



PATIENT

Katara Lecompte

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9 Years

WEIGHT

10.5 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Ashley McCaughan

HOSPITAL NAME

Marina Village Vet

REFERRING VET

Dr. Ashley McCaughan

INVOICE

46122

DATE

3/22/23

PRESENTING CLINICAL SIGNS

Presents for persistent low grade fever, lethargy, inappetence Severe Monocytosis and Neutrophilia on labs run 3/21 Normal renal values Mild elevation to ALT, AST UA - proteinuria, no bacteria seen, no urine culture run

Abnormal PE/Chem/CBC/UA Results: QAR; T 103.2 mm pale pink, CRT > 2 sec, tacky 5-8% dehydration GIT/GU - soft and pliable, no obvious pain over kidneys on palpation - smooth and round No mass effect on abdominal palpation Eyes -LSOU Skin tent - mildly delayed halitosis CV - no HM, sl tachycardia A - suspect pyelonephritis ; FUO During ultrasound - painful over L abdominal quadrant, esp over L kid Plan Sedated abdominal u/s - initial impressions Painful over L kidney on scan, normal shape and size Small amt fluid in renal pelvis of Right kidney - 2 mm Concretions and sediment in bladder Spleen - SI scalloped borders Liver - mild mottling no abdominal fluid x 4 quadrants areas of hyperechoic mesenteric fat

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a moderate to large amount of echogenic non-shadowing debris, which could be partially consistent with incidental suspended lipid in a cat, likely combined with exfoliated cells, mucous and/or small blood clots, etc. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right 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.

The left kidney is normal in size (3.89 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.

Spleen

Spleen is subjectively large in size (1.2 cm thick) 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.

Liver

Liver is subjectively enlarged (swollen 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.

Gallbladder is moderately distended with anechoic bile as well as mild 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.



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Gastrointestinal

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.

The visible small intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen is empty with no evidence of obstruction or foreign material.

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

Pancreas

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.

Free Abdomen

There is no apparent lymphadenopathy noted in these images.

A small amount of anechoic free fluid is present, primarily surrounding the mid right abdomen/right kidney area.

PRIMARY FINDINGS

- **Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- **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.
- **Inflammatory bowel disease (IBD) pattern** – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Small amount of anechoic free fluid, primarily around the right kidney.

SECONDARY FINDINGS

- Large amount of urinary bladder debris
- **Mild 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.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's fever, neutrophilia, monocytosis, etc., inflammation affecting the spleen and liver and potentially resulting in the free fluid is suspected, and could be secondary to an infectious disease, infiltrative neoplasia, autoimmune disease, etc.

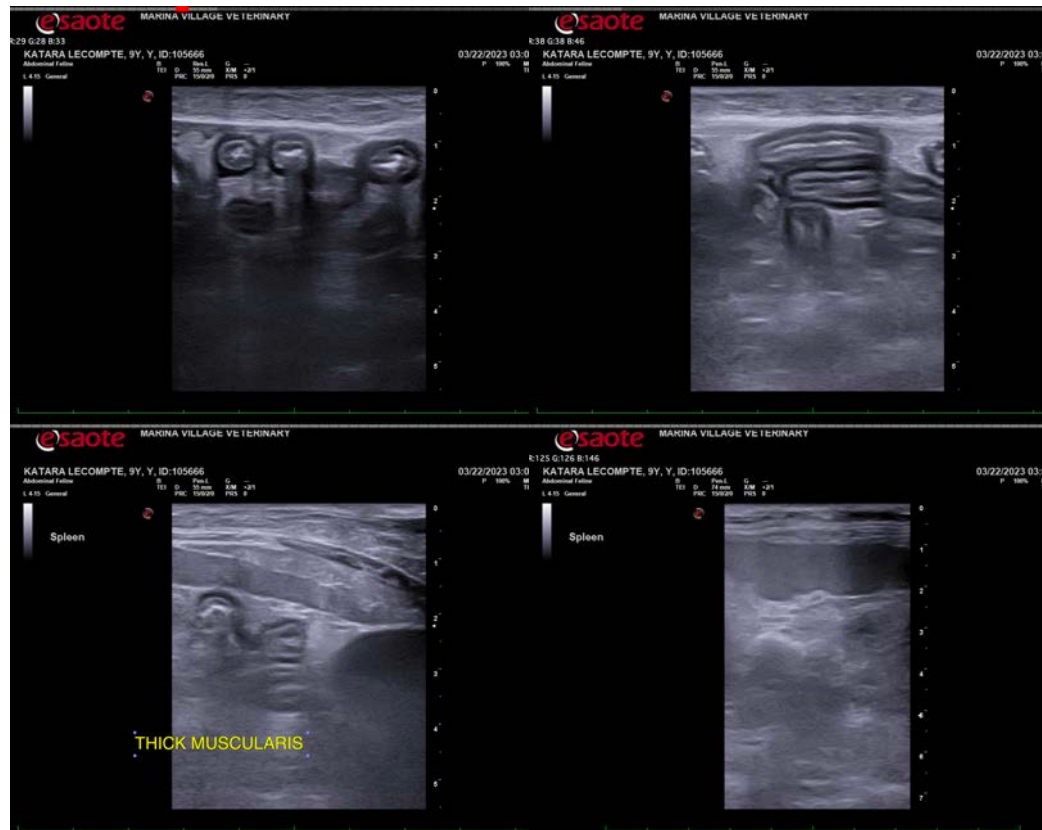
Recommendations include fine needle aspirates of the liver and spleen if patient's coagulation status is appropriate, as well as (if not recently evaluated) a urinalysis and, if indicated based on urinalysis results, urine culture. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Additionally, comprehensive infectious disease testing including viral disease, tick borne diseases, toxoplasma, etc. is recommended.

