SonoPath
Clinical Sonography & Telecytology
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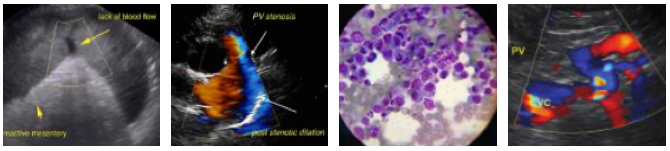


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Wabi-sabi Anderson

SPECIES
Feline

BREED
Domestic shorthair

SEX
Male, neutered

AGE
7 Yrs.

WEIGHT
5.04 kg.

INTERPRETED BY
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Dr. McKelvey

INVOICE
14492

DATE
1/24/23

PRESENTING CLINICAL SIGNS

History: Wabi-Sabi presented to the MVS Emergency Service on Jan 23, 2023, at , for evaluation of fever of unknown cause. Wabi-Sabi had an episode of vomiting on Saturday, which the owner didn't pay much mind to since he has been known to do so on occasion. He continued to become more lethargic on Sunday, which owner felt may have been related to "new puppy" stress the previous day. Wabi-Sabi's appetite and energy continued to decline, and today he vomited once and had no interest in food the whole day. He was hiding more than usual, and acting quite uncomfortable, so owner took Wabi-Sabi to be examined by his vet today. At one point it was noted that he passed a large amount of blood-tinged urine. Wabi-Sabi has a history of some constipation, for which he is currently getting Miralax daily, but is not on any other medications. He does not have a history of urinary obstruction.
Abnormal PE/Chem/CBC/UA Results: Temperature: 104.5 °F Abdomen: Tense, very resistant to palpation, more comfortable on a fentanyl CRI. Still uncomfortable on deep palpation Urogenital: M/C; urinary bladder small and soft, resistant to palpation WBC 15.43k Neu 14.73k Lym 0.6k TP 8.1 Alb 3.6 Glu 198 Chol 302 Cal 8.7

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is distended. A scant amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1 cm, are normal.

The left kidney is normal size (3.96 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (4.33 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.38 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

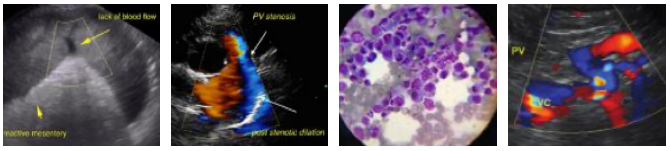
The right adrenal gland is normal in size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent in size (1.10 cm in width at the level of the hilus) with a swollen medial contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or



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regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is minimally fluid distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The cecum is prominent with a slightly thickened wall (up to 0.22 cm). The cecum contains a small amount of echogenic material. The colonic wall is normal. No obvious obstructive disease is noted.

Pancreas

The left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is mildly hyperechoic.

Free Abdomen

Trace free fluid is observed. 1-2 prominent mesenteric lymph nodes are visualized, the largest measuring 1.87 cm in length. In addition, a few prominent colic lymph nodes are seen, the largest measuring 0.90 cm in length. The mesentery surrounding the nodes is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes in the left limb are suggestive of mild pancreatitis.
- The cecal wall thickening could be consistent with typhlitis or may be a normal variant for this patient.
- The splenomegaly could be consistent with a benign process (i.e., antigenic stimulation, splenitis, extramedullary hematopoiesis, lymphoid hyperplasia or similar). Alternatively, emerging neoplasia (i.e., round cell tumor) is possible.
- Trace ascites.

Secondary Findings:

- Scant urinary bladder debris.
- Bilateral chronic age-related renal changes.
- The abdominal lymphadenopathy is most consistent with reactive change. However, emerging neoplasia cannot be completely excluded.

*It is unclear whether the patient's abdominal pain is secondary to an occult urinary tract infection, pancreatitis, typhlitis, and/or other illness.

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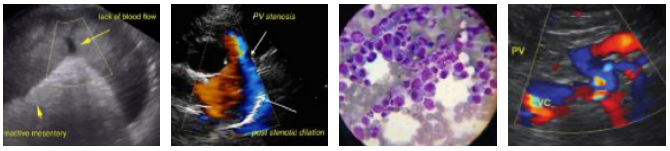

