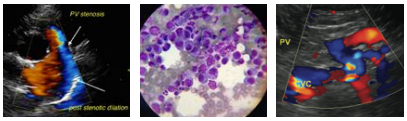
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

8/14/23

PATIENT

Henry Appel

SPECIES

Feline

BREED

Persian

SEX

Neutered male

AGE

4/23/15

WEIGHT

9.3 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

HOSPITAL NAME

Eastern AH

REFERRING VET

Dr. Sole

INVOICE

46589

PRESENTING CLINICAL SIGNS

Presented 8/14/23 for 3 bouts of vomiting on 8/13, slightly lethargic at home, not eating well, overall ADR. Slightly abdominal effort when breathing noticed on PE. Mild wheezes in lung fields.
O states that P has had increased respiratory effort at home, more sneezing and coughing fits than normal. Cardiac silhouette extremely enlarged on radiographs, unable to identify the liver on radiographs. Stomach appears to be sitting flush to the diaphragm.
Current Medications: None.
Lab Results: ALT 159 (12-130), ALP 13 (14-111), BUN 14 (16-36), Neutrophils 1.79 (2.3-10.29), Lymphocytes 7.82 (0.92-6.88), Monocytes 0.83 (0.05-0.67), Eosinophils 0.03 (0.17-1.57)
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 3.7 cm. The left kidney measured 3.6 cm.

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 0.42 cm. The right adrenal gland measured 0.42 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 was noted.

Liver and Thorax

The **liver** in this patient was displaced cranially owing to diaphragmatic hernia. The liver extended cranially into the pericardial space with mild areas of hepatic vein congestion. The hepatic vein congestion is not likely a primary issue; however, theoretically GI hypoxia may be a chronic issue in this patient. The vena cava was mildly dilated owing to congestion from physical congestion from the diaphragmatic hernia. A minor amount of hepatic remodeling was noted with echogenic lipid plaques, these are not pathological.

Gastrointestinal

The **stomach** was also displaced cranially, yet not pathological. The gastrointestinal tract revealed largely normal curvilinear patterns with slight muscularis thickening, yet there was no evidence of significant disease.

Pancreas

The **pancreas** was slightly hypoechoic to the surrounding mesentery and was slightly irregular measuring 0.65 cm in width.

Heart

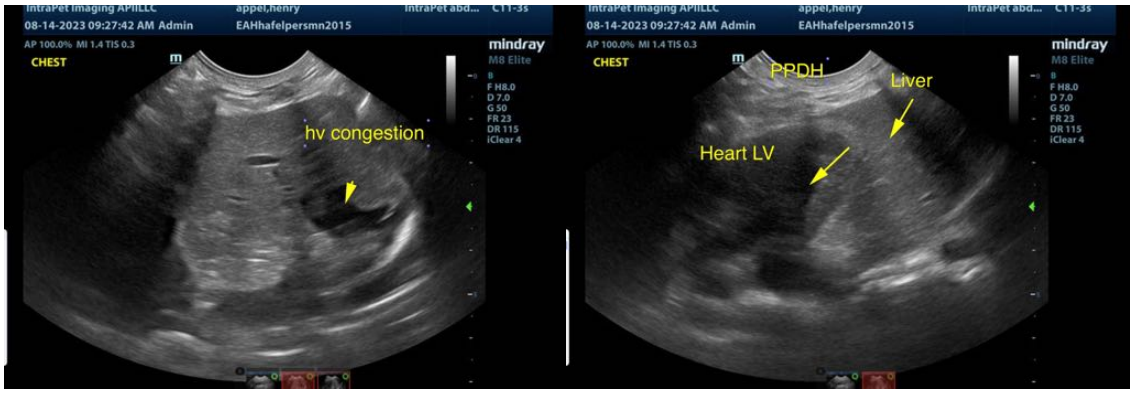
Cardiac parameters, contractility, volumes and structure other than the pericardial diaphragmatic hernia all appear unremarkable from a subjective standpoint.

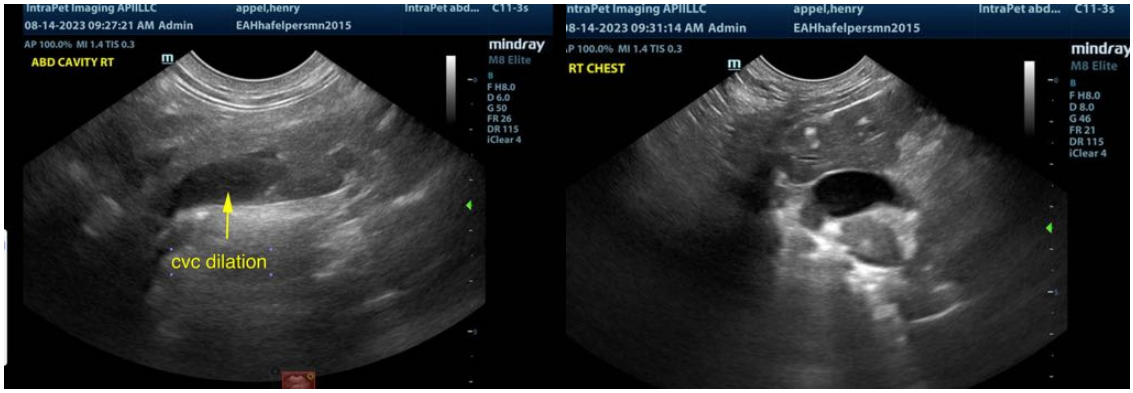
ULTRASONOGRAPHIC FINDINGS

Pericardial diaphragmatic hernia of the liver, stable. Mild vascular congestion.
Minor intestinal thickening with reactive mesenteric lymph nodes.
Age related renal changes.
Prominent pancreas, low-grade pancreatitis is possible or history of pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

