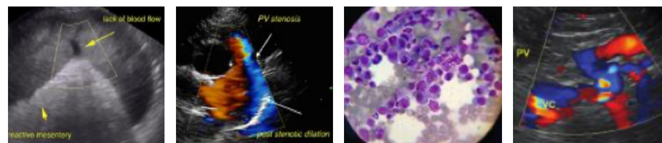

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PATIENT

Cole Matthews

SPECIES

Feline

BREED

Siamese Mix

SEX

Male, neutered

AGE

11 Yrs.

WEIGHT

5.92 kg.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Hayley Biederbeck

HOSPITAL NAME

Lomsnes VH

REFERRING VET

Dr. Tara Snow

INVOICE

12772

DATE

1/3/22

PRESENTING CLINICAL SIGNS

History: Presented for inappetence and coughing. Has a history of asthma (suspect flare up today) as well as severe pancreatitis in October 2021.
Abnormal PE/Chem/CBC/UA Results: Abdominal pain noted on palpation. TPR WNL. Heart and lung sounds WNL. No other apparent physical exam abnormalities. Radiographs showed an unremarkable thorax. Empty stomach and small intestine. Normal liver contour. VERY large amount of gas throughout the colon, irregular soft tissue opacity in caudoventral abdomen, large smooth soft tissue opacity in mid ventral abdomen.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

***31 still images and 21 video clips are available for interpretation.

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is mildly distended. A scant amount of suspended echogenic debris is observed within the lumen. The walls are normal in thickness with a smooth mucosal surface. No cystic calculi are observed.

The left kidney is normal size (3.86 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.76 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

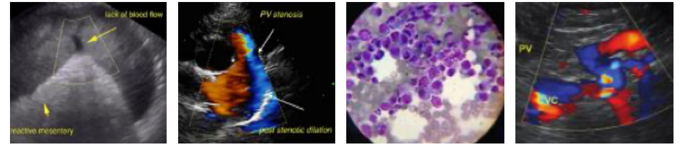
The region of the adrenal glands is evaluated. No obvious pathology is observed.

Spleen

The spleen is subjectively prominent in size (1.19 cm in width at the level of the hilus) with scalloping of the medial contour. The parenchyma is subtly mottled in appearance with ill-defined heterogeneous nodules/areas near the hilus. A mineralized thrombus is also observed in the region of the hilus.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen. The gall bladder lumen is moderately distended. A bi-lobed confirmation is suspected. The wall is thin and smooth. A small amount of aggregated echogenic



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suspended debris/sludge is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The cecal lumen contains irregular fecal material. The mesentery effacing the serosal surface is slightly reactive. The remaining colonic wall is normal.

Pancreas

The pancreas is diffusely prominent to enlarged with irregular peripheral contours, particularly in the region of the left limb. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. The pancreatic duct is mildly dilated (0.29 cm in diameter). The mesentery effacing the serosal surface of the left limb is hyperechoic.

Free Abdomen

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

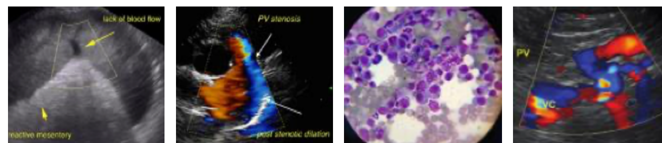
- Mineralized splenic thrombus, likely old given the mineralized areas. The splenic parenchymal changes, particularly the heterogeneous areas could be consistent with neoplasia (i.e., lymphoma, sarcoma). Alternatively, benign pathology (i.e., extramedullary hematopoiesis and/or lymphoid hyperplasia) may be present.
- The pancreatic changes are consistent with chronic active pancreatitis. Pancreatic neoplasia (particularly in the left limb) cannot be completely excluded but is considered less likely. Regional peritonitis is present.
- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.

Secondary Findings:

- Minor, bilateral age-related renal changes.
- Bowel pattern suggestive of inflammatory bowel disease.
- Possible mild typhlitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for acute on chronic pancreatitis is recommended including fluid therapy, gastric protectants, anti-nausea medication and pain medication as needed. Also consider a fresh frozen plasma transfusion. Given the possibility of typhlitis, broad spectrum antibiotic



