



PATIENT

Rosie Atamian-Crown

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

17 y

WEIGHT

11.4 lbs.

INTERPRETED BY

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

**IMAGING
 PERFORMED BY**

Pamela Harrigan, RDMS

HOSPITAL NAME

Wood River Animal
 Hospital

REFERRING VET

Casey Schuelke, DVM

INVOICE

14959

DATE

9/23/22

PRESENTING CLINICAL SIGNS

Presenting for decreased appetite the past few days and lethargic, Icteric on exam. ALP and GGT, Tbili increased. History HCM, no medications at the moment otherwise has been healthy. Concern for triaditis and secondary hepatic lipidosis. Current meds: Unasyn q8h, Zeniquin 25 mg q24h, Cerenia 0.4ml q24 hours. IVF plasmalyte, Vit K 0.25ml q12h, Vit B12 0.25ml SID
 Abnormal PE/Chem/CBC/UA Results: ALP 266, GGT 8, Bilirubin 3.9

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.

Borderline subnormal size was noted 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. Bilateral mild pyelectasia was present. The left kidney measured 3.0 cm in length. The right kidney measured 3.3 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 0.38 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.45 cm width.

Spleen

The spleen exhibited borderline to mild enlargement with mild asymmetrical to scalloped medial capsule contour and potential for minor splenic folding. Uniform subjectively mildly decreased splenic parenchyma echogenicity comparable to the liver was noted. The spleen measured 1.1-1.2 cm width at the level of the hilus. No splenic masses or nodules were noted.

Liver/ Gallbladder

The liver presented 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. Intermittent, nondisruptive, cystic-appearing intraparenchymal nodules were noted with an example measuring 1.4 -1.5 cm in diameter.

The gallbladder was non-distended in size containing anechoic content with mild luminal debris. The proximal common bile duct was dilated and tortuous. The common bile duct contained anechoic content with potential for mild mucus. No obvious evidence of post hepatic obstructive criteria was noted. The proximal common bile duct measured 0.3 cm diameter.



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Gastrointestinal

The visualized gastric walls were sonographically normal with no evidence of gastric distention. The lumen of the stomach contained ingesta exhibiting distal acoustic shadowing. The gastric body wall width measured 0.25 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 0.21 cm width. The jejunum wall measured up to 0.26 cm width. The ileocolic wall measured 0.31 cm width.

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

Pancreas

The pancreas was normal in size and contour with heterogeneous to isoechoic parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. Minor pancreatic duct dilation was noted.

Free Abdomen

Multiple, variably sized, jejunocolic lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of regional perilymphatic to peri intestinal mildly hyperechoic mesentery was evident. An example of lymph node size was 2.5 cm x 0.77 cm. No omental masses were noted. Small pockets of scant anechoic peritoneal free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hepatopathy exhibiting intermittent cystic intraparenchymal nodules - nodules suggestive of benign cystic biliary adenomas
- Mild gallbladder debris with mild nonobstructive proximal common bile duct dilation
- Overtly normal gastrointestinal tract with shadowing gastric ingesta - nonspecific
- Suspect jejunocolic lymphadenitis
- Possible chronic pancreatitis
- Small pockets of scant peritoneal free fluid

Secondary Findings

- Bilateral chronic renal changes with mild pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The overall liver was nonspecific yet did not exhibit classic parenchyma hyperechogenicity typically seen with hepatic lipidosis. Potential for hepatic lipidosis, inflammatory hepatic parenchymal or hepatobiliary process, i.e., cholangitis / cholangiohepatitis, with the possibility of infiltrative round cell neoplasia, are possible.



