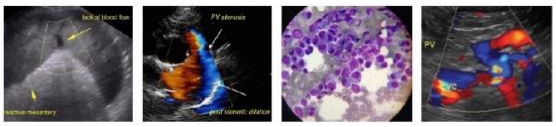


PATIENT
Lucille Potruff

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
10 Years

WEIGHT
2.66 kg

INTERPRETED BY
Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY
Kelly Reschny

HOSPITAL NAME
The Cat Clinic Hamilton

REFERRING VET
Dr. Germain

INVOICE
20502

DATE
1/9/23

PRESENTING CLINICAL SIGNS

History: Adopted from rescue 1 year ago, unsure of exact age. Hyperthyroid, weight loss, decreased/picky appetite, hypocobalaminemia, chronic vomiting.

Current Medications Cobalequin (250mg B12) PO SID in pm, Felimazole 2.5mg po SID in pm, Flexaden BID (except not morning of ultrasound), Since Jan 5: Cerenia 4mg po SID for 4-day trial, has also mirtazapine 1.8mg to give po q 2-5 days PRN (not day of US). Abnormal PE/Chem/CBC/UA Results: No rads done.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 3.0 cm.

Both kidneys have mildly decreased corticomedullary differentiation. There is an infarct present in the cortex of the left kidney, as well as cortical mineralization. There is no evidence of nephrolithiasis, pyelectasia or hydronephrosis. The proximal ureter is not visible (normal). The left kidney is 3.2 cm in length. The right kidney is 2.9 cm in length.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 2.6 mm at the caudal pole. The right adrenal gland height 2.2 mm at the caudal pole.

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. Thickness at the splenic hilus is normal at 5.8 mm.

Liver

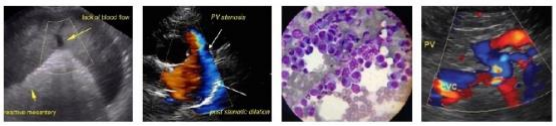
The liver is diffusely enlarged, and the parenchyma is disrupted by the presence of numerous large and small cysts. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is empty. The gastric wall is 2.5 mm with normal deviations due to rugal folds and exhibits appropriate wall layering. The pylorus is of normal appearance.

The small bowel has focal changes to the normal 1:3 muscularis to mucosa ratio. Wall measurements are mildly increased up to 2.2 mm for duodenum and 2.4 mm for jejunum. Overall wall layering is preserved. Intestinal motility appears normal.



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The visible portions of the colon are of normal thickness, up to 1.2 mm, with intact wall layering. The ileocecal junction is not visualized.

Pancreas

The pancreas is hypoechoic, but of normal size and with no changes to the surrounding mesenteric fat. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- A diffusely enlarged and cystic liver
- Mildly thickened small intestines, consistent with infiltrative bowel disease

Secondary Findings

- Chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes to the liver could indicate either a biliary cystadenoma, other hepatic neoplasia, or possibly severe polycystic liver disease. A biopsy would be necessary for a definitive diagnosis. Given that hepatic functional values are still normal, it is possible that this problem is not the cause of the current clinical signs. The low cobalamin and changes to the intestines would support infiltrative bowel disease as well, though biopsy would be needed to confirm this, and to differentiate inflammatory from neoplastic disease. Finally, the mildly elevated serum calcium could indicate idiopathic hypercalcemia, which is another potential cause for vomiting and weight loss. Thus, additional recommendations would include:

- A malignancy or hypercalcemia panel
- Fecal parasite testing and empiric fenbendazole treatment trials with a novel protein or hydrolyzed diet
- Empiric therapy with prednisolone at 2-4mg / kg daily could be considered if a diet trial is unsuccessful.
- Definitive diagnosis would require biopsy of the affected tissue, ideally with intra-operative ultrasonographic guidance. If there is concurrent lymphadenopathy, ultrasound-guided sampling of the lymph node using a 25 or 22G needle could be considered.

