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Clinical Sonography & Telecytology
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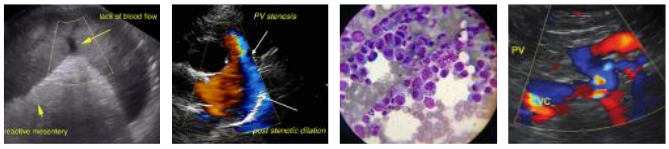

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Max Kacaj

SPECIES

Feline

BREED

DSH

SEX

Male

AGE

9 Years

WEIGHT

3.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Matthew Olcha

HOSPITAL NAME

East Meadow VC

REFERRING VET

Matthew Olcha

INVOICE

17076

DATE

8/27/22

PRESENTING CLINICAL SIGNS

History: Presented today for lethargy and poor appetite. No c/s/v/d/PUPD. Intermittent poor appetite since June but much worse the past couple days. UA normal and FIV/FeLV negative in June.

Abnormal PE/Chem/CBC/UA Results: Quiet, noted to have lost 2 pounds since June. Mild hyperglobulinemia otherwise unremarkable labs today (attached). Chest x-ray shows mild bronchial pattern with hepatobiliary calcification noted in collimated abdomen.

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. Primarily anechoic urine was present in the lumen. Mild dependent to nondependent particulate to focally 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. Aortic trifurcation was normal.

The kidneys were normal in size and margination with maintained 1:3 cortex to medulla ratio. Both kidneys exhibited uniform increased cortex echogenicity with mildly enhanced corticomedullary border demarcation. The left kidney measured 3.9 cm. The right kidney measured 3.9 cm.

Adrenal Glands

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

Liver

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.

The gallbladder and cystic biliary duct contained several variably sized calculi, exhibiting distal acoustic shadowing. The proximal common bile duct exhibited mild tortuous dilation not consistent with post hepatic obstructive pattern. The gallbladder and common bile duct walls were overtly normal without obvious inflammatory changes. No evidence of peripheral gallbladder or common bile duct effusion.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Mild luminal gas was present with mild retained mildly echogenic chyme and fluid in the antrum and pylorus. No evidence of mechanical pyloric outflow obstruction. The gastric body wall measured 0.25 cm.

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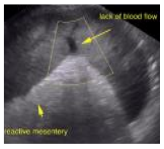

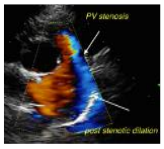

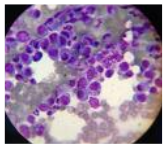
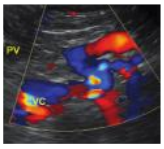

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The small intestine exhibited intact wall layering with subjective propensity for mildly prominent muscularis layer yet without evidence of loss of intestinal wall layering, masses or significant hypertrophy. The jejunum wall measured 0.26 cm – 0.27 cm.

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

Pancreas

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.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Mild urinary bladder sediment
- Nonspecific chronic renal changes, exhibiting uniform increased cortex echogenicity
- Mild retained pyloric chyme/fluid
- Suspect possible low grade to mild inflammatory enteropathy
- Nonobstructive cholelithiasis with mild nonobstructive proximal common bile duct dilation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

Although not definitive, with potential for patient variant, the small intestine exhibited subtle mural changes, which may suggest underlying inflammatory enteropathy/IBD. Minor potential for emerging neoplastic infiltrative enteropathy with round cells, such as lymphoma is considered a less likely differential diagnosis. No sonographic evidence of active pancreatitis. Further assessment of the weight loss in conjunction with intestinal presentation may include a GI panel to include PLI/TLI/Cobalamin/Folate.

The gallbladder choleliths and mildly dilated proximal common bile duct is likely incidental given the lack of cholestasis on blood work. At times choleliths and proximal common bile duct have been associated with underlying chronic hepatobiliary inflammation, such as cholangitis/cholangiohepatitis if previous history of hepatic enzyme elevations. Monitoring for evidence of increasing cholestasis or hepatic enzyme elevations going forward is recommended.

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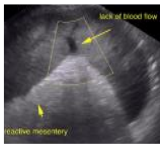
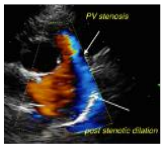
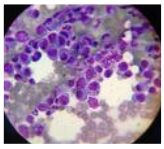
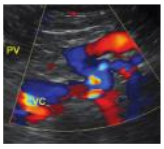

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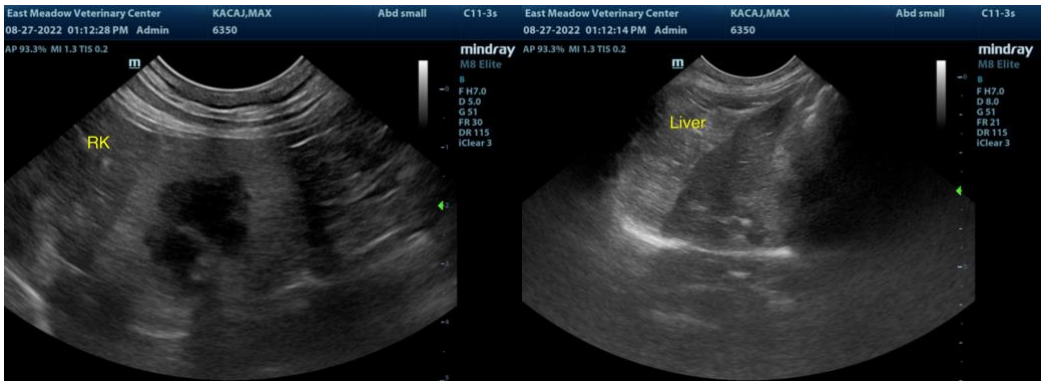

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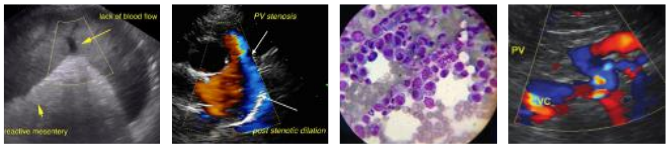

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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