Additionally, pending results of the above, given bowel changes, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, ideally followed by biopsies of the GI tract if a diagnosis is not obtained from cytology, being sure to include ileum, if possible, which may ultimately be necessary to definitively diagnose and therefore manage the infiltrative disease.

In the meantime, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.

Additionally, empirical deworming with a 5-day course of Panacur is recommended.





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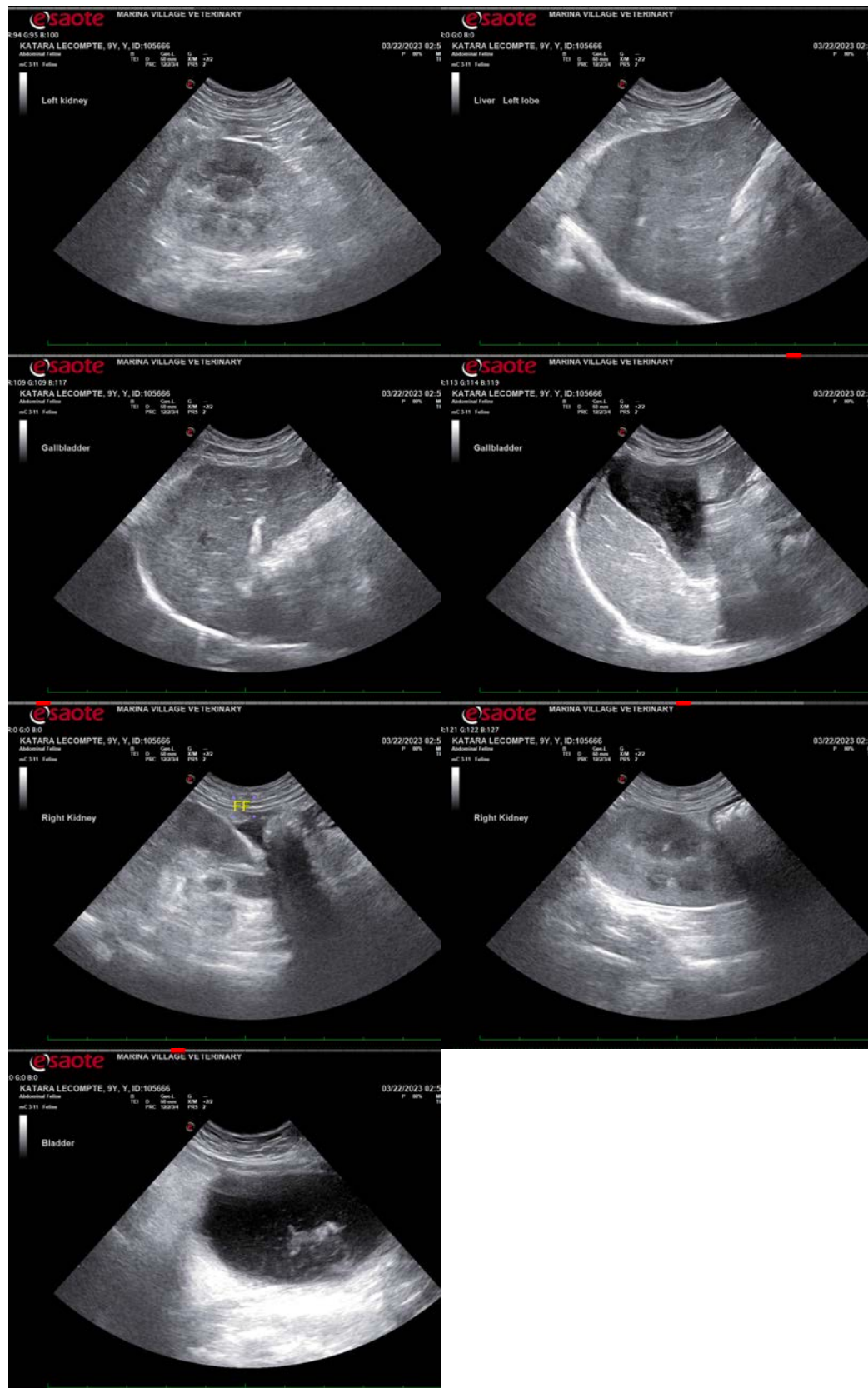
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com