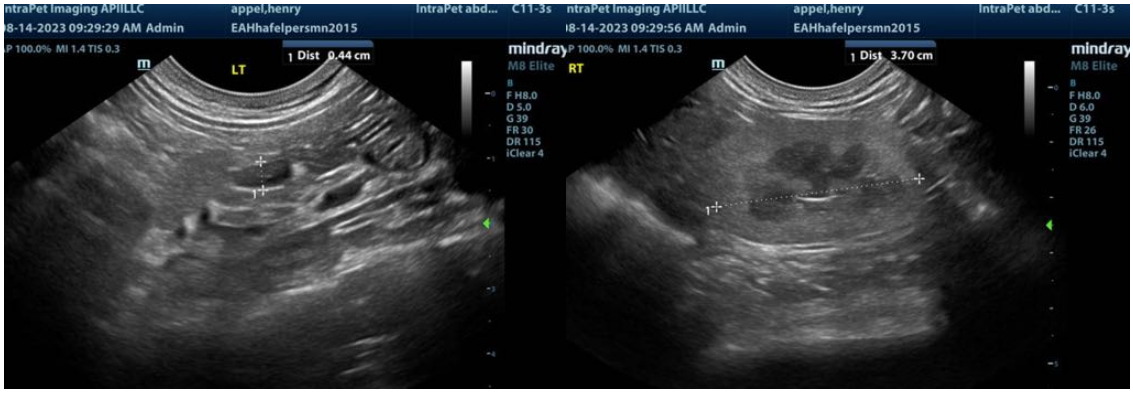
There is no evidence of inflammation associated with the pericardial diaphragmatic hernia. ALT elevation may be owing to mild passive congestion of the liver. There was no evidence of cardiac dysfunction present. I recommend treating this patient for inflammatory bowel/pancreatitis/triaditis type patient with hydrolyzed diet. Anti-parasitic protocol is recommended. FNA of the liver can be considered for further definition. No intervention upon the pericardial diaphragmatic hernia is warranted in this patient. This appears to be stable and not causing any significant dysfunction other than minor vascular congestion. If any respiratory issues occur, then recheck echocardiogram/cranial abdominal sonogram is indicated.

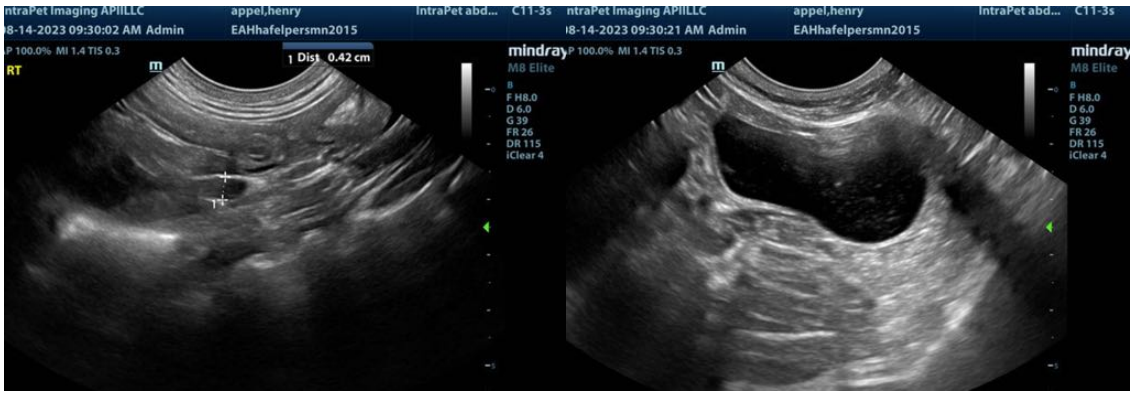

08-14-2023 09:27:42 AM Admin
EAHhafelpersmn2015
CHEST
hv congestion
08-14-2023 09:27:42 AM Admin
EAHhafelpersmn2015
CHEST
PPDH
Liver
Heart LV


08-14-2023 09:27:21 AM Admin
EAHhafelpersmn2015
ABD CAVITY RT
cvc dilation
08-14-2023 09:31:14 AM Admin
EAHhafelpersmn2015
RT CHEST


08-14-2023 09:35:11 AM Admin
EAHhafelpersmn2015
MES
1 Dist 1.40 cm
2 Dist 0.44 cm
08-14-2023 09:35:28 AM Admin
EAHhafelpersmn2015
1 Dist 0.30 cm


08-14-2023 09:29:04 AM Admin
EAHhafelpersmn2015
Pancreas
1 Dist 2.25 cm
2 Dist 0.65 cm
08-14-2023 09:29:26 AM Admin
EAHhafelpersmn2015
LT





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.

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