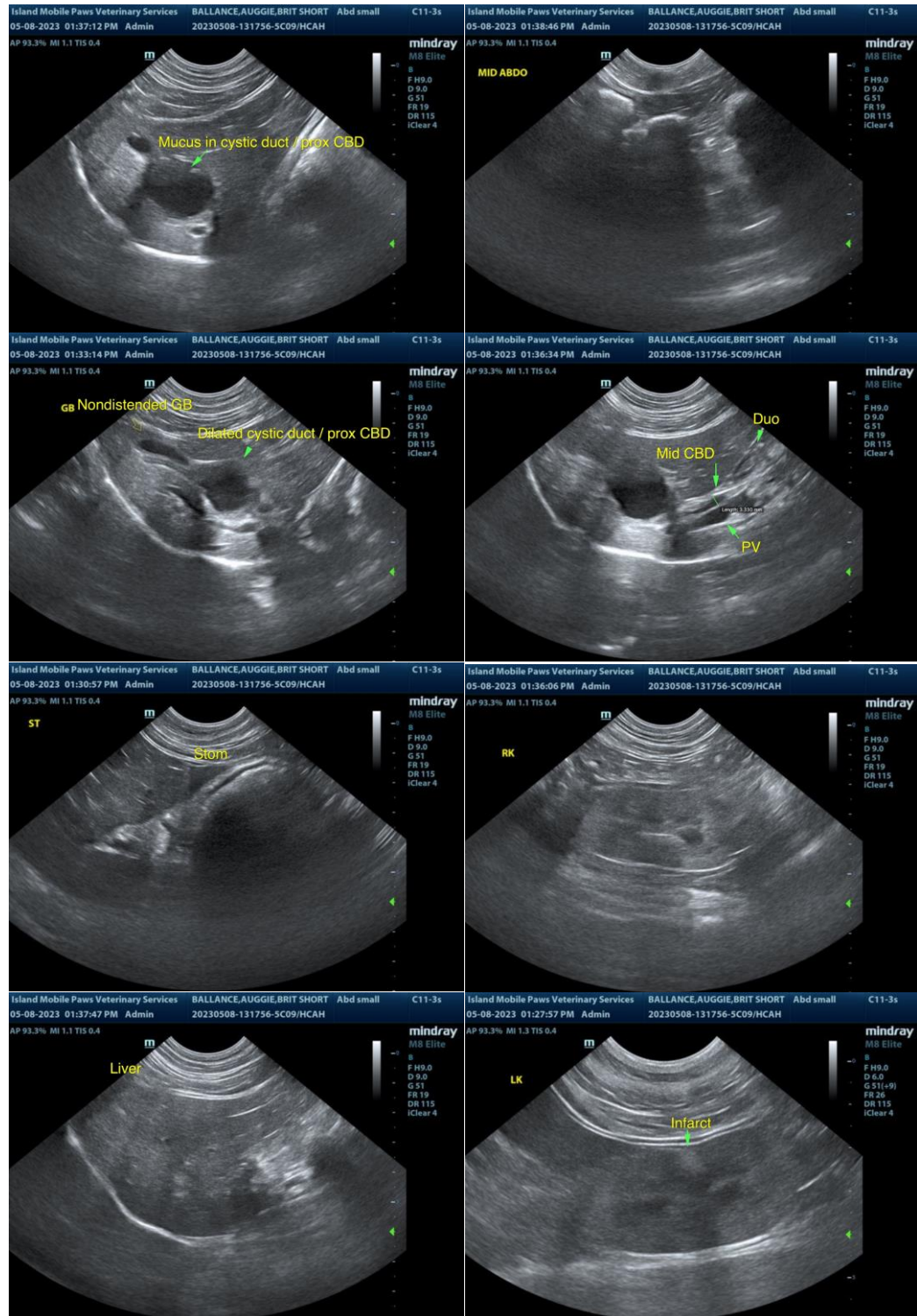
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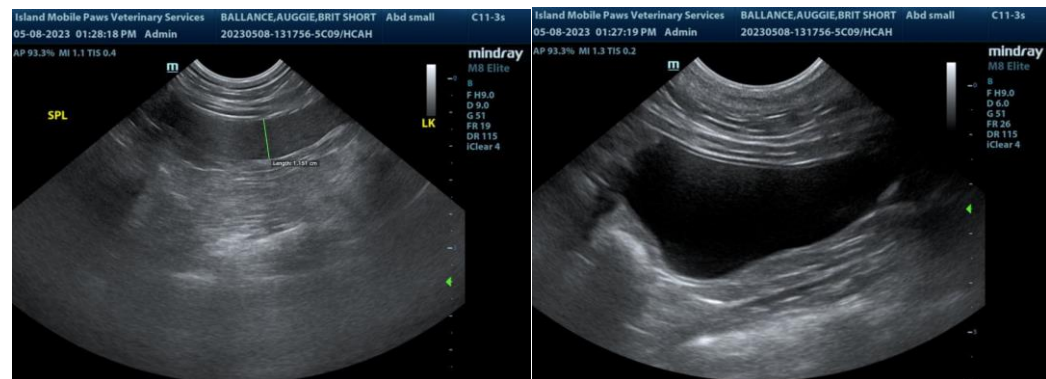
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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