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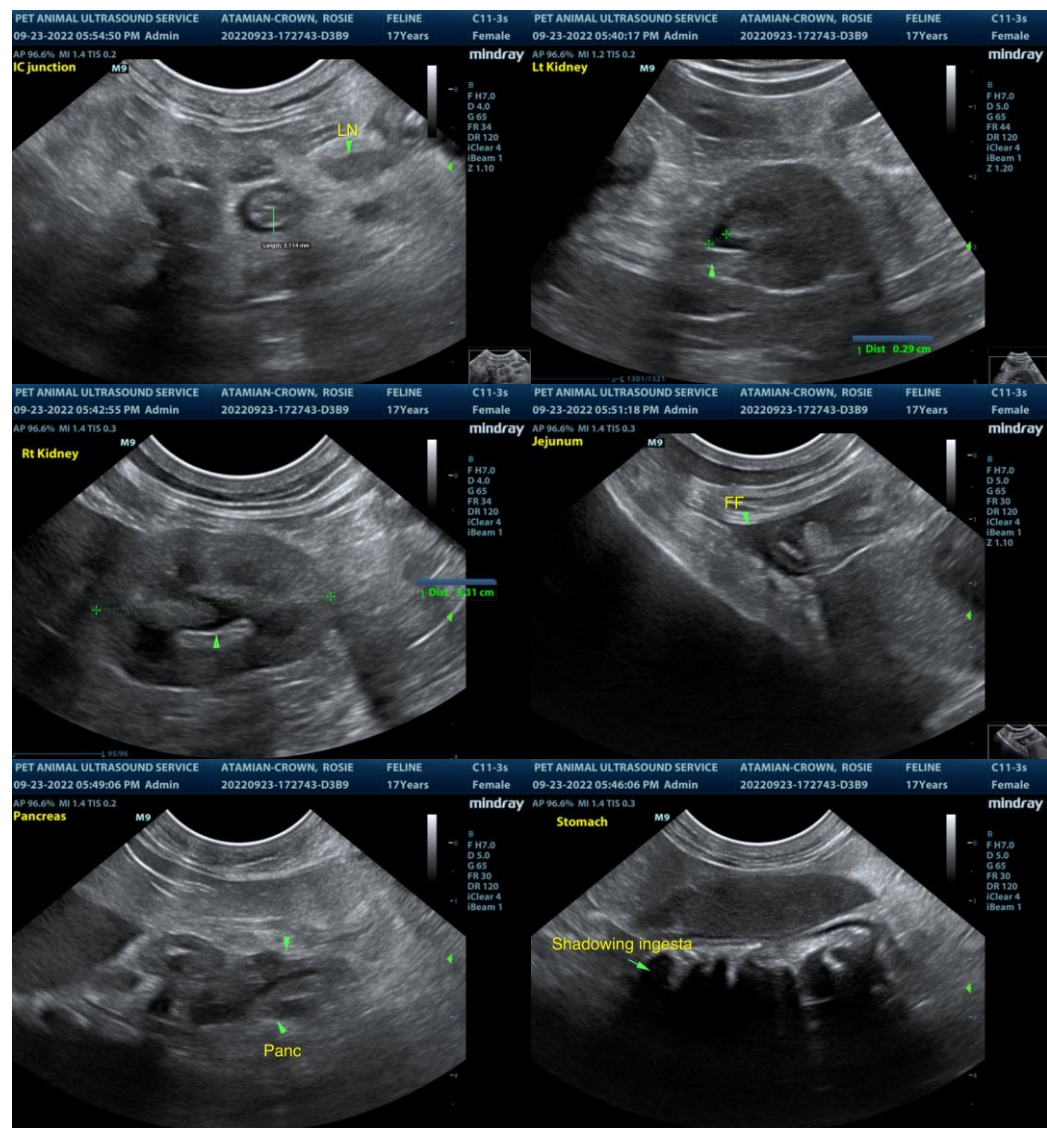
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Triad Disease may be a consideration in this patient, yet no obvious evidence of intestinal mural changes or pathology, as well as lack of gastrointestinal signs, i.e., weight loss or diarrhea. Further assessment may include, assuming normal clotting status screening hepatic FNA cytology using a 25-gauge needle, as well as a GI panel to include PLI/TLI/Cobalamin/Folate.

Nonobstructive hepatic cholestasis is considered most likely at this stage. Empirical gastrointestinal support and therapy for inflammatory hepatobiliary disease, pending additional diagnostics and with an assessment of clinical response, would be reasonable. Recheck sonogram as needed if progressive hepatic enzyme elevations or evidence of cholestasis are noted.





