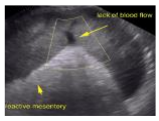
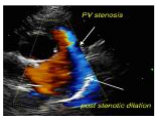
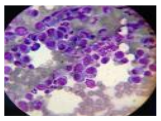
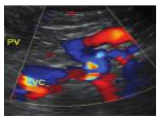

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**PATIENT**

Rasta Shriner

**SPECIES**

Feline

**BREED**

DSH

**SEX**

MN

**Age**

12 years

**WEIGHT**

6.5 #

**INTERPRETED BY**

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

**IMAGING PERFORMED BY**

Meghan Myers, VMD

**HOSPITAL NAME**

Hershire Animal Hospital

**REFERRING VET**

Susan Zhang DVM

**INVOICE**

304119

**DATE**

4/13/23

## PRESENTING CLINICAL SIGNS

History: Weight loss with voracious appetite, occasional vomiting and intermittent soft stool.

Physical Examination: Severe sarcopenia, thickened small intestines, dehydration, pale mucosa.

Urinalysis: N/A.

CBC: Pending.

Serum Biochemistry: Pending.

Radiographic Findings: N/A.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Full urinary bladder with a normal thickness and irregular appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal trigone area, proximal urethra, and iliac blood vessels.

Normal iliac lymph nodes. Ureters not visualized.

Normal renal size, echogenic appearance, cortico-medullary differentiation, pelvis, and capsule. Incidental small non-obstructive renoliths.

### *Reproductive System*

N/A.

### *Adrenal Glands*

Poorly visualized but appear to be in normal position with normal echogenic appearance, shape, and size.

### *Spleen*

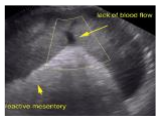
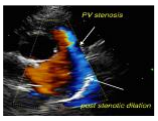
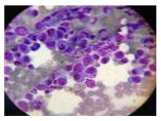
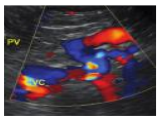
Small with a normal echogenic appearance. Smooth homogenous parenchyma, regular curvilinear capsule, and normal vasculature. No inflammatory, neoplastic, infarction, or infiltrative changes evident.

### *Liver*

Normal size with increased echogenic appearance, prominent portal markings, and regular curvilinear capsule. No nodules or masses evident.

### *Gall bladder*

Full containing normal anechoic bile. Thickened and hyperechogenic appearance of the wall. Normal bile duct.

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### *Gastrointestinal*

Normal appearance of the stomach, duodenum, ileo-cecal junction, and colon with no loss of layering, normal wall thickness (stomach 0.36 cm, duodenum 0.32 cm) and peristalsis, and no distension of the lumen. Prominent hypoechogenic appearance of the submucosal layer of the small intestine with sections showing an increased muscularis to mucosa ratio but with no loss of layering or distension of the lumen. Large amount of chyle within the small intestine, fecal material within the colon.

### *Pancreas*

Normal size and echogenic appearance. Regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

### *Free Abdomen*

Mesenteric lymphadenomegaly with normal shape and hypoechogenic appearance.
Large amount of acellular ascites present.

## ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Hepatopathy.
- Enteropathy.
- Mesenteric lymphadenomegaly.
- Ascites.

Secondary Findings:

- Previous cholecystitis.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the hepatopathy would be reactive, metabolic, cholangio-hepatitis complex, and early lipidosis, with infiltrative neoplasia, a less likely differential diagnosis.

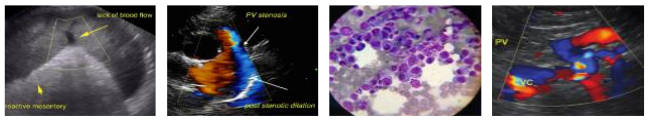
Etiologies for the enteropathy would be dietary hypersensitivity, parasitic enteritis, inflammatory bowel disease, granulomatous disease, and emerging lymphoma.