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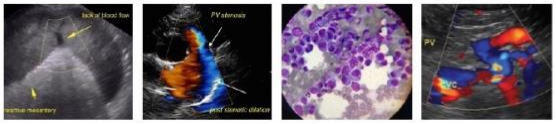

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

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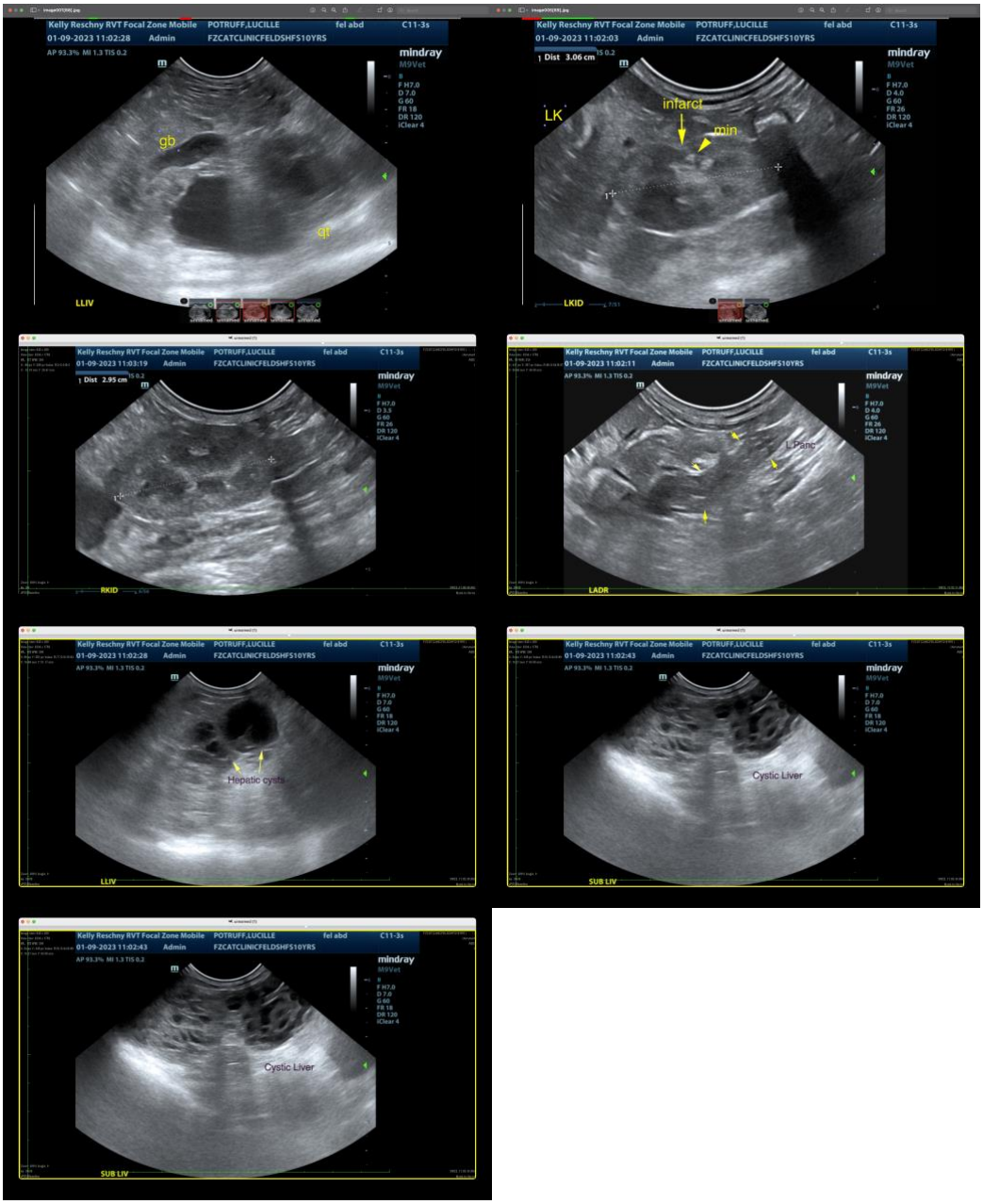

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice) info@SonoPath.com

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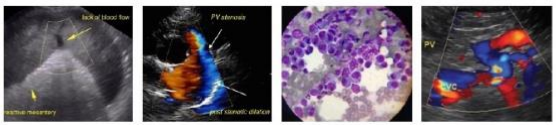

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