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Clinical Sonography & Telecytology
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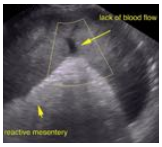
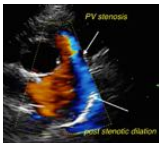
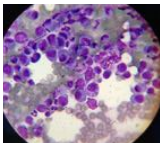
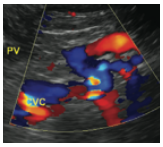





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Oliver Ekman

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

15 years

WEIGHT

12.4 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Barron

HOSPITAL NAME

Northshore VH

REFERRING VET

Dr. Barron

INVOICE

46637

DATE

8/16/23

PRESENTING CLINICAL SIGNS

History: not eating well or drinking much. lethargic, coughing for the past 2 weeks. Here are the conclusions from the rad report. 1) Suspect small volume abdominal effusion or inflamed abdominal fat. A definitive cause is not identified. 2) Impression of bronchitis. 3) Incidental spondylosis deformans and left meniscal mineralization.
CBC/chem 18/lytes NSF, Mild hypocalcemia, mild hypokalemia usg is 1.055 NSF on UA.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The visible urinary bladder, was of normal thickness. The trigone and neck of the bladder were not visualized. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Mobile debris present in the urinary bladder.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. The left kidney measured 3.77 cm and the right kidney measured 4.17 cm.

Adrenal Glands

The adrenal glands were not distinctly visualized.

Spleen

The spleen was normal in size with a smooth homogeneous hypoechoic parenchyma with normal splenic vasculature with no signs of congestion or thrombosis. No specific nodules or masses were visualized.

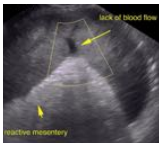
Liver

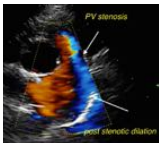
The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally

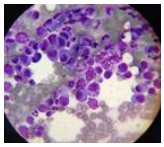
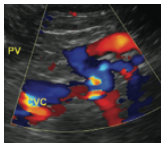
Gastrointestinal

The stomach contains ingesta and gas shadowing obstructing visualization of contents.. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

Visualization of the small intestines was limited by gas shadowing. They appeared to have a relatively uniform diameter with minimal fluid distension. Wall thickness is subjectively normal with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed. Colon was not distinctly visualized.





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Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

Falciform fat appears hyperechoic, as does the visible mesentery consistent with peritonitis. There is a small volume of anechoic effusion visible between liver lobes and in the cystocolic view.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Anechoic effusion
2. Hyperechoic abdominal fat and mesentery – peritonitis
3. Hypoechoic spleen
4. Degenerative kidney changes
5. Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal effusion and hyperechoic fat and mesentery are consistent with peritonitis though a definitive cause is not identified on this ultrasound. Aspiration of the fluid and submission for fluid analysis, cytology and culture is warranted. Submission for evaluation of FIP using the mRNA marker should be considered given the biphasic nature of this virus (presents in both young and old animals). Supportive care includes fluid and GI support as clinically indicated. An echocardiogram may be considered to rule out congestive heart failure as a cause if clinically indicated, despite lack of cardiomegaly on thoracic radiographs.

I suspect that the spleen appears hypoechoic at least in part due to the surrounding hyperechoic mesentery. Still, given the finding of effusion, splenic aspirate would be of use to rule out infiltrative disease such as lymphoma, mast cell disease, etc.

While the pancreas did not appear overtly enlarged or abnormal on ultrasound, pancreatitis cannot be definitively ruled out on ultrasound exam. Treatment is supportive and involves fluid and GI support. A fPLI could be considered to further define, though this value can increase due to abdominal effusion/inflammation for any reason, so an increased value does not definitively identify pancreatitis as the primary cause of peritonitis at the exclusion of other causes.

Continue to correlate significance of degenerative renal changes and urinary bladder debris with semi-annual bloodwork and urinalysis. They are not like clinically significant at this time based on reported current lab work values.

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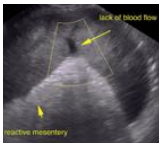
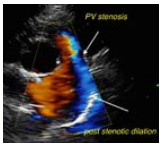
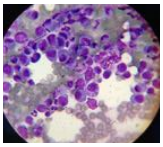
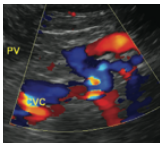

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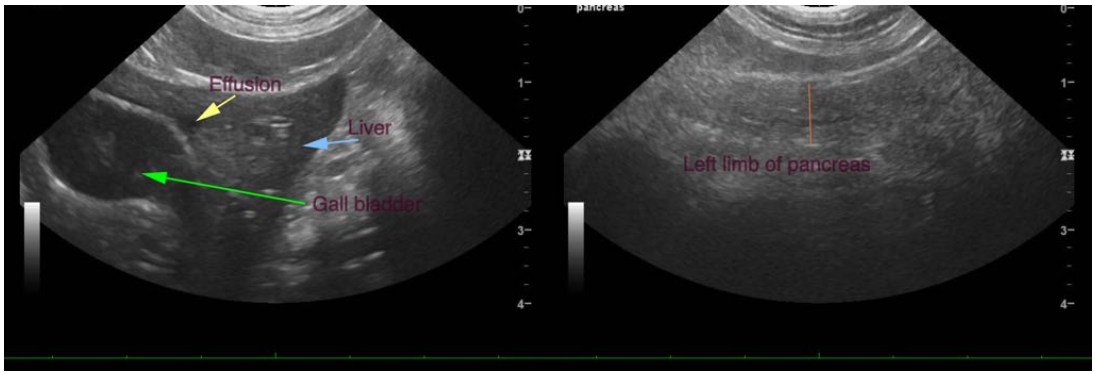

