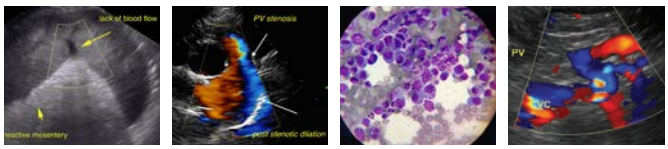
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT
Toby Blakley

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
2 Years

WEIGHT
5.5 Pounds

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Dr. Harold Mike Beard

HOSPITAL NAME
Animal Care VC

REFERRING VET
Dr. Carl Fulton

INVOICE
39480

DATE
7/14/22

PRESENTING CLINICAL SIGNS

In February presented for respiratory dz and apparent blindness. RDVM diagnosed fungal pneumonia. Treated with fluconazole. 7/6/22 represented with weight loss, vomiting intermittently, and blindness. RDVM now has him on Clindamycin.

Abnormal PE/Chem/CBC/UA Results: Blind cat with sarcopenia, palpably thickened bowels. CBC mild anemia, neutrophilic leukocytosis, eosinophilia, thrombocytosis. GHP globulins are elevated and cholesterol is low.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is moderately distended. It has a normal uniform wall thickness (<0.2 cm). Contents include primarily anechoic fluid combined with suspended echogenic non-shadowing debris within the fluid. 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 (4.3 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 (3.3 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 right adrenal gland is normal in size (0.44 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is unable to be well visualized.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

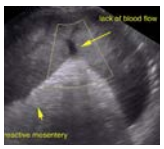
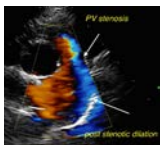
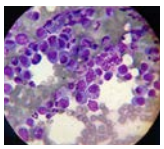
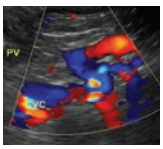
Liver

Liver is subjectively enlarged. Margins are smooth but round. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The 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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is markedly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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

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 a small to moderate amount of anechoic free fluid noted.

Diffusely hyperechoic/enhanced fat and mesentery

There is suspicion for enlarged isoechoic lymph nodes versus possibly nodules within the mesentery. However, priority is given to lymph nodes.

Ringdowns are noted at the level of the diaphragm, suggestive of concurrent pulmonary pathology.

PRIMARY FINDINGS

- Hyperechoic hepatomegaly – consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- Free fluid and enhanced mesentery throughout the abdomen – suggestive of inflammation/peritonitis, possibly secondary to previously described fungal disease. Enlarged, isoechoic lymph nodes are either reactive, or infiltrative neoplasia can't be ruled out, but is considered less likely, given the previous diagnosis of fungal disease.
- Ringdowns noted, suggestive of concurrent pulmonary pathology.

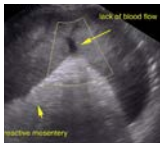
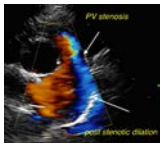
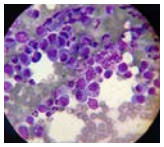
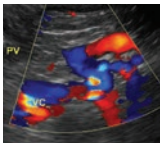
SECONDARY FINDINGS

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's history of a fungal disease diagnosis (unsure which fungal disease), current hyperglobulinemia and hypereosinophilia, a recurrence or flare up of the fungal disease is suspected. Other infectious disease such as FIP or even potentially lymphoma causing the high globulin count are also differentials. Recommendations include:

- Pursue testing for the previously mentioned fungal disease as well as FIP. If these are not diagnosed, then recommend a fine needle aspirate of the enlarged mesenteric lymph nodes versus nodular mesentery, if patient's coagulation status is appropriate.
- A fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate and a diagnosis is not obtained from lymph node aspirate.

