



PATIENT

Milo Shadle

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

3.7 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Law

INVOICE

23242

DATE

7/8/23

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for not eating, vomiting, and diarrhea for 2 days. P began vomiting and having diarrhea ~2 days ago. O took to RDVM where bloodwork was ran and thought there was infection. P was prescribed metro, Veraflox, and cerenia. P not eating this evening, O attempted to give cerenia, P vomited during attempt. O found plastic tape within the vomit. Previous Health Concerns: missing rear right foot Current Medications: metro, Veraflox, cerenia

Abnormal PE/Chem/CBC/UA Results: Abdominal: irregular firm "mass" in mid abdomen; gas in colon Cbc: wbc 22.9 (primary neuts) Chem: bun 13.2, ca 8.6 (lo) alb 1.9 globuin 5.0 tbili 0.6 Epc: bun 12 Rads: thickened stomach lining; generalized thickened stomach lining. Decreased detail in the abdomen; rounded kidneys.

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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. 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.

Left kidney is normal in size (4.06 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 (4.26 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 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 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



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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with fluid, as well as echogenic nonshadowing luminal contents and gas, consistent with normal ingesta/chyme. 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. 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. *See "Free Abdomen" section.

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The colon wall is normal, but the colon appears to be filled with liquid stool.

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Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

AGE

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In the mid abdomen, there is an approximately 5.0 cm in diameter markedly heterogenous, partially cavitated mass. The origin of the mass is difficult to definitively identify in these images. Involvement of bowel cannot be excluded and is actually suspected. Additionally, there is a small amount of free abdominal fluid noted. No additional lymphadenopathy is noted in these images, however, the mass could be a lymph node.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- A mid abdominal mass near the root of the mesentery could be lymph node in origin, however, it is closely associated with several bowel loops and is difficult to determine if its possibly bowel in origin with involvement of the ileoceccocolic junction unable to be definitively ruled out.
- Free abdominal fluid is also present.

Secondary Findings

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If possible, a fine needle aspirate of the abdominal mass is recommended if patients coagulation status is appropriate. Given the patients young age and reported laboratory changes, hyperglobulinemia, etc., infiltrative neoplasia, such as lymphoma vs potentially aggressive infectious disease, such as FIP vs other, are top differentials. Therefore, if cytology does not yield a definitive diagnosis, additional testing for FIP could be considered.

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If not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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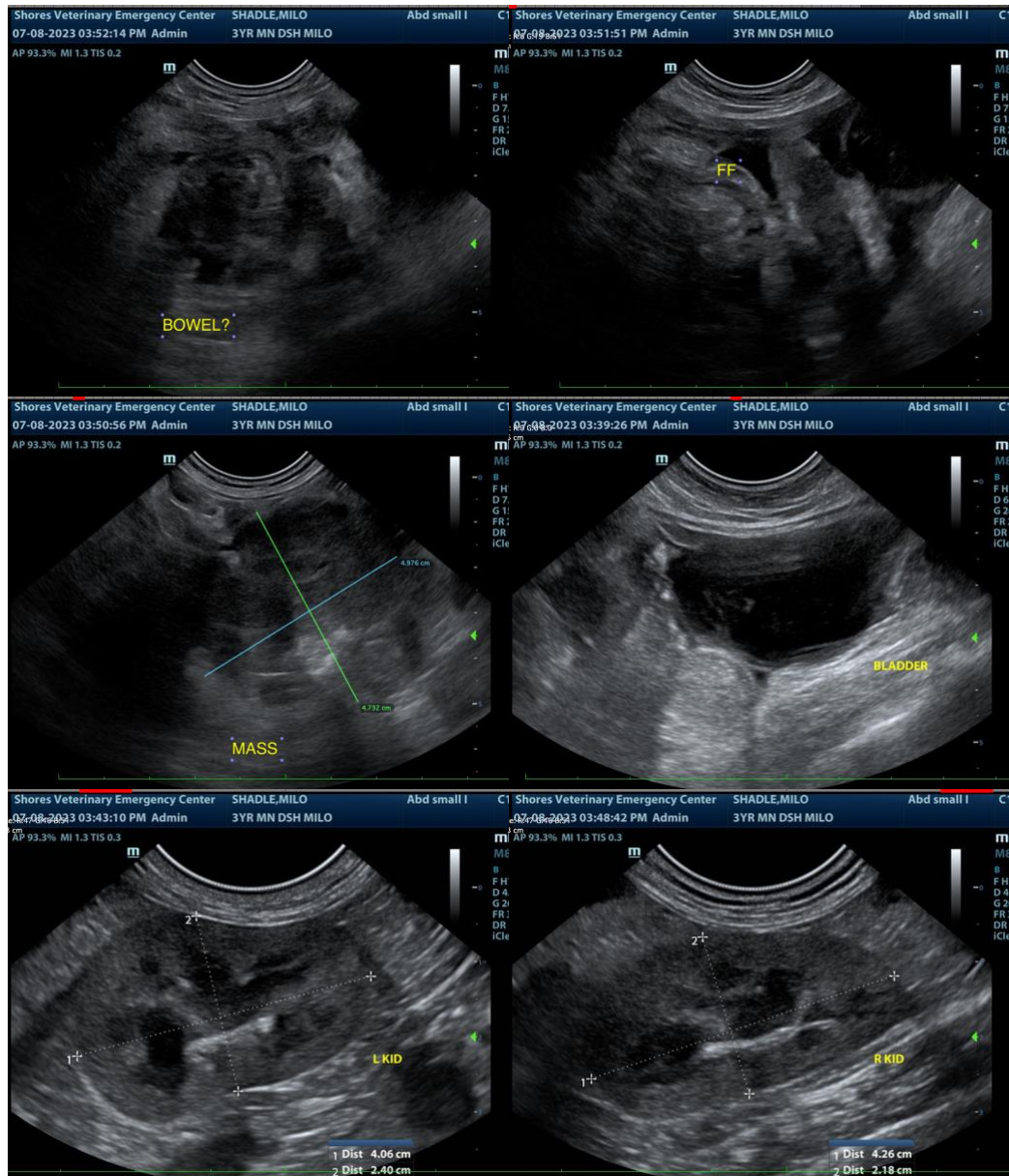
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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