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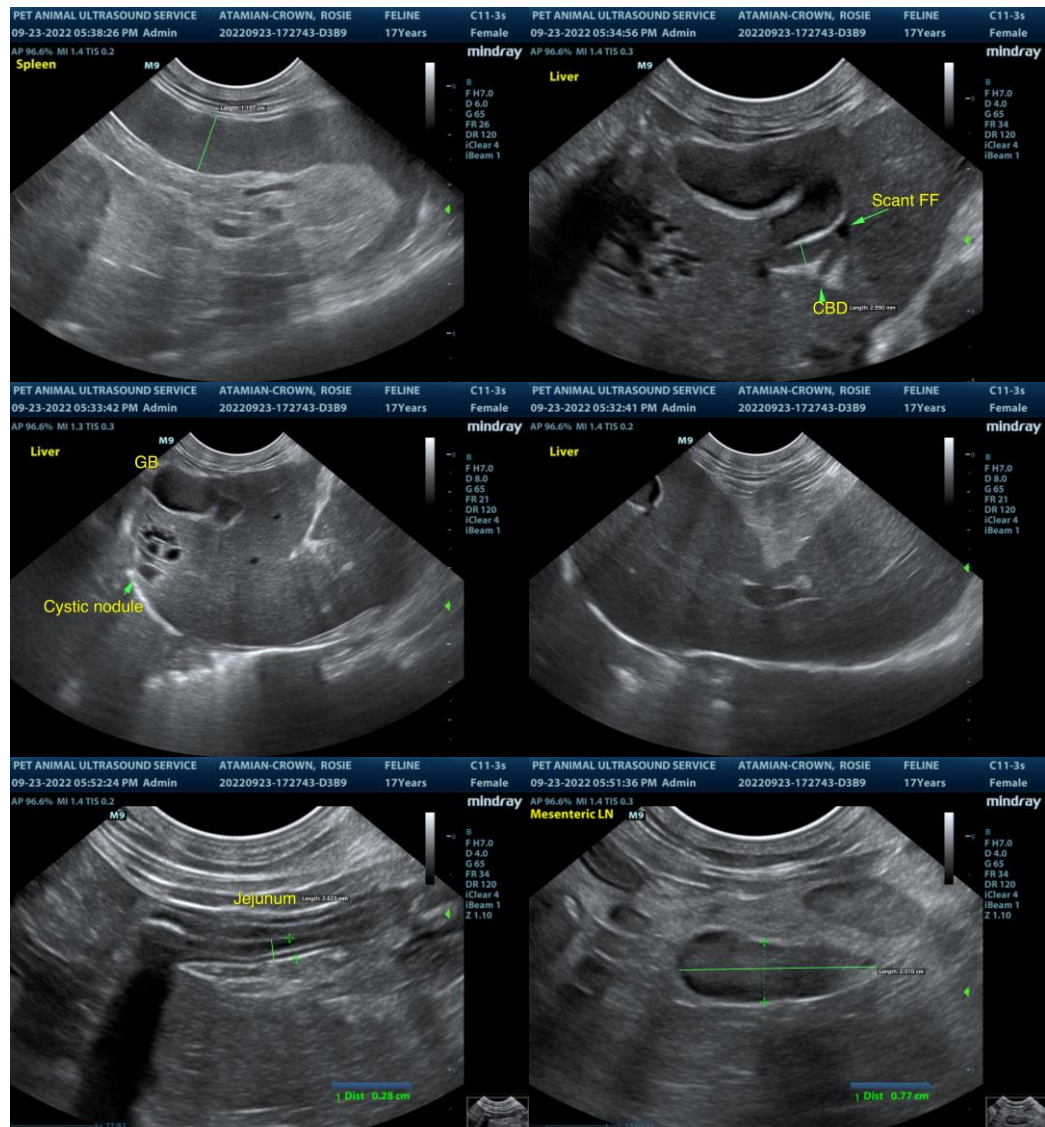
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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