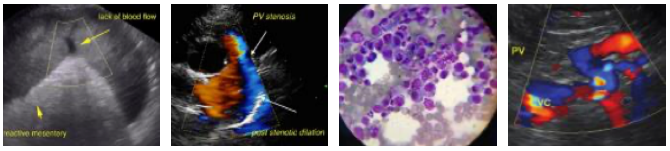
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Pippin Brady

SPECIES
Feline

BREED
Persian

SEX
Male, neutered

AGE
2 Yrs.

WEIGHT
10.16 lbs.

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

IMAGING PERFORMED BY
Dr. Hadi

HOSPITAL NAME
Bethany Family Pet Clinic

REFERRING VET
Dr. Hadi

INVOICE
14760

DATE
3/20/23

PRESENTING CLINICAL SIGNS

History: P presented yesterday for a history of vomiting of a few days and anorexia. T: 103.2, P: 180, RR: 60. X-rays were taken by a colleague and revealed a possible linear foreign body. Radiograph interpretation was declined. P was treated supportively and did not improve. CBC/Chem 17/FeLV/FIV testing was performed. Minimal findings other than a moderate elevation in CPK and a mild polycythemia. On exam today, P was QAR. T: 104.2, P: 220, R: 40. Firm structure around 3x3 cm palpated in the mid/cranial abdomen. Non-painful on palpation of this structure.
Abnormal PE/Chem/CBC/UA Results: CPK: 3432 U/L, HCT: 55%, , Neutrophils: 3245 U/L (WNL)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (3.39 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (xxx 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.35 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

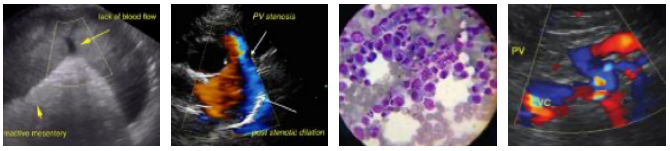
The spleen is prominent to enlarged (1.23 cm in width at the level of the hilus) with slightly irregular peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogeneous in appearance. No focal lesions are observed. Hepatic biliary tracts appear normal. Hepatic veins are subjectively mildly dilated. The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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 segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet



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masses are not identified. The ileocecocolic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. No obstructive disease is noted.

Pancreas

The left limb of the pancreas is visible/prominent with normal curvilinear peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is visible but not overtly dilated.

Free Abdomen

There is no obvious evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 0.84 cm in length. The mesentery surrounding the nodes is mildly hyperechoic. In addition, a 1.16 cm lymph node is observed in the caudal abdomen.

Other

There is questionable subjective mild dilation of the caudal vena cava.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

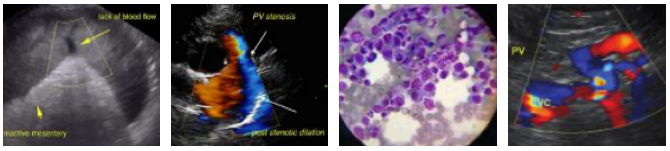
- The splenic parenchymal changes could be consistent with a benign process (i.e., antigenic stimulation, splenitis, lymphoid hyperplasia, extramedullary hematopoiesis) or emerging neoplasia (i.e., round cell tumor).

Secondary Findings:

- Mild bilateral age-related renal changes.
- 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.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The mild subjective dilation of the hepatic veins and caudal vena cava may be a normal variant for this patient or may be secondary to an upstream problem (i.e., congestive heart failure, obstruction of the thoracic caudal vena cava).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a fine needle aspirate of the spleen, if clotting status is appropriate. A 25-gauge needle should be used.
- Three-view thoracic radiographs are also recommended to assess for pneumonia or other potential causes of fever in the chest.
- Feline infectious disease testing (i.e., feline leukemia, FIV, FIP, toxoplasmosis) should also be considered.
- A urinalysis with culture and sensitivity is also recommended to assess for an occult urinary tract infection.



