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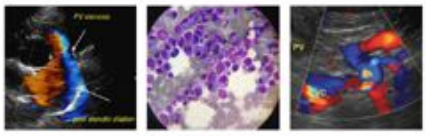

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PATIENT

Petey King

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

16yr

WEIGHT

7.8lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Dr.Gentile

INVOICE

10044

DATE

2/14/2023

PRESENTING CLINICAL SIGNS

Off/on decreased appetite and losing weight past 6 weeks. Last week no appetite and vomiting once daily (bile). Abnormal PE/Chem/CBC/UA Results: Thin. Please see attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae, and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses, or cystic calculi.

The left kidney has a normal shape and size (3.69 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.09 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.39 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.42 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.74 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is a hyperechoic cystic lesion visualized in the left caudal ventral aspect of the liver. Additionally, in the right side of the liver there is a somewhat cystic lesion measuring 1.09 cm x 1.27 cm and a smaller lesion (possibly associated with the cystic region measuring 0.95 cm x 1.32 cm.)

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate/large amount of non-organized echogenic debris. The cystic and common bILE duct appear dilated with a thickened wall measuring approximately 0.67 cm with a small amount of intraluminal debris and no obvious stones or mass lesions.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.26 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is

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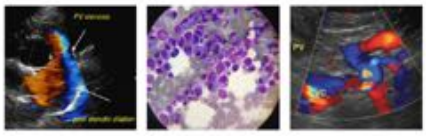

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adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis: mucosa layer ratio. The jejunum measured 0.19 cm in diameter. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is hypoechoic and prominent to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is mild cranial abdominal lymphadenopathy with lymph nodes measuring 0.36 cm and 0.41 cm. The omentum is slightly hyperechoic in the cranial abdomen.

PRIMARY FINDINGS

- Moderate to large gallbladder debris with a dilated thickened cystic common bile duct. Findings are most consistent with cholecystitis although underlying neoplasia or an unseen obstruction cannot be ruled out.
- Hypoechoic prominent pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Heterogenous liver. Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Mildly prominent muscularis layer of the small intestine. The small intestinal wall changes could be consistent with an underlying inflammatory process. These types of changes can sometimes be seen in normal older cats. Correlate with clinical signs.
- Visible/mildly prominent mesenteric lymph nodes. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Cystic and hypoechoic lesions visualized in the liver. The appearance of the cystic regions (particularly the hyperechoic ones) trends towards a benign hepatic cyst. Some of the more solid regions could be consistent with a benign or a neoplastic lesion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the serve elevation in liver enzymes, the primary clinical lesion in this patient is likely the large amount of gallbladder debris and the dilated thickened bile duct. These findings are most consistent with cholecystitis but biliary lymphoma and an unseen obstruction mass, stone etc. are also possible. Recommend initiating treatment with antibiotics, probiotics, and ursodiol, while obtaining a fine needle

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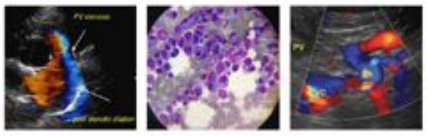