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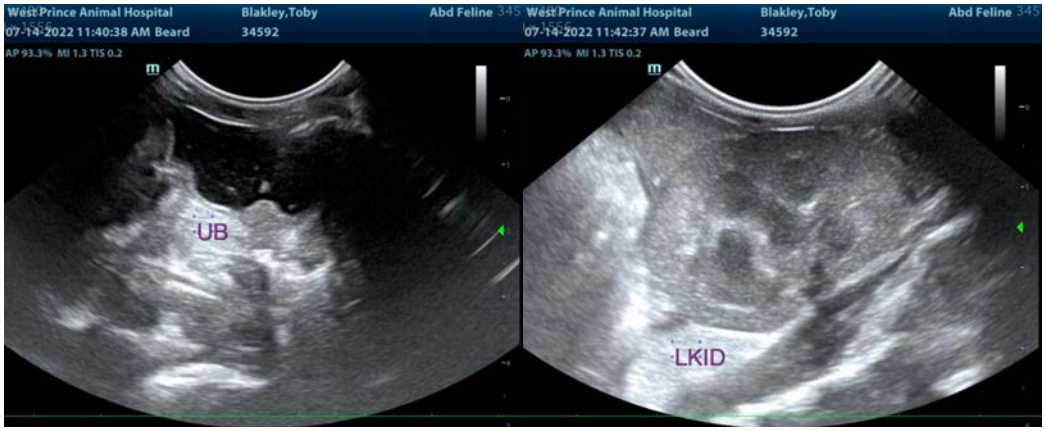
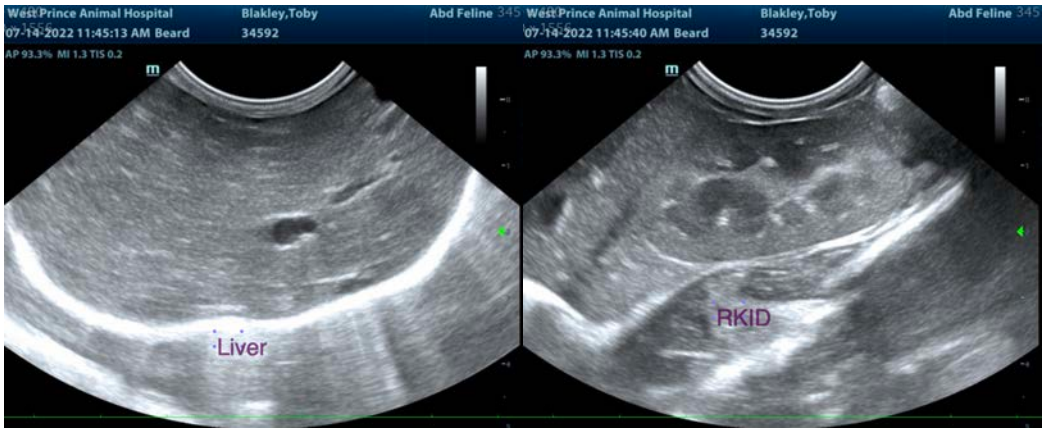
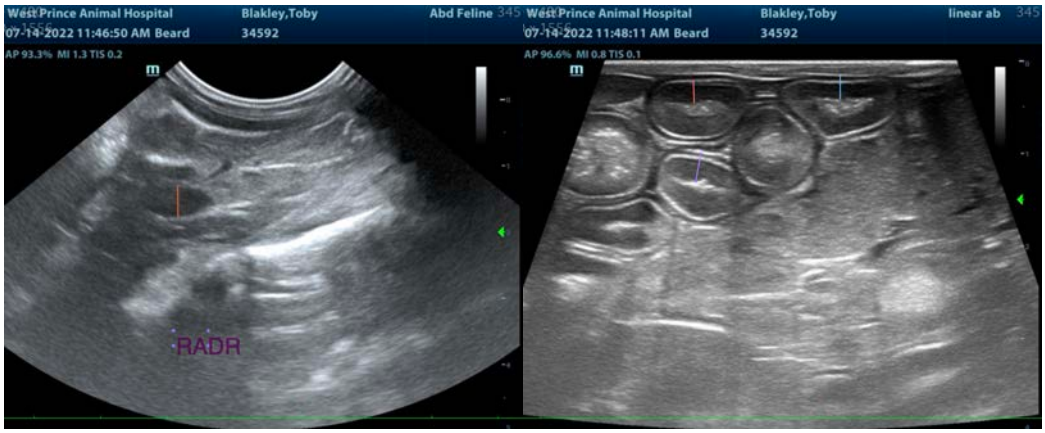
- Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.







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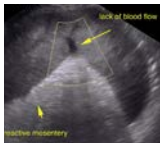
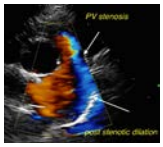
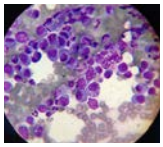
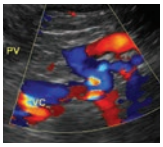

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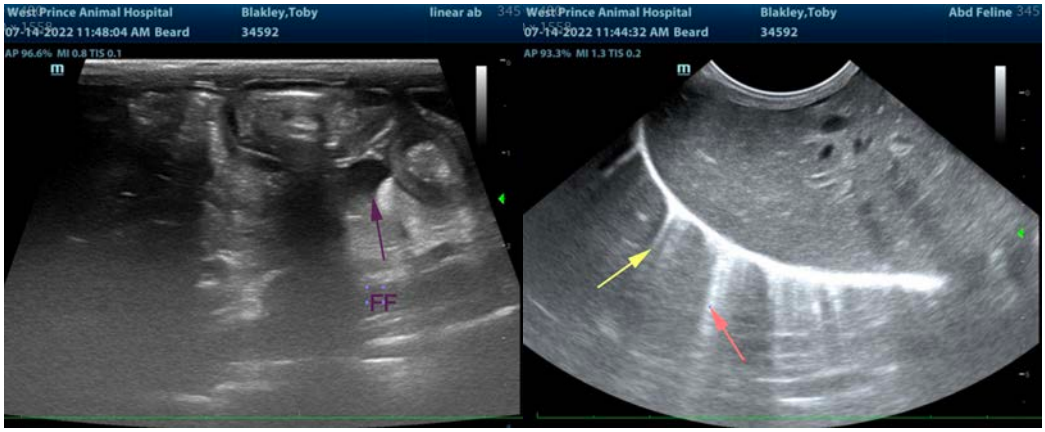

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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