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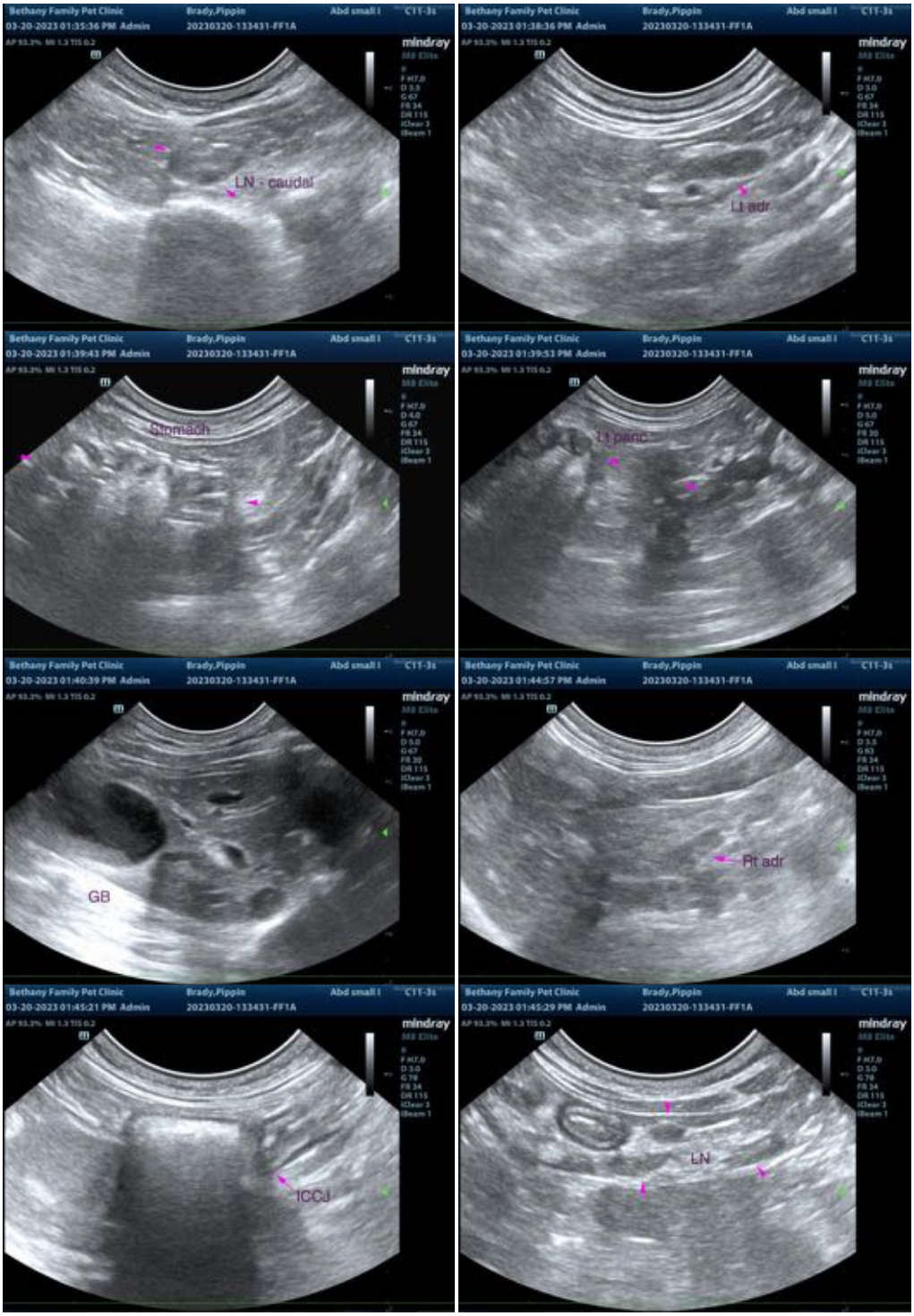
- A repeat CPK is also recommended. If persistently elevated, myositis may be present and consultation with a board-certified neurologist may be warranted for further workup.
- If all tests prove inconclusive, consider an echocardiogram to assess for endocarditis/myocarditis.



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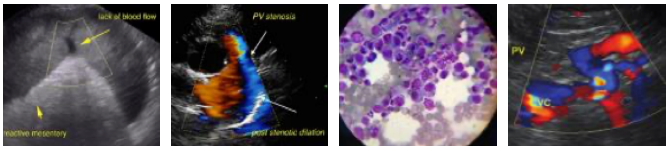

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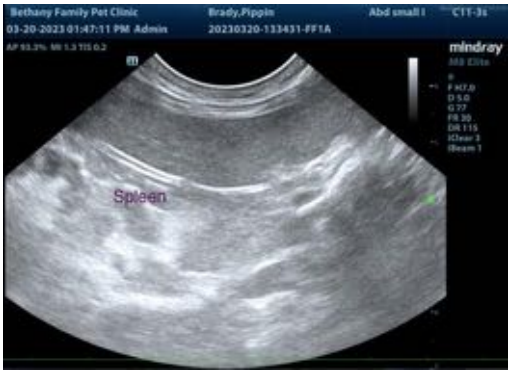

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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