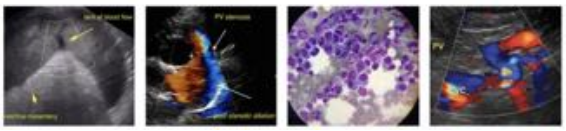
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com



Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Poppy Reiche

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

02/28/2020

WEIGHT

11.30 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Veterinary Dental Care

REFERRING VET

Suzy Shannon

INVOICE

12406

DATE

3.13.23

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Feline chronic gingivostomatitis; proliferative stomatitis/gingivitis. The patient has fleas. Indoors only.

Abnormal lab-work values:
RBC 3.90
Hematocrit 15.7
Hemoglobin 5.0
Monocytes 1.05
Hyperglobulinemia

Current Medications: Depomedrol and convenia 2 weeks ago

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is moderately distende. A moderate 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 2 cm, are normal.

The left kidney is normal in size (4.00 cm in length) with a slightly irregular shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A cortical infarct is observed at the cranial pole. There is no evidence of pyelectasia, nephroliths, or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.34 cm in length) with a slightly irregular shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Cortical infarcts are observed at the caudal pole. There is no evidence of pyelectasia, nephroliths, or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.26 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent in size (1.00 cm in width at the level of the hilus) with normal curvilinear peripheral contours. 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 regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder is moderately distended. A bilobed conformation is present. The wall is normal in thickness. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not 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 ileocecocolic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

Pancreas
The pancreas is normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

Other
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The mild splenomegaly is likely secondary to a benign process (i.e., extramedullary hematopoiesis, lymphoid hyperplasia, antigenic stimulation, splenitis). However, emerging neoplasia (i.e., lymphoma) cannot be completely excluded.

- Bilateral renal cortical infarcts, the cause of which is unclear. There is mild loss of corticomedullary distinction, which is suggestive of chronic disease.

Secondary Findings

- Bilobed gall bladder – incidental

- The urinary bladder debris could be consistent with cells, crystals, exfoliated material, mucous, and/or lipid droplets.

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

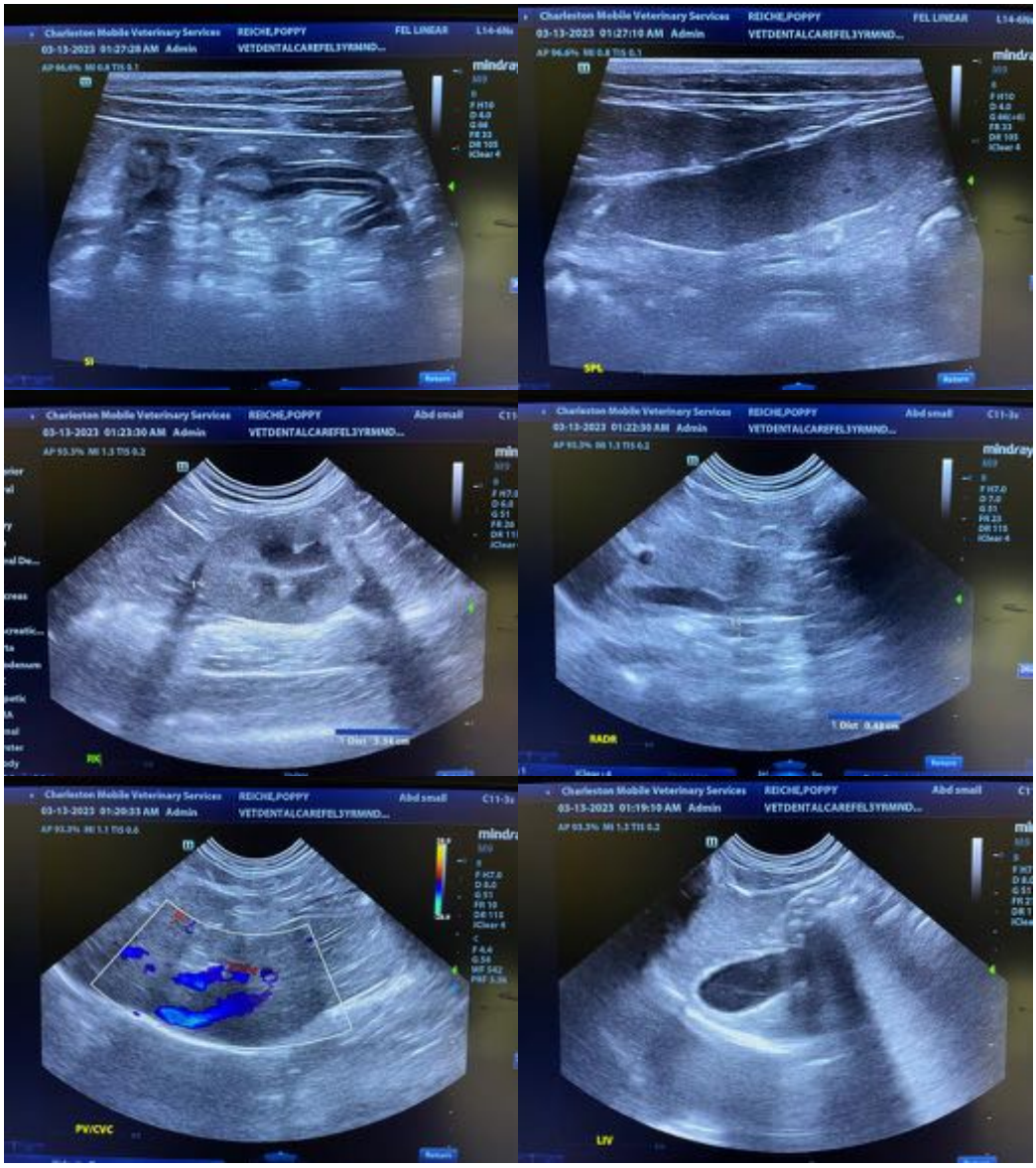
- Regarding the anemia and hyperglobulinemia, consider the following:

