



PATIENT

Riffle Lin Liu

PRESENTING CLINICAL SIGNS

TFAST: moderate pleural effusion, La: Ao WNL Got permission from O for thoracocentesis - no additional sedation needed - 65ml from left side - mild amount of pleural effusion remained In house cytology: fluid was light yellow, clumps of uniform cells present.

SPECIES

Feline

Abnormal PE/Chem/CBC/UA Results: rads - pleural effusion CBC: WBC 100.82 (H), neut 94.81 (H), Plt 74 (L) Chem: BUN 23.6 mg/dl (normal on their reference range), creat 1.2, TP 6.6, all other values WNL. BW from rDVM: WBC 125.61 (H), Neut 122.44 (H), Hct 35.4, Plt 191.

BREED

DLH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

SEX

Neutered Male

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

AGE

12 Years

The right kidney is normal in size (4.5 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

WEIGHT

3.6 Pounds

The left kidney is normal in size (4.1 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

INTERPRETED BY

Beth Johnson, DVM
DACVIM

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

IMAGING PERFORMED BY

Dr. Kristin Peterson

Liver

Liver is subjectively enlarged with a swollen, irregular/scalloped contour. Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

HOSPITAL NAME

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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

REFERRING VET

Dr. Kristin Peterson

Gastrointestinal

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The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

DATE

10/13/22

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.



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Riffle Lin Liu The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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Pancreas

Feline

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no evidence of free peritoneal effusion noted in these images. However, pleural effusion is noted through the diaphragm.

SEX

Neutered Male

Cranial abdominal (hepatic, splenic, mesenteric, pancreaticoduodenal) lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

AGE

12 Years

PRIMARY FINDINGS

- **Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

WEIGHT

3.6 Pounds

- **Scalloped spleen** – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.

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DACVIM

- Cranial abdominal lymphadenopathy
- Pleural effusion

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SECONDARY FINDINGS

- **Gallbladder debris** - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

HOSPITAL NAME

Wilvet Salem

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Unfortunately, given the described pleural effusion combined with the pathology noted in the abdomen and marked leukocytosis, top differential for this patient is infiltrative neoplasia. A severe inflammatory infiltrative disease can't be ruled out, but is considered less likely. Round cell neoplasia such as lymphoma is the top differential.

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Recommendations include submission of the obtained pleural effusion for cytology. If a cytologic diagnosis is not obtained from the fluid, recommendations include a fine needle aspirate of the liver +/- the spleen and/or enlarged lymph nodes if patient's coagulation status is appropriate. Additionally, given this patient's marked leukocytosis, a pathology review of the cells could also be considered.

