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IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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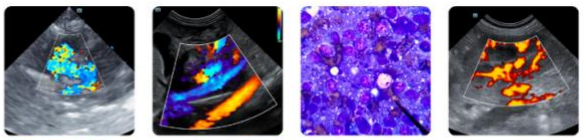

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Cashew Forster

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

3/4/2014

WEIGHT

6.94

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

BluePearl MP ER

REFERRING VET

Dr Danielle Fraser

INVOICE

22962

DATE

5-2-26

PRESENTING CLINICAL SIGNS

Severe, chronic, non-regenerative anemia, weight loss, and hyporexia.

Abnormal lab-work values: CBC: RBC 2.88 M/µL, Hematocrit 17.6%, Hemoglobin 5.6 g/dL, MCV 61.1 fL, RDW 18.4%, Reticulocytes 37.4 K/µL, WBC 4.06 K/µL, Eosinophils 0.02 K/µL, Basophils 0.00 K/µL, Platelets 85 K/µL, MPV 21.6 fL. Manual platelet count: 168K. Chem 17: ALT 155 U/L, GGT 26 U/L, Total bilirubin 0.6 mg/dL

Current Medications: Cerenia, Dexamethasone Sp, Doxycycline

Radiographic Findings
- Mild splenomegaly.
- No focal thoracic or abdominal radiographic abnormalities identified.
- No radiographic evidence of metastatic disease, pulmonary pathology, gastrointestinal obstruction, or overt abdominal mass effect is identified on the current study.

The mild splenomegaly is nonspecific and may reflect reactive/extramedullary hematopoiesis, congestion, inflammatory disease, infiltrative disease, or less likely neoplasia. Given the history of severe chronic non-regenerative anemia, weight loss, hyporexia, and mild leukopenia, the imaging findings do not provide a definitive explanation for the patient's systemic illness.
Importantly, absence of radiographic abnormalities does not exclude clinically significant infiltrative or bone marrow disease, including lymphoma, leukemia, myelodysplastic disease, aplastic marrow disorders, or other chronic systemic/inflammatory processes.
No radiographic evidence of cardiopulmonary compromise is identified prior to transfusion.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is prominent-in-size (4.59 cm in length) with a normal architecture and smooth peripheral contours. 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. Renal vasculature is normal.

The right kidney is prominent in size (4.93 cm in length) with a normal architecture and smooth peripheral contours. 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. Renal vasculature is normal.

Adrenal Glands

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

The right adrenal gland is normal size (0.45cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is enlarged (1.48 cm in width at the level of the hilus) with swollen peripheral contours. The parenchyma is subtly mottled in appearance, with a few, ill-defined hypoechoic nodules/areas. No focal lesions are observed. Splenic vasculature is normal.

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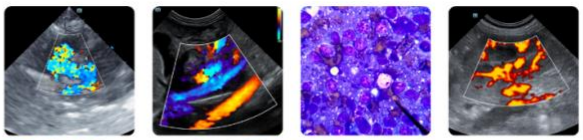

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Liver

The liver is prominent in size with normal peripheral contours. The parenchyma is isoechoic 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 portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal.

Gastrointestinal

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 is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas are normal- to promi-in-size with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- Equivocal hepatomegaly

Secondary Findings

- Mild bilateral nonspecific age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

*Ultrasound-guided fine-needle aspiration was performed at the end of this study without incident.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Depending on the cytology results as well as the CBC with path review, and infectious disease panel, further work-up (i.e., bone marrow aspirate) may be indicated. In the meantime, continued symptomatic care is recommended.

