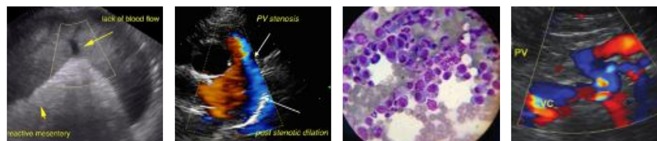

SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Daphne Britnell

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Female Spayed

AGE

14 years

WEIGHT

5.9 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sharon Rosenberg

HOSPITAL NAME

London Cat Clinic

REFERRING VET

Dr. Sharon Rosenberg

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14148

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6/28/22

PRESENTING CLINICAL SIGNS

Limited history, adopted from O sister a few months ago. Daily vomit HB or clear fluid, Possibly PP, PU, PD. Undermuscled. Very borderline hyperthyroid, IRIS stage 2 CRI, N B12, high folate. Treated low dose methimazole - mild worsening renal values, still stage 2, with treatment to upper 1/2 of N T4. Mod hypertension, started treatment with amlodipine and currently moderate control, to fine tune still. Mod improvement in vomiting, ongoing weight loss despite good calorie intake. Noted 2 tiny abdominal nodules (derm/sq) ventral abdomen- didn't ultrasound yet, will consider FNA if also do spleen (mammary? MCT?). No chest rads done yet.

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 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.

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 was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Right kidney pinpoint medullary mineral was present. No evidence of pelvic dilation was present. The left kidney measured 3.4 cm in length. The right kidney measured 3.1 cm in length.

Adrenal Glands

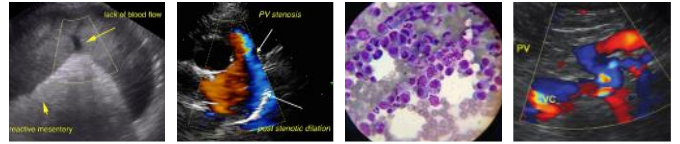
The bilateral adrenal glands were normal in size and contour. Pinpoint areas of mineralization were present without capsular distortion or overt tumors. This is an age-related finding and not pathological. The left adrenal gland measured 0.45 width and the right adrenal gland measured 0.39 width.

Spleen

The spleen was borderline enlarged measuring 1.0 cm width at the level of the hilus. Subtle generalized hypoechoic micronodular parenchyma was present with no overt masses. Normal splenic vascularity was noted.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. Multifocal, primarily pinpoint areas of parenchymal or biliary tree mineralization were present, including hyperechoic intraparenchymal nodule exhibiting evidence of distal acoustic shadowing. The nodule may Indicate a focal area of parenchymal mineralization or fibrosis, not consistent with neoplastic criteria. Concurrent solitary, moderately sized, thinly-walled intraparenchymal cyst was noted deep mid liver measuring 1.3 cm in diameter. The gallbladder was non distended in size



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with mild echogenic, nonmineralized biliary sludge. The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction. The common bile duct measured 0.22 cm diameter.

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. The pylorus wall width measured 0.30 cm.

The small intestine presented intact yet mildly prominent generalized wall layering yet without evidence of significant mural hypertrophy or loss of intestinal wall layering. No Intestinal masses were noted. The jejunum wall width measured 0.23 cm.

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

Pancreas

The pancreas was normal in size with mild asymmetrical capsule contour and mild hypoechoic parenchyma compared to adjacent omentum with minor pancreatic duct dilation.

Free Abdomen

Subtle subjective benign / reactive colic lymphadenopathy was present. No evidence of peritoneal free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

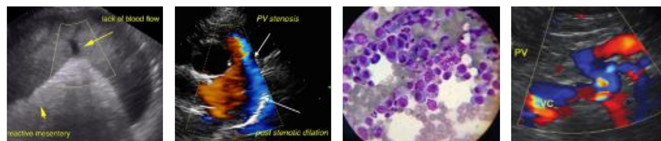
- Hepatic parenchymal remodeling exhibiting multifocal primarily pinpoint parenchymal or biliary tree mineralization, concurrent benign intraparenchymal cyst - subjectively benign
- Mild gallbladder debris with mild nonobstructive proximal common bile duct dilation
- Borderline splenomegaly exhibiting subtle micronodular parenchyma
- Chronic active pancreatitis pattern
- Bilateral chronic renal changes
- Intact yet subjective mild prominent small bowel walls

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The mildly dilated proximal common bile duct may indicate age-related or chronic common bile duct dilation possibly owing to past episodes of cholangitis. At times, this may potentially cause low-grade lethargy and anorexia. The high folate noted in this patient is nonspecific in cats yet may potentially indicate concurrent low-grade to mild essentially structurally Insignificant gastrointestinal disease. Likewise, some contribution to the patient's vomiting may be owing to chronic active pancreatitis. As-needed gastrointestinal support and hairball therapy, if clinically indicated, would be appropriate.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

The splenic presentation is nonspecific and may correlate with reactive or benign borderline splenomegaly i.e., lymphoid hyperplasia. However, the possibility of early neoplasia such as lymphoma,



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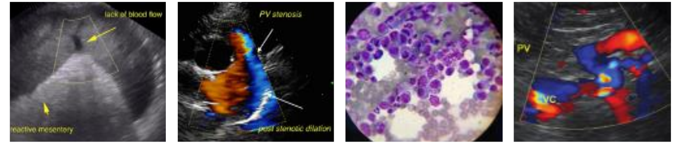
and mast cell neoplasia cannot be definitively excluded. Ultrasound-guided FNA of the spleen using a 25-gauge needle and assuming normal clotting status is warranted for screening cytology, especially if evidence of weight loss.

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)



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