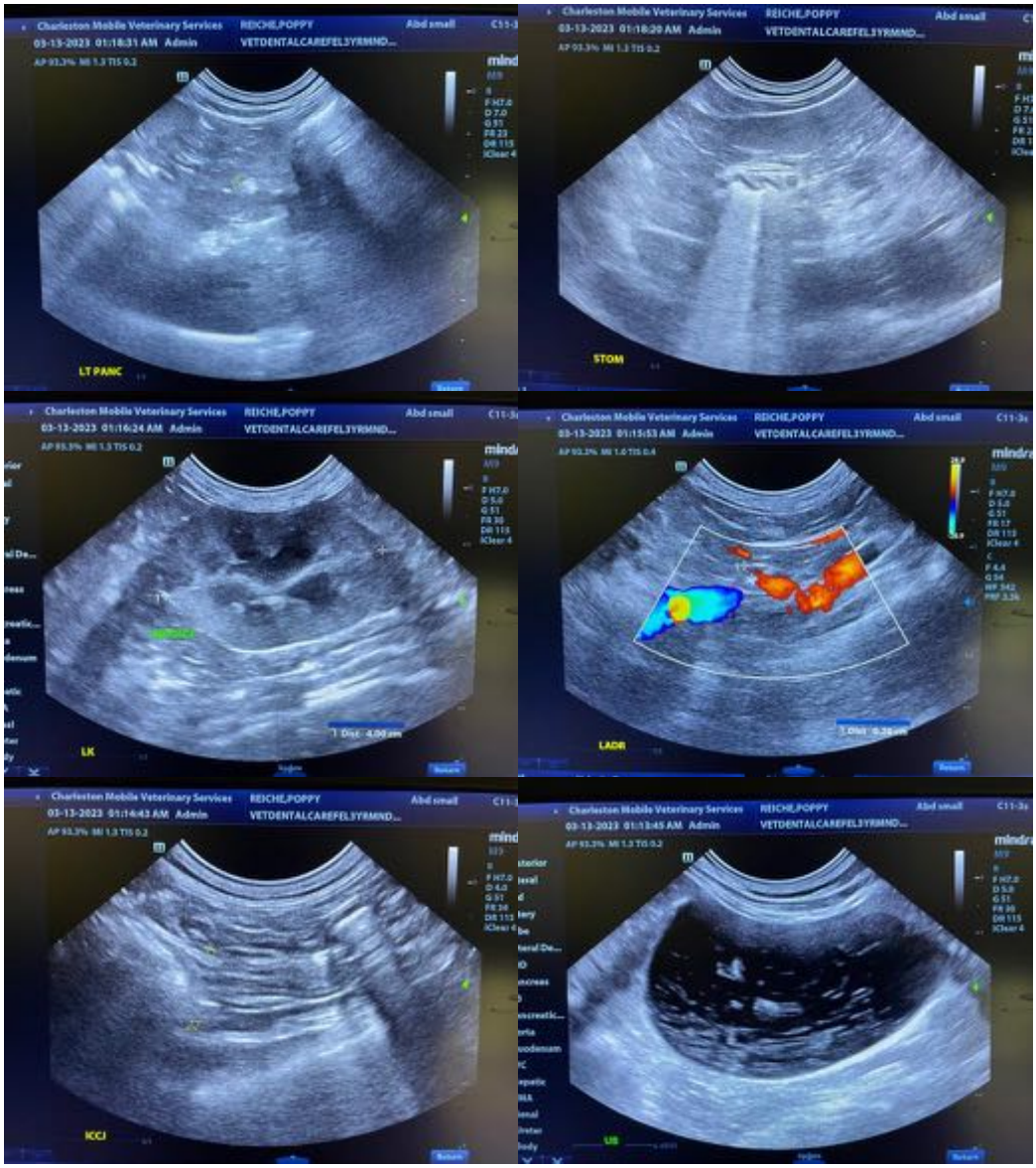
    1. CBC with reticulocyte count and clinical pathology review
    2. Feline leukemia and FIV testing is also recommended, if not already performed.
    3. Mycoplasma PCR panel

4. Three-view thoracic radiographs to assess for occult neoplasia in the chest
5. Serum protein electrophoresis
6. Depending on the results of the above diagnostics, a bone marrow aspirate may be warranted.
7. In the meantime, consider empirical treatment for *Mycoplasma*, particularly given the patient's history of fleas.

- Regarding the renal changes, consider the following:

1. Urinalysis
2. Serial monitoring (i.e., every 3-6 months) of the patient's renal values to assess for the development of azotemia





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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com