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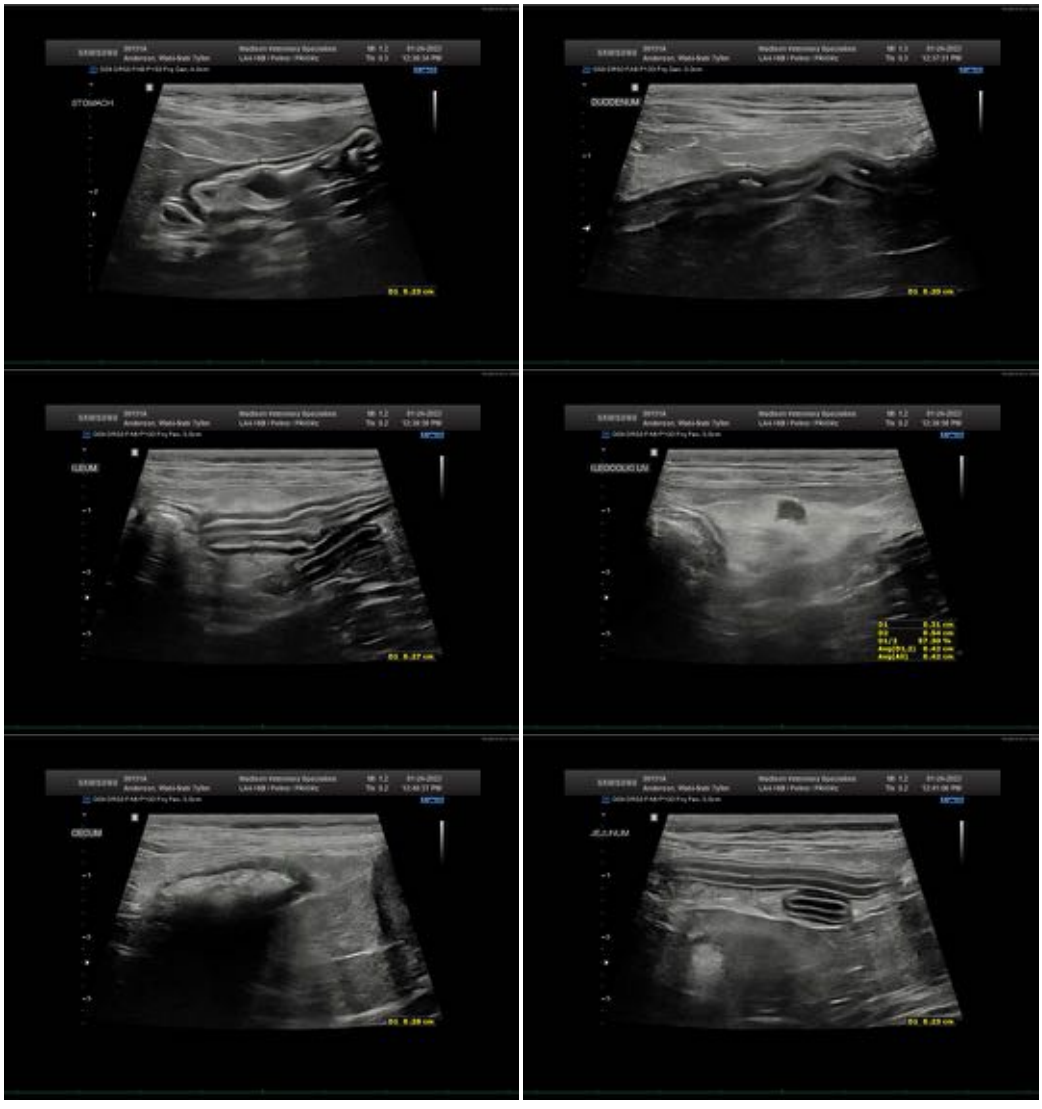
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the pancreatic changes, consider an fPLI to further assess for pancreatitis.
- A fine needle aspirate of the spleen can also be considered (if clotting status is appropriate) to further evaluate for round cell neoplasia. A 25-gauge needle should be used for aspiration.
- Given the history of hematuria, a urinalysis along with a culture and sensitivity are recommended.
- Also consider thoracic radiographs to rule out occult disease in the chest.
- Orthopedic and neurologic examinations are also recommended to rule out non-metabolic causes of pain and fever.
- While awaiting test results, empirical treatment for urinary tract infection, pancreatitis and typhlitis is recommended.



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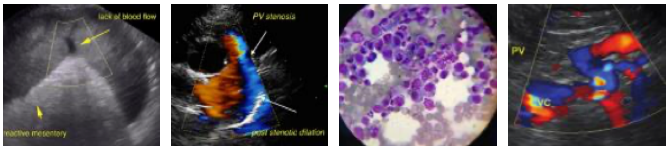