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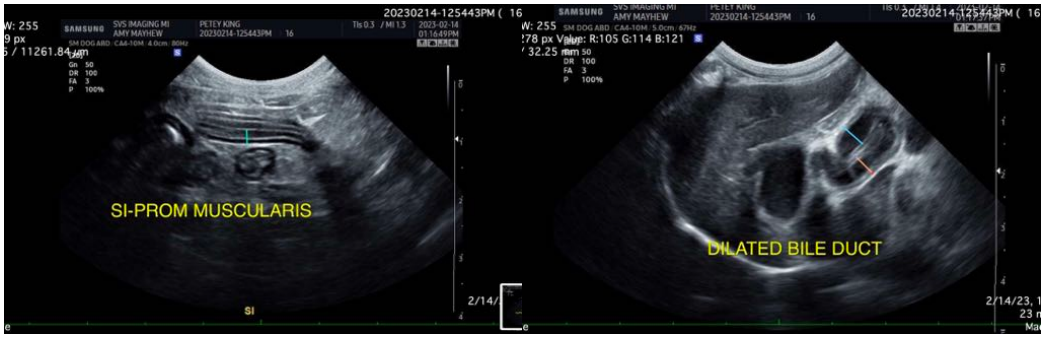
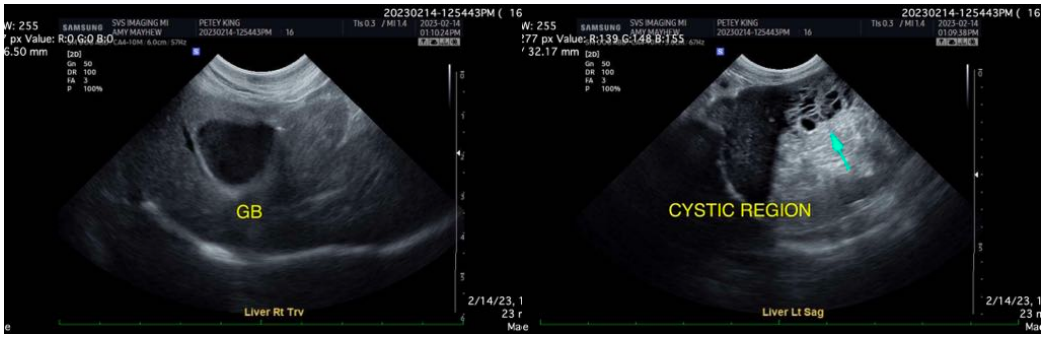
aspirate of liver looking for any evidence of round cell neoplasia.

Additionally, the pancreas is somewhat prominent, and the small intestine appears mildly “ropey” this could be indicative of concurrent triaditis. Consider a GI panel to Texas A&M for qualitative fPLI/TLI/Cobalamin/Folate to further evaluate for concurrent pancreatic and gastrointestinal disease. Hydrolyzed or novel protein diet may be warranted as well as treatment for pancreatitis. If lab work is not improving with this therapy, consider adding in anti-inflammatory steroids with the knowledge that this could temporarily inhibit an underlying neoplastic process if present.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

There are several cysts occupying “mass type lesions” within the liver. Most of these have a cystic component potentially indicating a more benign nature. Although, some of these mass lesions have a more solid component. Options include continued monitoring with ultrasound, or contrast CT scan to further evaluate for possible surgical intervention. The larger hyperechoic cystic lesion is peripheral and somewhat pedunculated and would likely be a very good surgical candidate, but this lesion primarily has the characteristics of a benign lesion. If the patient is not improving with this therapy, consider reevaluation with ultrasound as possible surgical intervention may be necessary.





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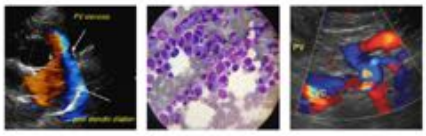

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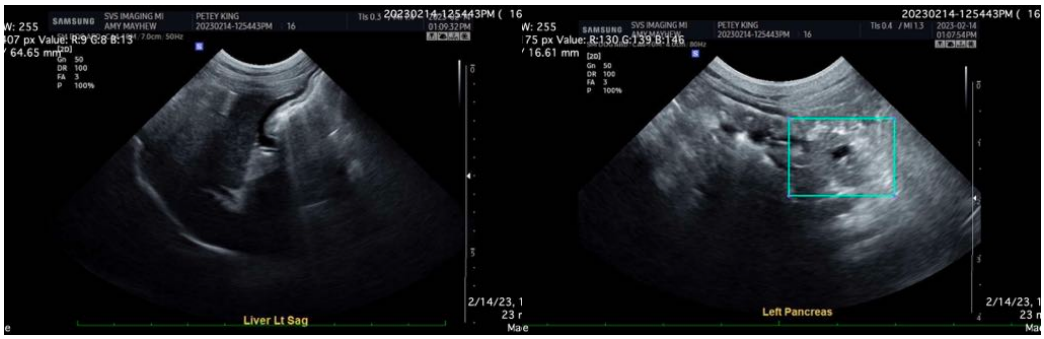