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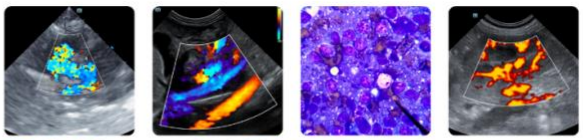

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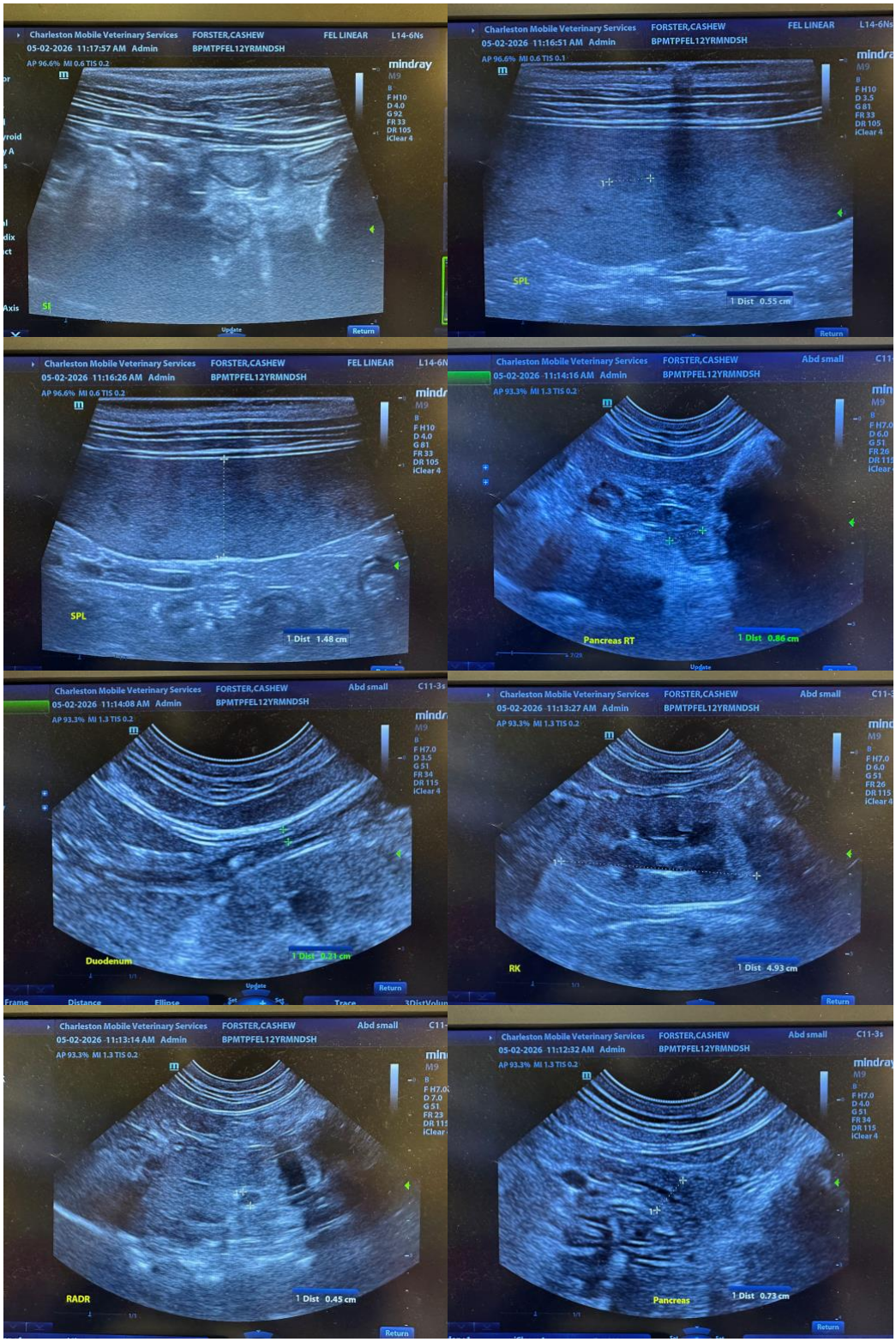

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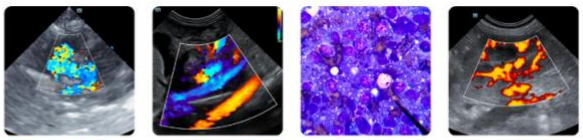