Etiologies for the lymph nodes would be reactive, lymphadenitis, and infiltrative neoplasia.

Although the ascites can be ascribed to the intestinal and lymph node changes, hypoalbuminemia and portal hypertension needs to be considered.

With the presenting clinical signs, pancreatic insufficiency and hyperthyroidism would be important diagnoses.

Further assessment needs to be based on the pending results but could include fecal analysis/intestinal panel, T4 assay, analysis of the ascitic fluid, thoracic radiographs, FNA of the liver and lymph nodes, and endoscopy of the upper GI tract with biopsies.



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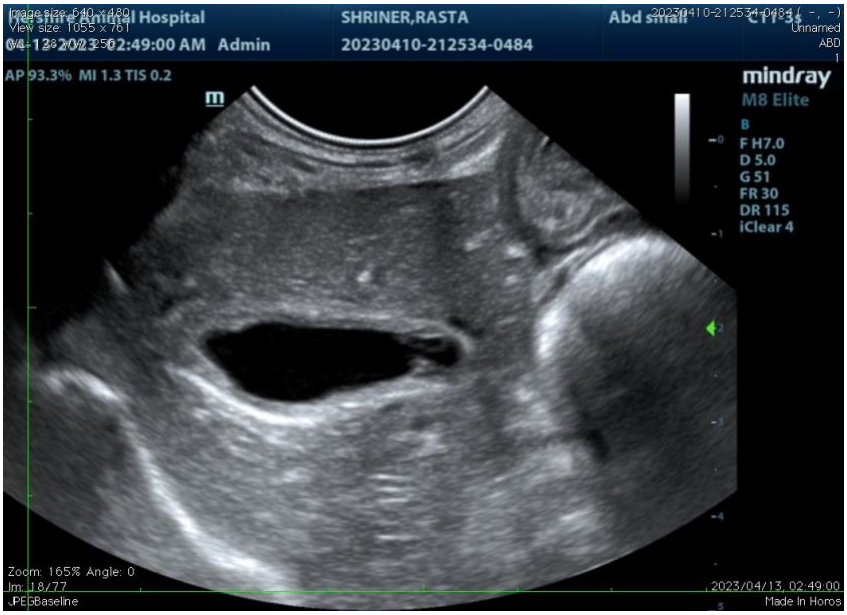
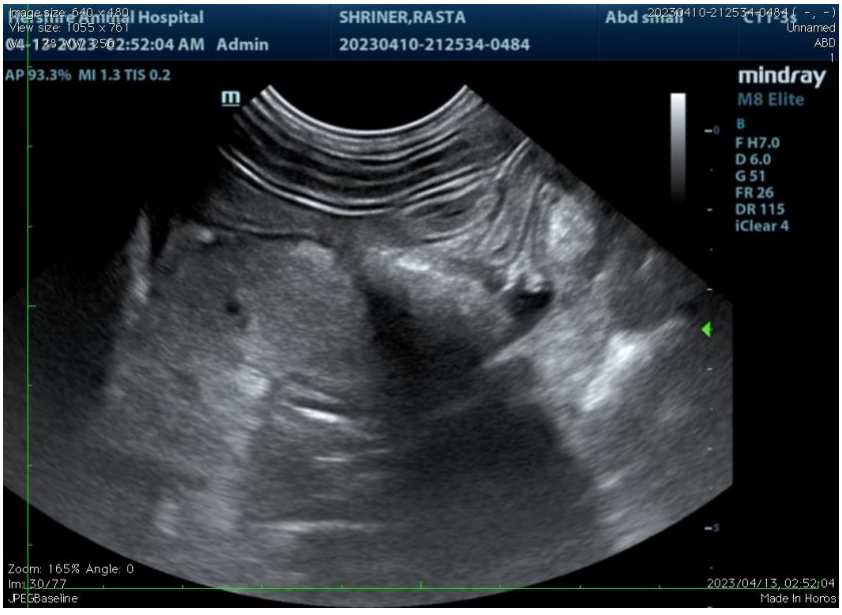
Specific therapy would be dependent on an etiological diagnosis. Symptomatic management would be hypoallergenic /novel protein diet, cobalamin supplementation, course of fenbendazole, and possibly prednisolone.

