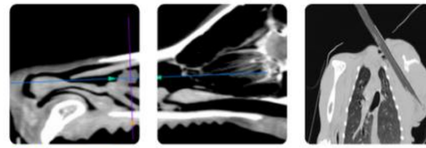


PATIENT

Carrot Crockett

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

5 Years

WEIGHT

4.12 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Colborne VC

REFERRING VET

Dr. Featherstone

INVOICE

14946

DATE

04/08/26

PRESENTING CLINICAL SIGNS

Presenting with significant anorexia, marked lethargy, and severe anemia, weight loss, decreased appetite, chronic ocular discharge, a neck lesion with oral bleeding, dental discomfort, an abnormality in the cranial abdomen, and an unkempt hair coat with decreased grooming. Painful upon Abdominal palpation

Current Medications: Gabapentin 100mg/mL - 0.4mL BID

RBC : 5.27 (5.9-9.4) HGB: 9.1 (9.8-15.4) HCT: 27.51(30-45%) MCV: 520 (39-55) MCH: 17.3 Radiographic Findings - Recent diagnostic imaging revealed a possible soft tissue opacity, likely either a mass effect or inflammatory within the cranial mediastinum at the level of the sternum (measuring approximately 1.3–1.9 cm), as well as mild abdominal distension and evidence of abdominal effusion. The findings are suggestive of possible peritonitis, likely secondary to fluid leakage, with differential diagnoses including neoplastic, infectious, or other etiologies. Primary Question to Be Answered in This Exam Origin of fluid and if it is representative of cancer

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately 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.

Left kidney is normal in size (3.36 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.

Right kidney is normal in size (3.54 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

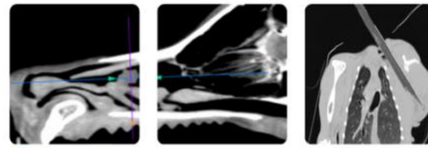
Left adrenal gland is normal in size (0.24 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.28 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal. Additionally, to the definitive splenic parenchyma, there is an approximately 2.7 cm by 3.3 cm ill-defined irregular homogenous hypoechoic density medial to the spleen surrounded by trace-free fluid and enhanced fat that appears in some images to originate from the spleen. Having said that, a pocket of cellular-free fluid medial to the spleen and/or a prominent inflamed pancreas budding up to the spleen can't be ruled out.

Liver



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Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness 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 intestines are normal in wall thickness and layering. 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.

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

Pancreas

There's no definitive pancreatic pathology. However, the tissue medial to the spleen described above in some views appears possibly consistent with a prominent inflamed left pancreas.

Free Abdomen

A small amount of anechoic free fluid is present in these images primarily medial to the spleen as described above.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

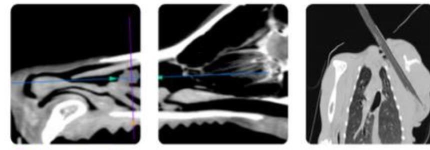
- Splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- As described above, the tissue medial to the spleen could represent a splenic mass with differentials including both infiltrative neoplasia as well as benign infiltrative conditions such as amyloidosis versus other. Having said that, however, tissue medial to the spleen and touching the spleen but not originating from the spleen as could be seen with a prominent inflamed left pancreas is also a possibility.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Comprehensive infectious disease evaluation is recommended.

Fine needle aspirates of the spleen as well as the hypoechoic ill-defined tissue medial to the spleen are



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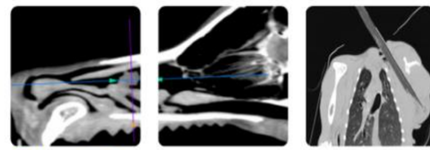
recommended if patient's coagulation status is appropriate. Additionally, given the thoracic radiograph interpretation, additional potentially advanced imaging of the mediastinum or sampling of that area could also be considered if patient's coagulation status is appropriate.

Other than supportive/symptomatic medical management of clinical signs, further diagnostics and treatment recommendations are largely dependent on results of the above.



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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

info@sonopath.com