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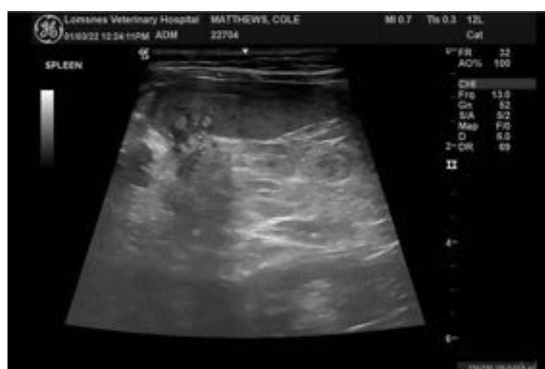
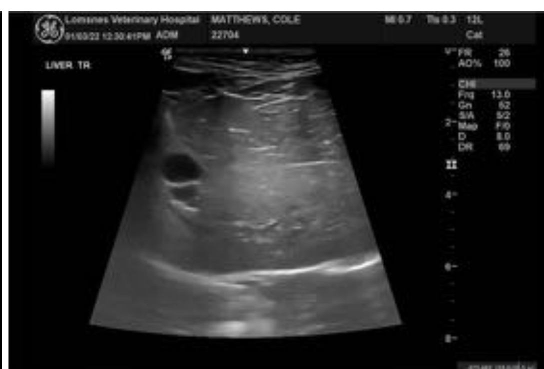
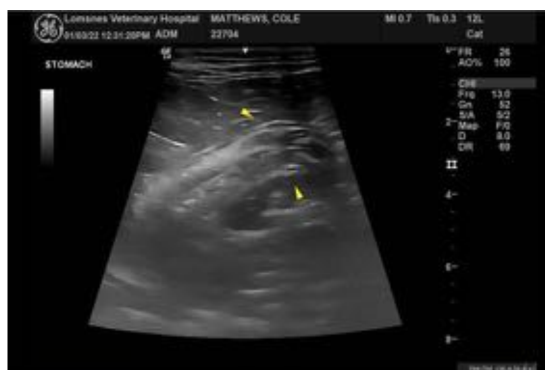
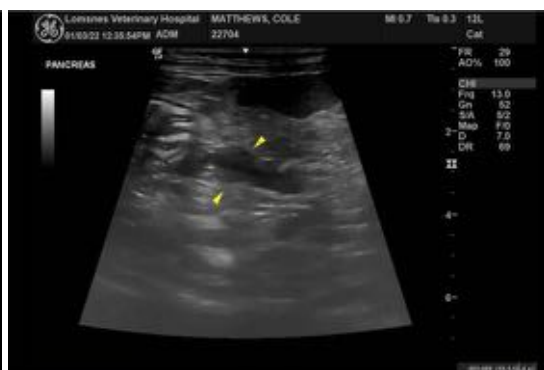
therapy should also be considered. Nutritional support (i.e., via nasogastric or esophagostomy tube) is recommended to help prevent/treat hepatic lipidosis.

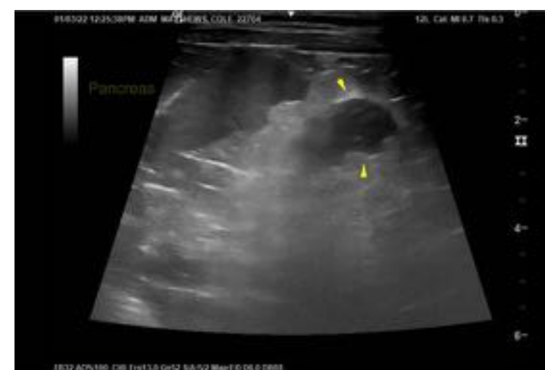
- Three-view thoracic radiographs are recommended to assess cardiopulmonary status.
- Consider fine needle aspirates of the spleen, liver, and left limb of the pancreas (if clotting status is appropriate). 25-gauge needles should be used. If cytology results are inconclusive, an abdominal exploratory with biopsies may be necessary to get a definitive diagnosis.
- Also consider a malabsorption including serum cobalamin, folate, TLI and PLI to help assess for concurrent gastrointestinal disease.

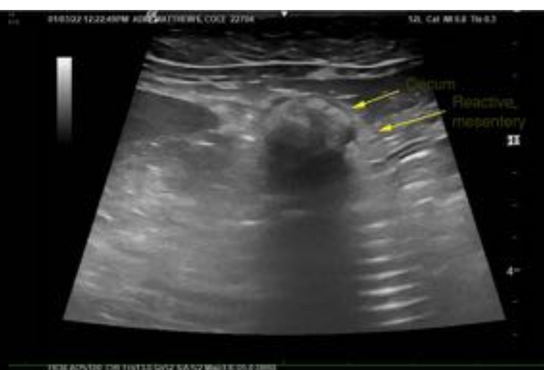


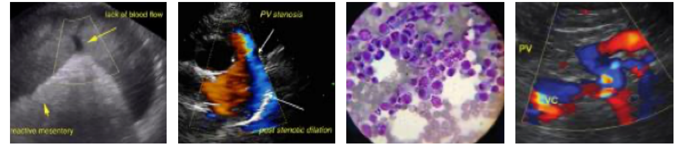












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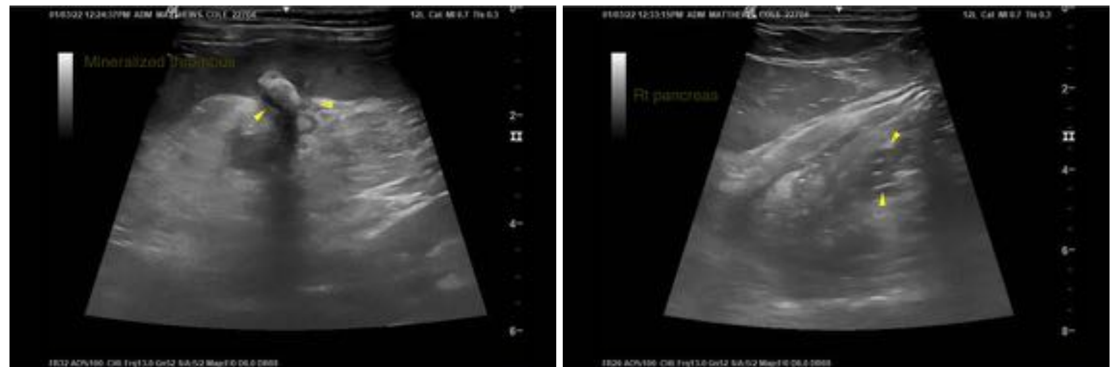

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

Andrea.nicastro@sonopath.com