



PATIENT

Cooper Breitenstein

SPECIES

Feline

BREED

Domestic Shorthair

SEX

M/N

AGE

12Y 11M

WEIGHT

13.31 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Carly Pate

HOSPITAL NAME

VCA McKenzie
Animal Hospital

REFERRING VET

Dr. Arpaia

INVOICE

14680

DATE

8/24/22

PRESENTING CLINICAL SIGNS

Appetite has increased over the last 6 months, but weight has decreased ~0.6# from February 2022. P's fur from previous ultrasound in February 2022 did not regrow. P is on Ursodiol 1/4 tablet once daily since 2020 discovery of cholelithiasis.

Abnormal PE/Chem/CBC/UA Results: Senior panel w/ SDMA pending. History of hypercholesterolemia (234), Amylasemia (1920) on Feb 2022 labwork.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint areas of medullary mineral to potential medullary fibrosis were present. No evidence of pyelectasia was present. The left kidney measured 4.2 cm in length. The right kidney measured 4.6 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 0.53 width and the right adrenal gland measured 0.53 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 0.75 cm width at the level of the hilus.

Liver/ Gallbladder

The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. Focal areas of nonobstructive biliary tree mineral were present primarily around the gallbladder. The gallbladder was non-distended in size with anechoic content with previously noted multiple dependent calculi. An example of a calculus measured 0.45 cm in diameter. No evidence of gallbladder or peripheral gallbladder inflammation was noted. The common bile duct was not definitively visualized, yet without evidence of dilation, stasis, or obstructive pattern.



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Gastrointestinal

The stomach presented intact and sonographically unremarkable wall layering with mild to possible moderate retained anechoic fluid. No evidence of mechanical pyloric outflow obstruction was noted. The gastric body wall width measured 0.20 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 duodenum wall measured 0.30 cm width. The jejunum wall measured 0.24 cm width.

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

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia. Potential uniform nodule was present in the distal left pancreatic limb vs. adjacent peripancreatic mesenteric lymph node measuring 1.0 cm x 0.74 cm.

Free Abdomen

No overt or significant free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Previously noted subjective static nonobstructive multifocal gallbladder calculi
- Hepatomegaly exhibiting intermittent focal nonobstructive biliary tree mineral
- Chronic active pancreatitis pattern with potential left pancreatic nodule vs. adjacent peripancreatic focal lymphadenopathy
- Overtly normal gastrointestinal tract with possible gastric stasis
- Mild chronic renal changes with pinpoint medullary mineral / possible medullary fibrosis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pending recheck lab work and assuming normal clotting status, screening hepatic FNA, as well as FNA of the left pancreatic nodule vs. peripancreatic lymph node could be considered for screening cytology. Sonographic monitoring of this potential pancreatic nodule or lymph node for evidence of progression with Initial recheck in 4-6 weeks would be a more conservative approach. Potential for pancreatitis would be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation.

Given the patient's weight loss, a GI panel to include PLI/TLI/Cobalamin/Folate to correlate with the pancreatic presentation, as well as assess for structurally insignificant or occult intestinal disease as a contributing factor, is suggested.

Continued hepatosupportive medications including current Ursodiol with serial monitoring for evidence of increasing cholestatic disease going forward is suggested.