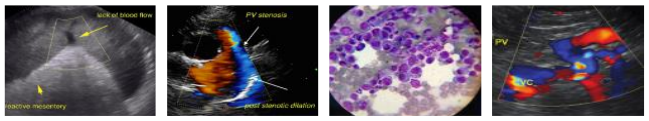
## IMAGES

### Liver/gall bladder




### Small intestine





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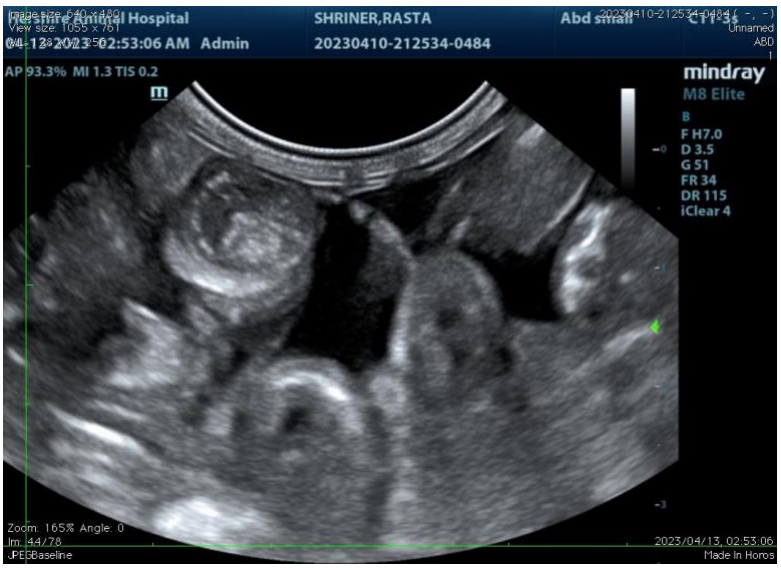
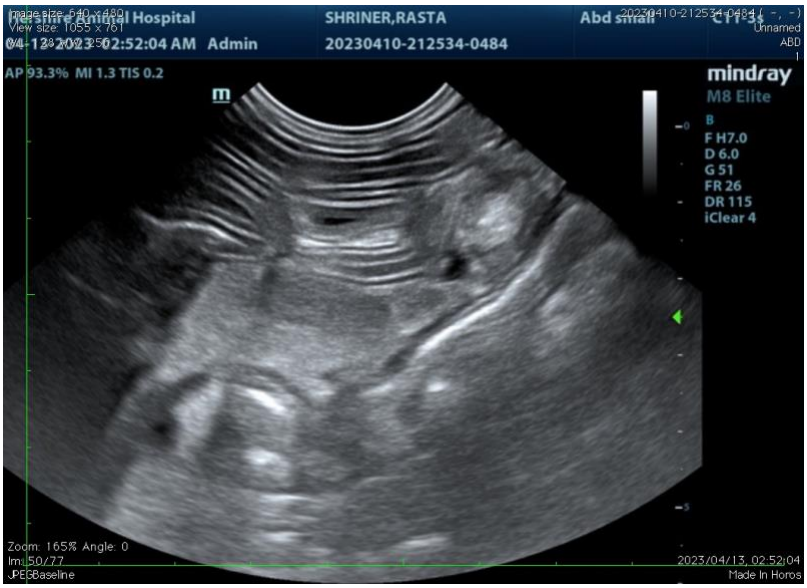
## Ascites




## Mesenteric lymph nodes




**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.

**Remo Lobetti**, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)
rlobetti@mweb.co.za