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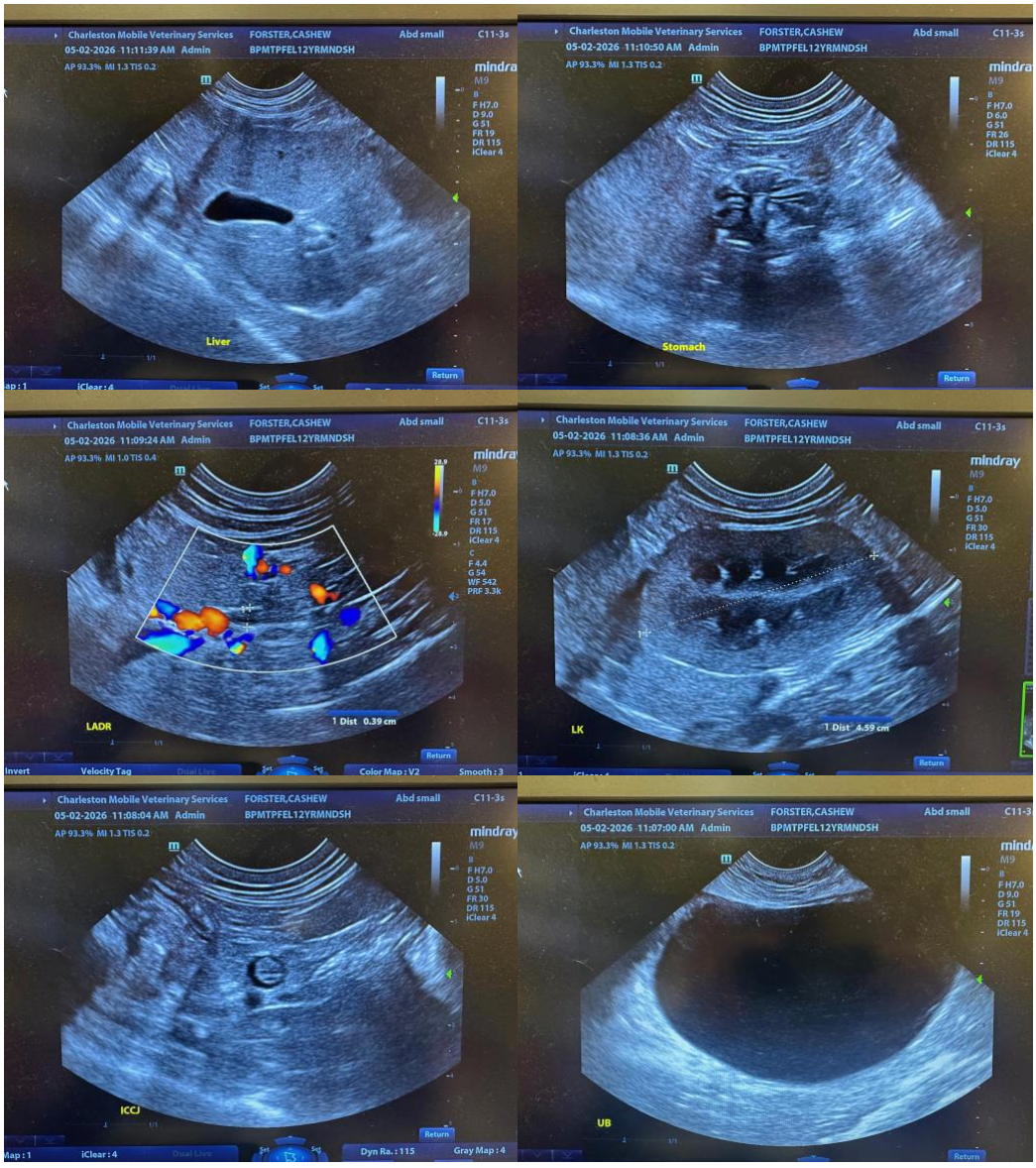

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com