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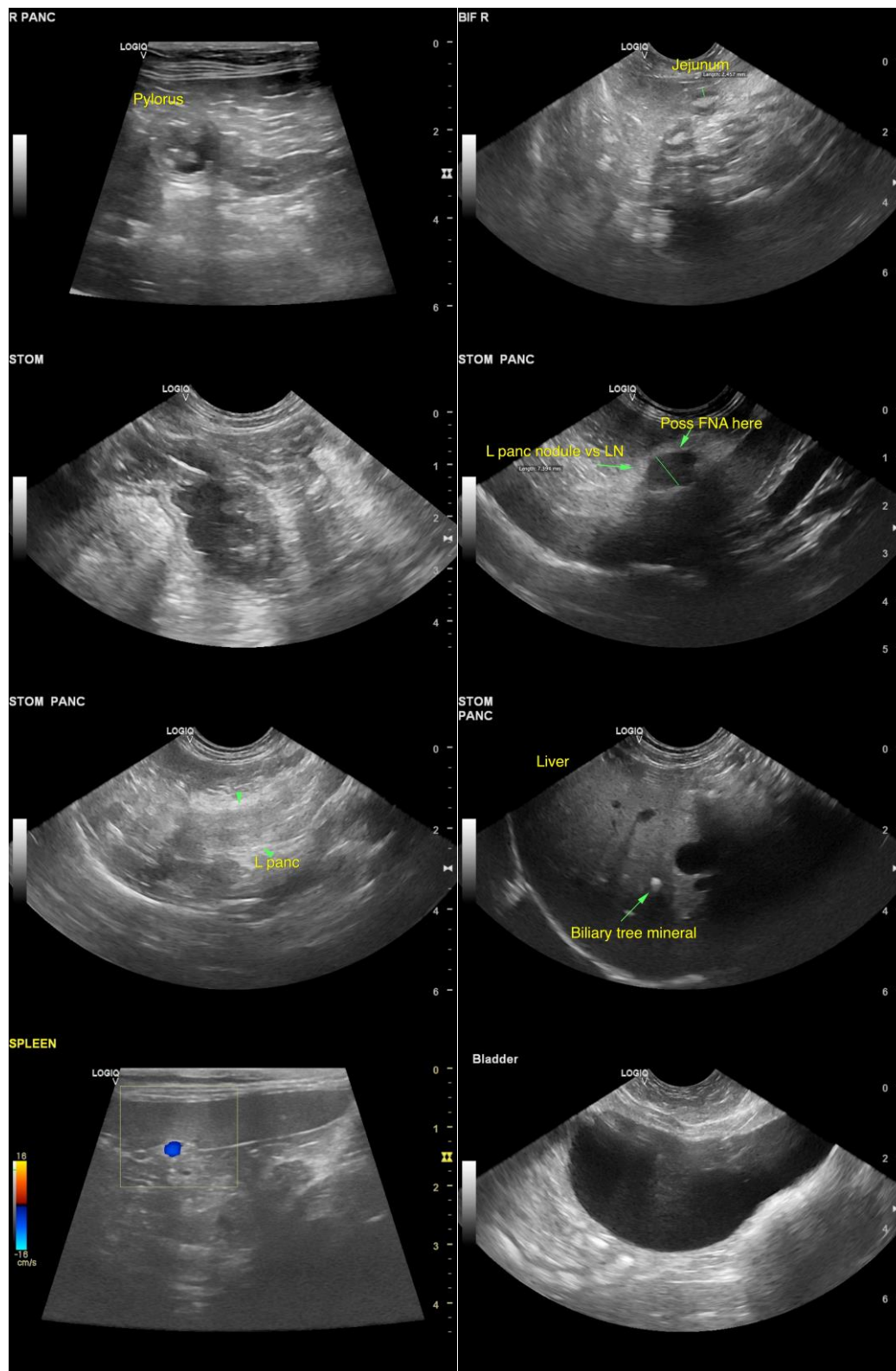
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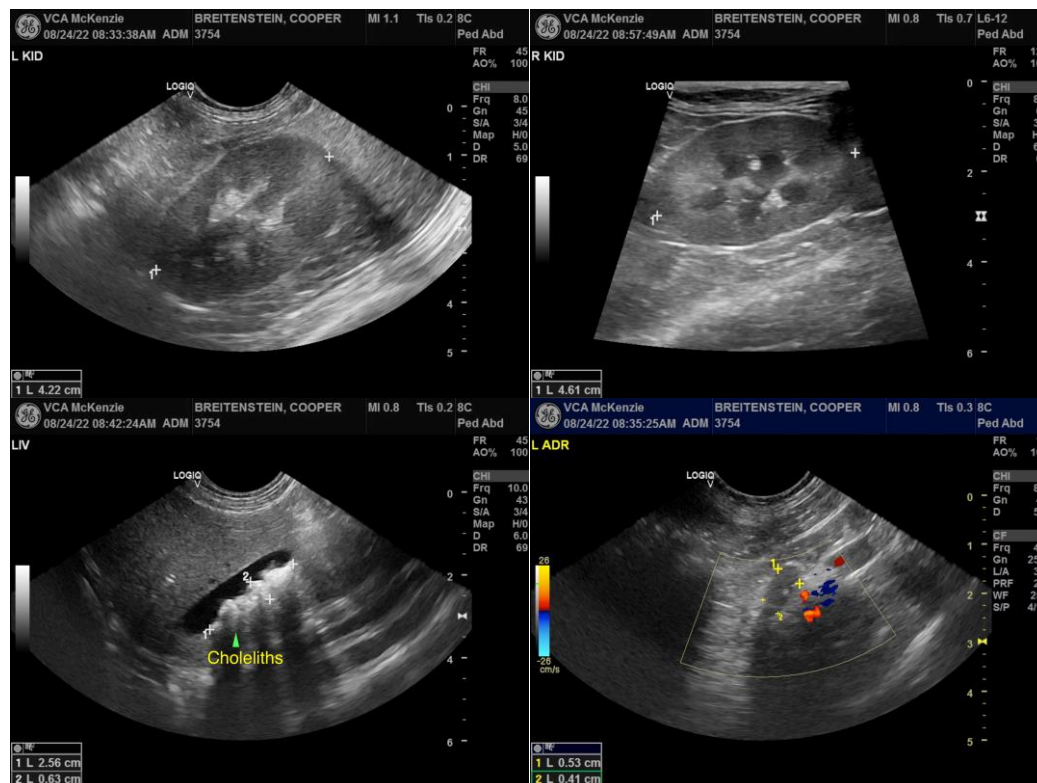
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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