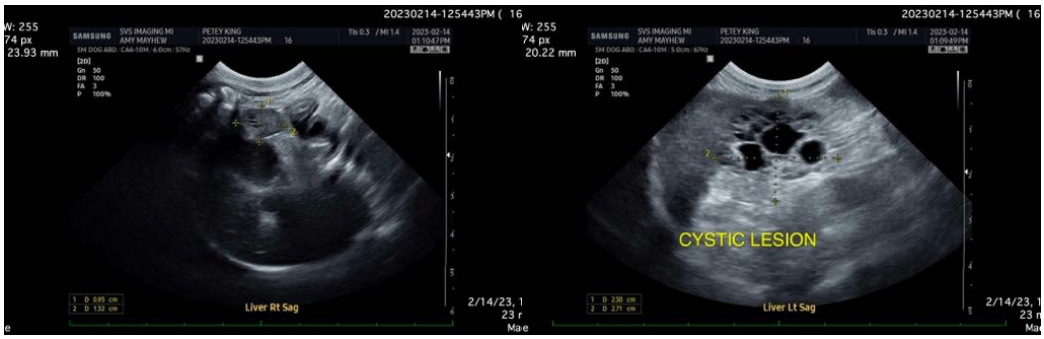

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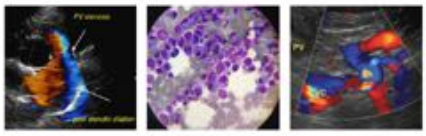

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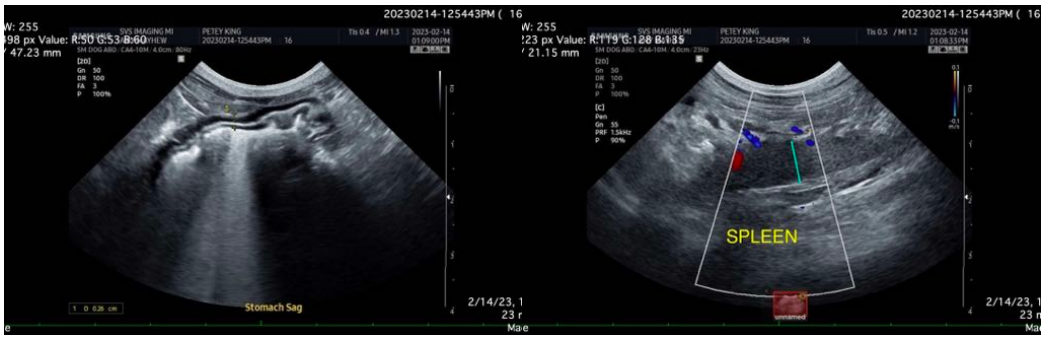

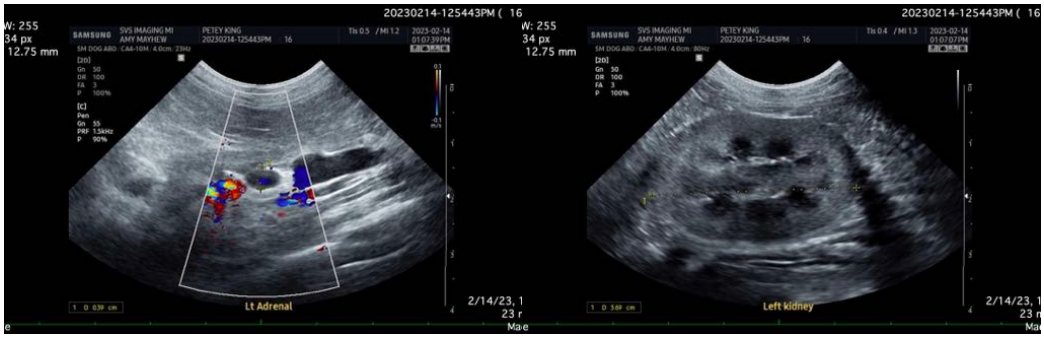

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com