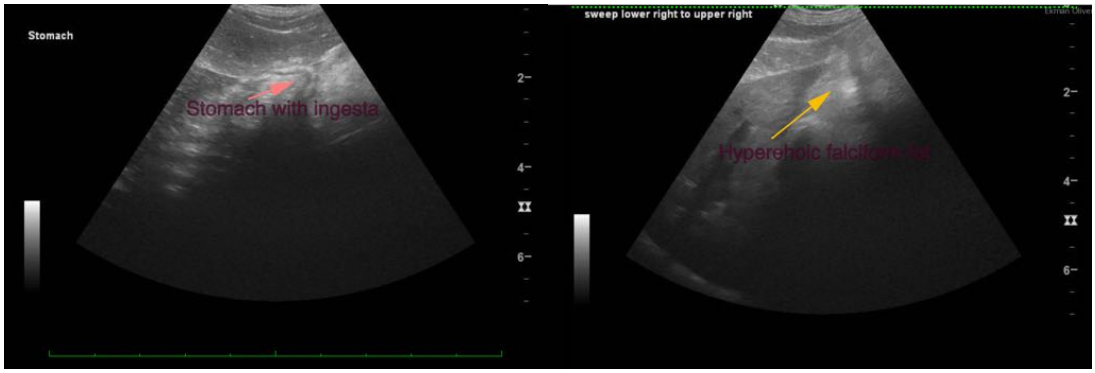

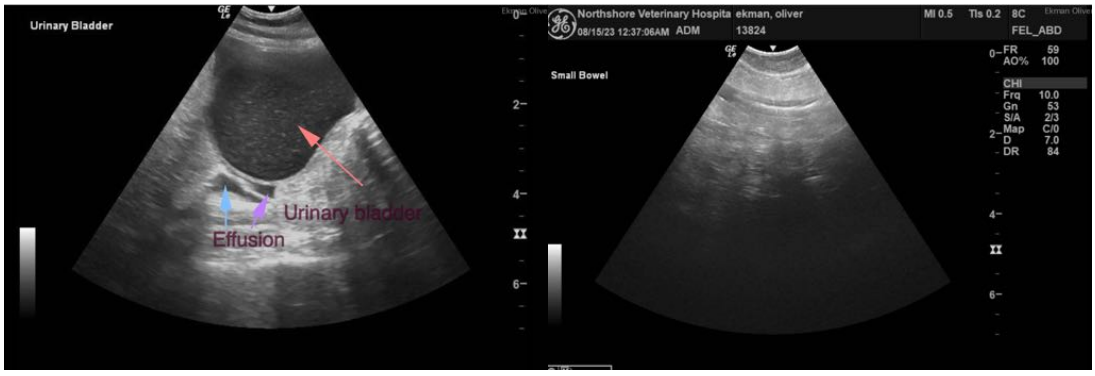

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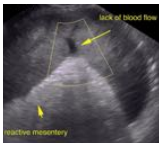
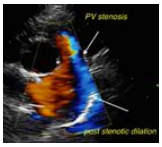
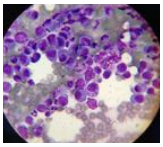
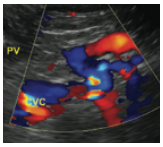

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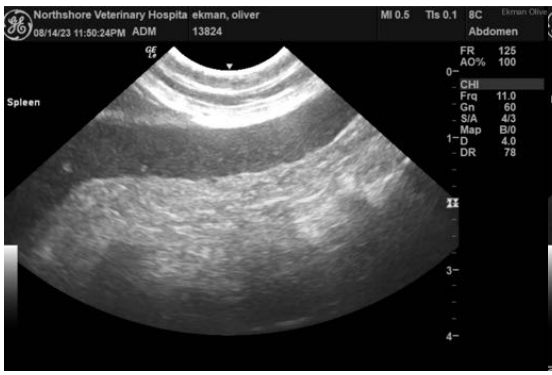

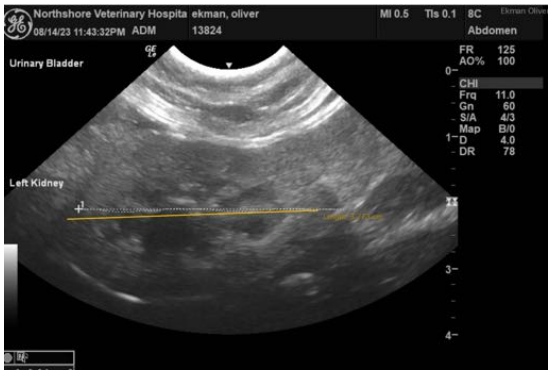

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com