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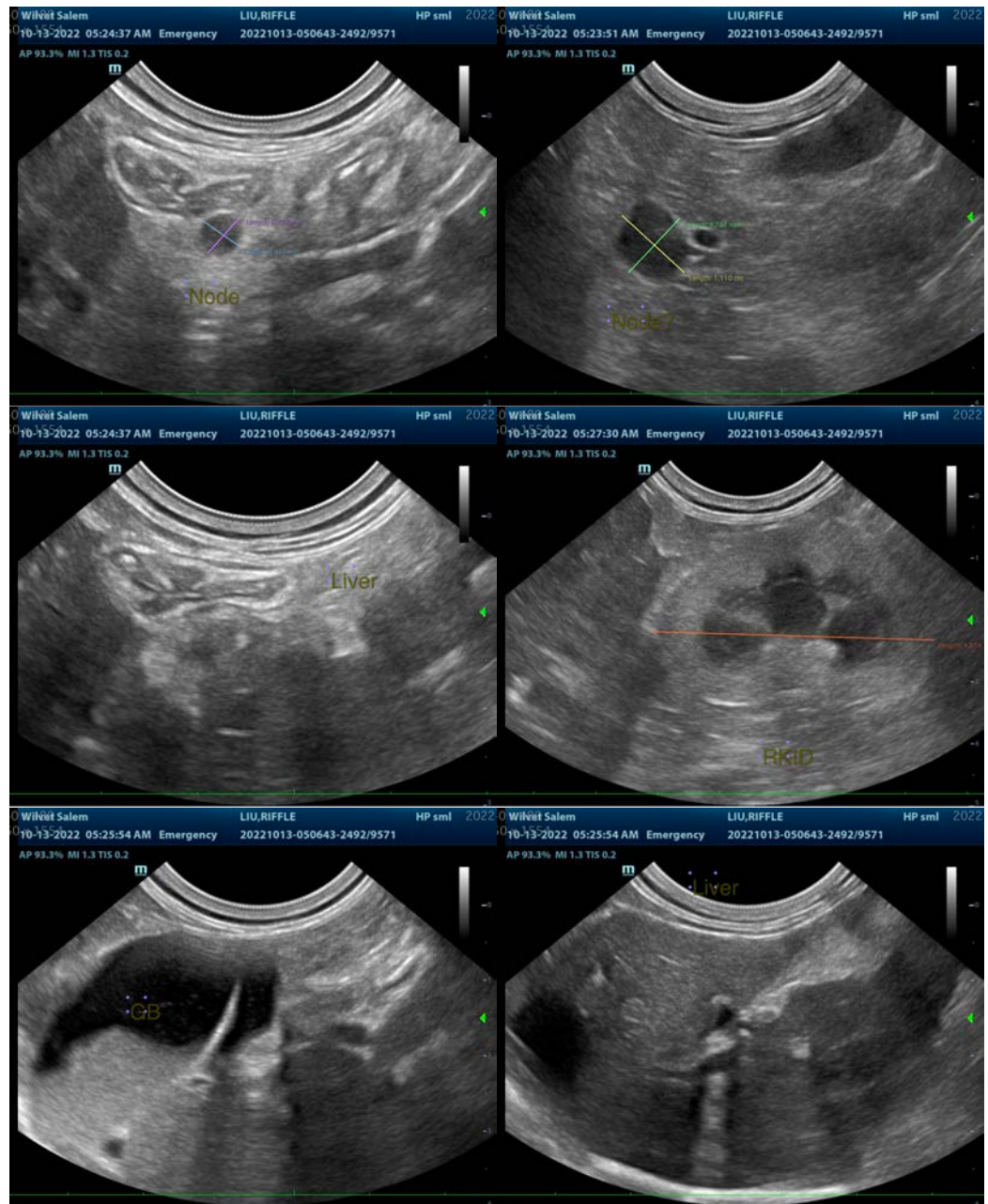
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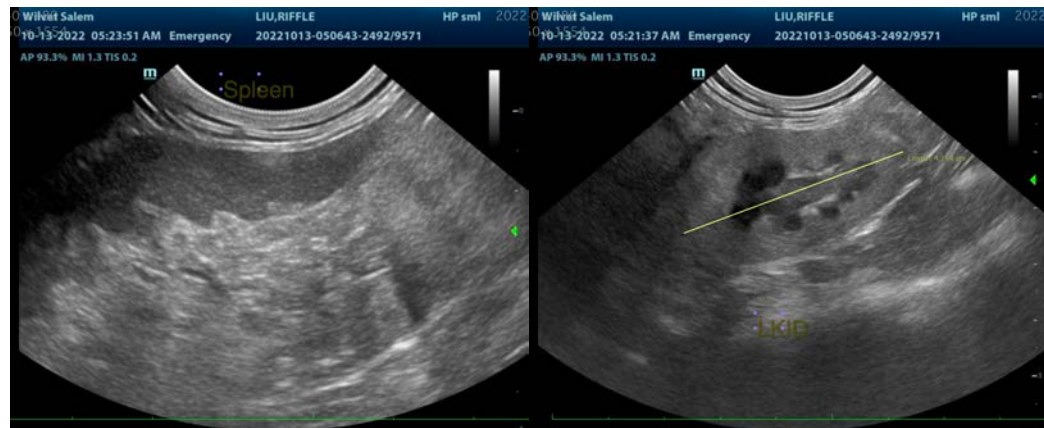
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
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