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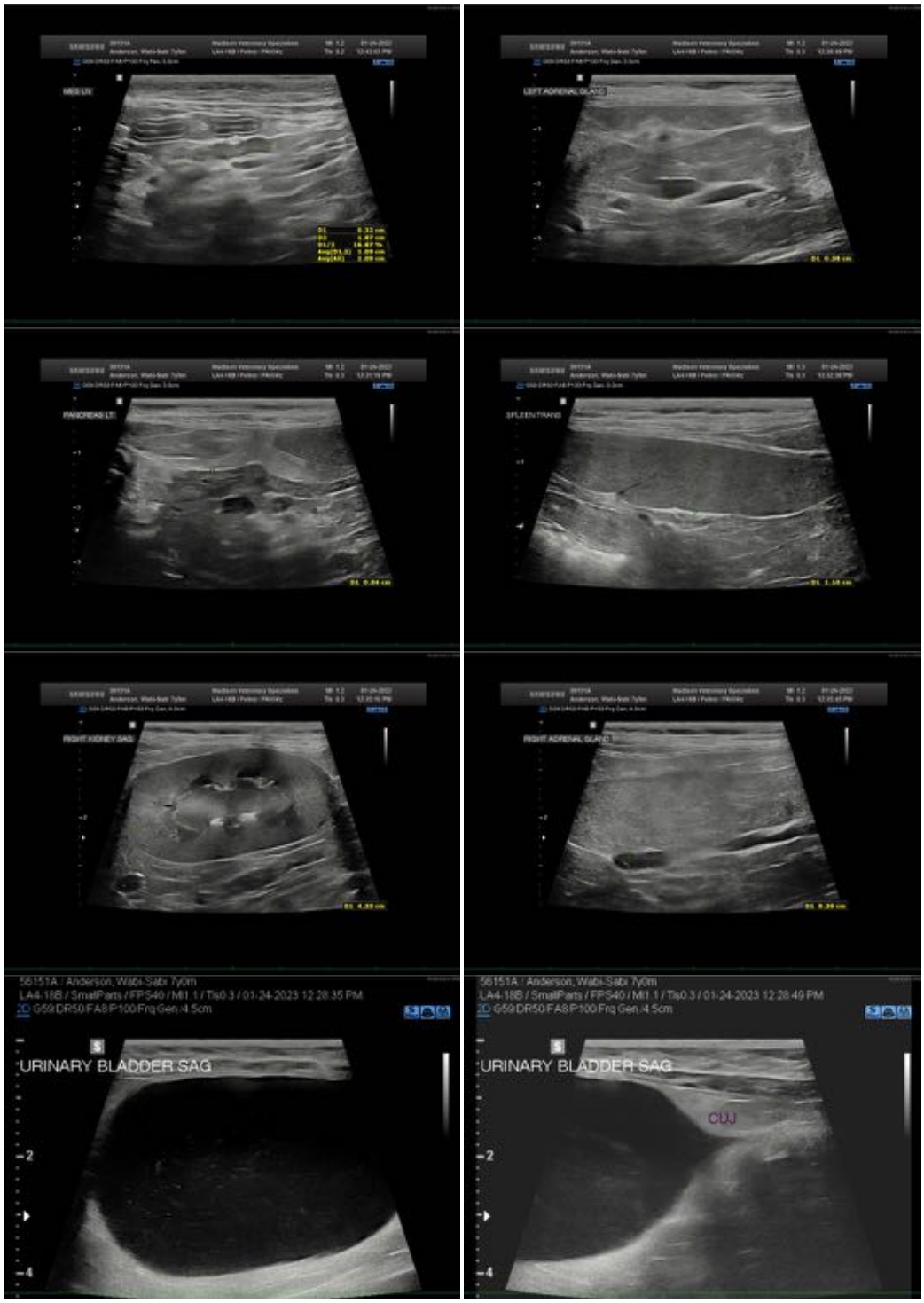

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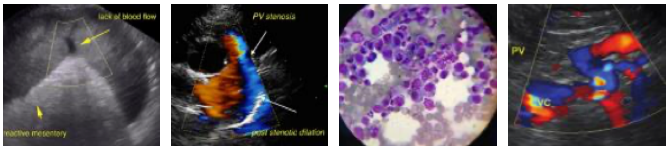

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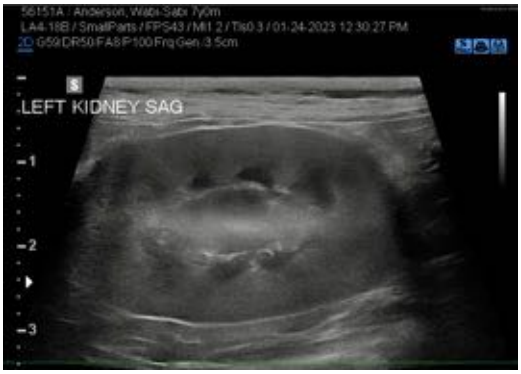

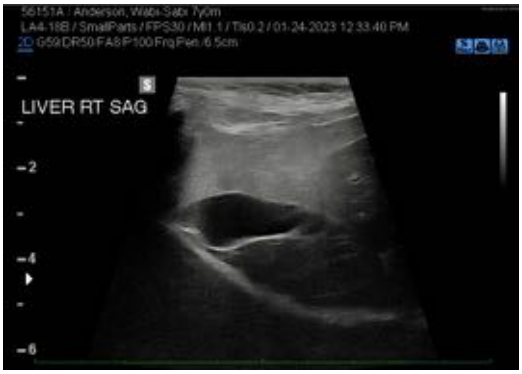

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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