



PATIENT

Cathy Okoye

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2 Years

WEIGHT

9 Pounds

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Ray Caughman

HOSPITAL NAME

Dogwood AH

REFERRING VET

Dr. Ray Caughman

INVOICE

33798

DATE

12/29/21

PRESENTING CLINICAL SIGNS

Rapid breathing and inappetence for 1 week duration. Cat is indoor/ outdoor
Abnormal PE/Chem/CBC/UA Results: Unable to auscult heart well. X-rays revealed cranial displacement of trachea and left sided increased opacity.
Bloodwork unremarkable.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** presented suspended and dependent debris without acoustic shadowing. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

The **kidneys** presented largely normal size and contour. A cortical infarct was noted at the cranial pole of the right kidney.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.5 cm. The right adrenal gland measured 0.6 cm.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Pleural effusion noted through the diaphragm.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

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



PATIENT

Thorax

Cathy Okoye

Volume contracted heart noted and surrounded cranially by a 5+ cm nodular tissue mass with areas of lung consolidation and echogenic pleural effusion. The visible diaphragm appeared to be intact, and the density in question is in the cranial mediastinum as opposed to the caudal thorax, which is where I would expect a hernia.

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ULTRASONOGRAPHIC FINDINGS

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- Right renal infarct
- Visible diaphragm intact
- Cranial mediastinal mass with pleural effusion

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend pleurocentesis and cytospin to assess for purulent changes that would be consistent with FIP or neoplastic cells. Thoracotomy would be necessary for further definition. I cannot completely rule out the potential for diaphragmatic hernia. However, I cannot support it, as the visible diaphragm appears to be intact. Recommend diagnostics with chest tube placement and pleurocentesis with cytospin. The cranial mediastinal density could represent a large blood clot. However, it appears to be too organized for this potential. Ultrasound guided FNA of the tissue in the cranial thorax would also be warranted for further definition.

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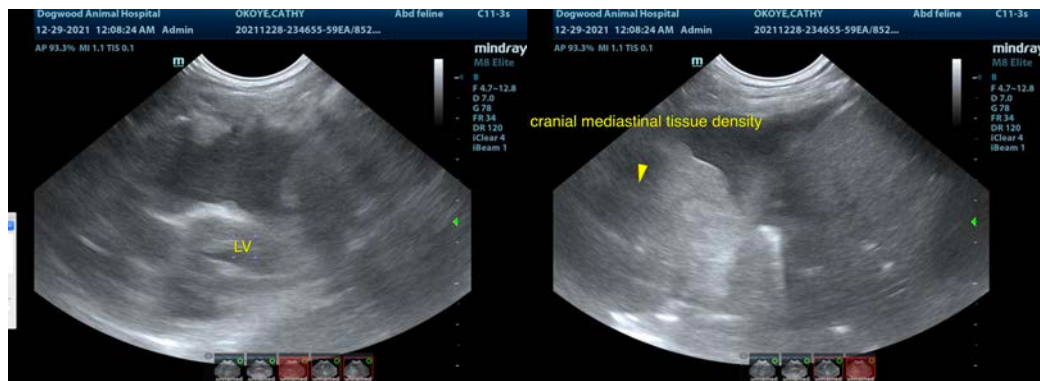


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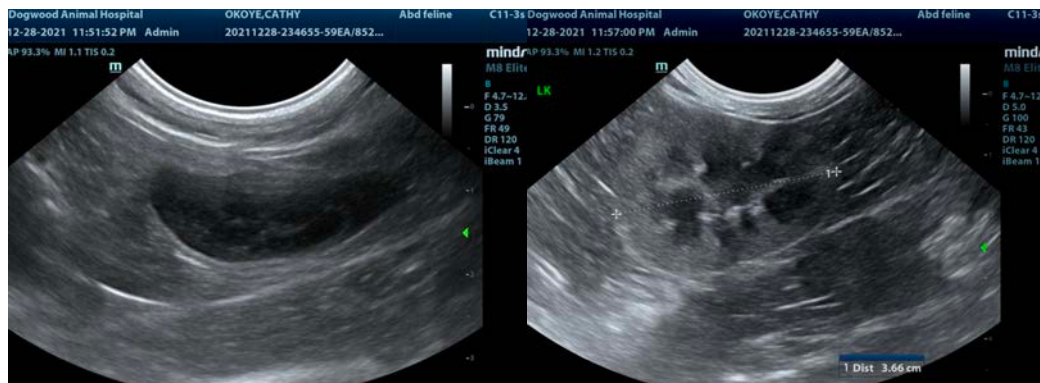
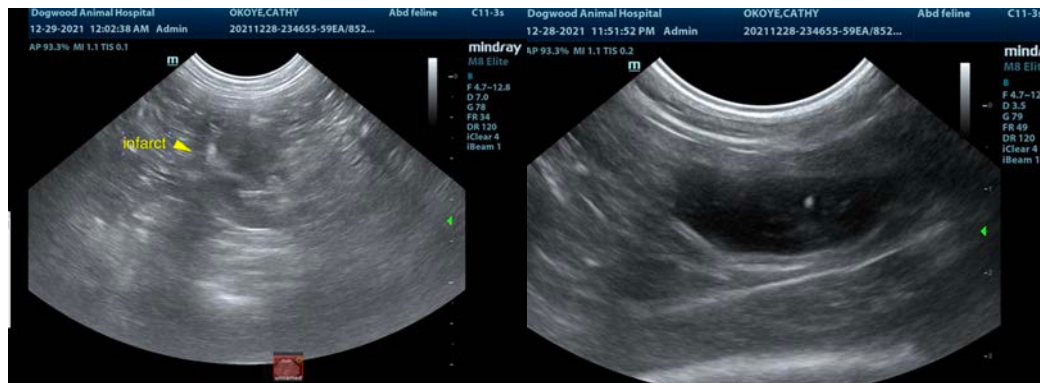
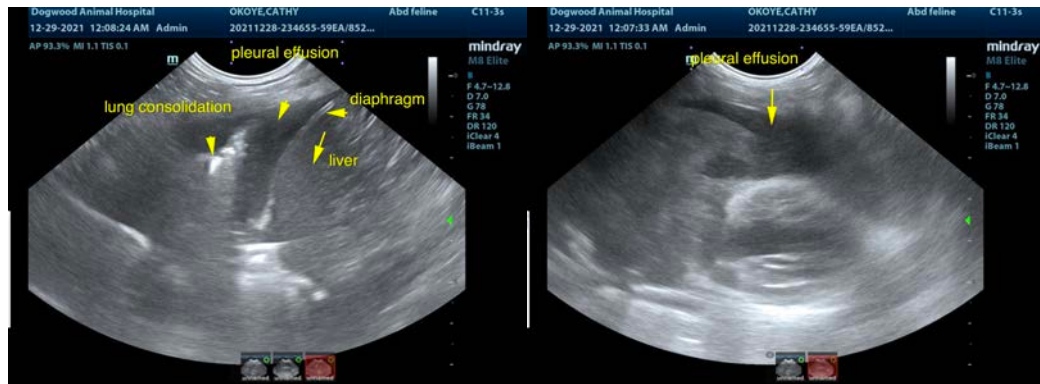
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com

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