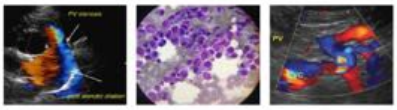


PATIENT

Max Chaboudy

SPECIES

Feline

BREED

American Shorthair

SEX

Neutered Male

AGE

16 Yrs.

WEIGHT

11.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

PMVU

HOSPITAL NAME

Banfield Sterling Cascades

REFERRING VET

Dr. Cathy Jarrett

INVOICE

13824

DATE

9/15/22

PRESENTING CLINICAL SIGNS

History: Presented today for distended abdomen. Grade IV/VI heart murmur. Severe muscle wasting. Rads with radiologist review: 1. Marked peritoneal effusion and hepatomegaly. Rt CHF less likely due to lack of pulmonary arterial or CVC distension and no pleural effusion. Hypoalbuminemia or coagulopathy less likely due to lack of changes in pleural space. 2. Moderate left atrial enlargement but no radiographic evidence of left sided CHF.
Abnormal PE/Chem/CBC/UA Results: CBC ne 13.5, RBC 7.2, MCH 18.3, MCHC 35.6, Plt 97, MPV 16.4 Chem ALB 2.2, ALT 194, BUN 41, GGT 9, U/A 3+leukocytes.

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 moderately 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 1-2 cm, are normal.

The left kidney is normal size (4.31 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.27 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

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

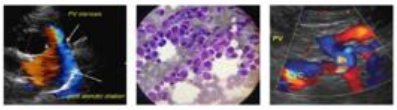
The right adrenal gland is normal in size (0.31 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent in size (1.22 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 enlarged with swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen and is diffusely heterogeneous in appearance bordering on a reticulated pattern when visualized using the linear probe. At least 2 cystic lesions are observed, the largest measuring approximately 4 cm. The larger cyst contains a small amount of echogenic debris and a few septations. Hepatic vascular and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. The gallbladder is mildly distended. The wall is normal in thickness. a small amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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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 to mildly thickened (up to 0.28 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

A 1.22 x 1.86 cm slightly heterogeneous nodule is observed at the base of the pancreas. The remaining parenchyma is largely isoechoic relative to surrounding omental fat. The pancreatic duct is not overtly dilated.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

Lymph Nodes

See *Other.*

Other

A large amount of echogenic free fluid is present. The mesentery throughout the abdomen is mildly hyperechoic. Several echogenic nodules are observed within the mesentery, the largest measuring 1.26 cm in its longest dimension.

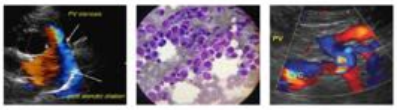
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The ascites may be secondary to increased vascular permeability (i.e., secondary to neoplasia), increased hydrostatic pressure (i.e., due to congestive heart failure, portal hypertension), or low oncotic pressure.
- The nodules within the mesentery may represent prominent lymph nodes, neoplastic lesions (i.e., carcinomatosis), granulomas, other.
- The hepatic cysts are likely benign (i.e., biliary cyst adenomas) with a lower possibility of neoplasia (i.e., cystadenocarcinoma). The diffuse hepatic parenchymal changes are non-specific and could be secondary to passive congestion, inflammatory hepatopathy (i.e., suppurative cholangiohepatitis, lymphoplasmacytic hepatitis), hepatic lipidosis, infiltrative neoplasia (i.e., round cell tumor), other.

Secondary Findings:

- Bilateral age-related degenerative renal changes.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).



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- The pancreatic nodule may represent benign nodular hyperplasia, neoplasia (i.e., metastatic lesion, granuloma, other).
- The small intestinal wall changes are most consistent with inflammatory bowel disease with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If the abdominal fluid cytology is inconclusive, consider the following:

1. Echocardiogram to assess for underlying cardiac disease as a cause for the ascites.
2. Fine needle aspiration of the hepatic parenchyma (if clotting status is appropriate).
3. +/- abdominal exploratory with hepatic, mesenteric +/- GI biopsies.
4. Also consider a malabsorption panel including serum cobalamin, folate, TLI and PLI.

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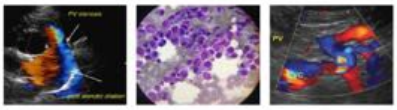
Potomac Mobile Veterinary Ultrasound



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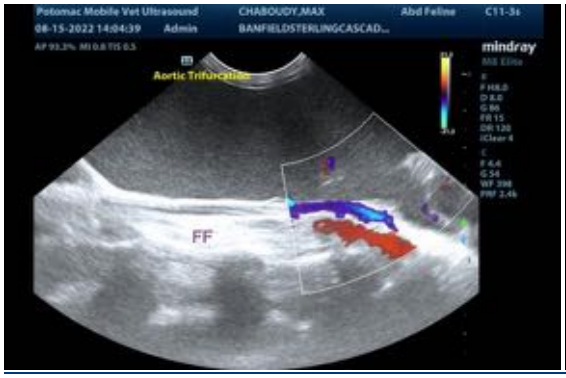

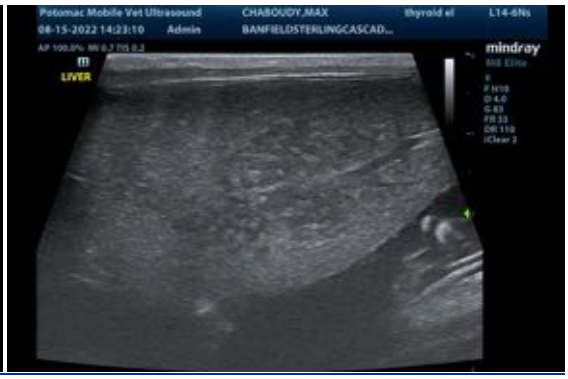

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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