



PATIENT

Fang Beaulieu

SPECIES

Feline

BREED

Bengal

SEX

Neutered Male

AGE

2 Years

WEIGHT

4.29

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Alastair Westcott

HOSPITAL NAME

Dr. Alastair Westcott

REFERRING VET

Dr. Alastair Westcott

INVOICE

25345

DATE

9/11/21

PRESENTING CLINICAL SIGNS

Declining appetite for ~ 2 weeks. Last ate a little 24 hrs ago. Only vomiting episode was 2 weeks ago (a few times). Increasing lethargy. Indoor only. No other cats in the home. Vaccines and prev.care UTD
Abnormal PE/Chem/CBC/UA Results: Quiet and extreme dehydration. Paradoxically eating well after fluid rehydration in hospital despite persistent, extreme azotemia Severe renal azotemia (possibly a pre-renal component - dehydration). Very elevated TP driven by extreme hyperglobulinemia (not sure of the globulin component). Appears to also be proteinuric (strip only and not UPC). Stress leukopenia with no inflammatory leukogram. Elevated LIPASE (no fPL). Hypercalcemia.

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 were noted. Ureteral papillae were normal. The pelvic urethra was imaged 3.0 cm beyond the cystourethral junction.

The **left kidney** was enlarged at 5.16 cm with subcapsular halo, minor pyelectasia and loss of corticomedullary definition. The **right kidney** presented similar changes at 5.7 cm. The kidneys were mildly hypervascular. Pericapsular pattern noted around the kidneys.

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 right adrenal gland measured 0.35 cm. The left adrenal gland measured 0.36 cm.

Spleen

The **spleen** was mildly enlarged with scalloping contour, measuring 1.01 cm.

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.

Gastrointestinal

The **gastrointestinal tract** was largely unremarkable. Minor areas of muscularis hypertrophy were noted. However, regions of reactive mesentery or remodeled mesentery noted with slight areas of free fluid.

Pancreas

The **pancreas** was enlarged and irregular with undulating contour and dilated duct, measuring 0.87 cm in the right limb and 0.66 cm in the left limb. Subxiphoid palpation is recommended to assess for pain or discomfort associated with the pancreas.



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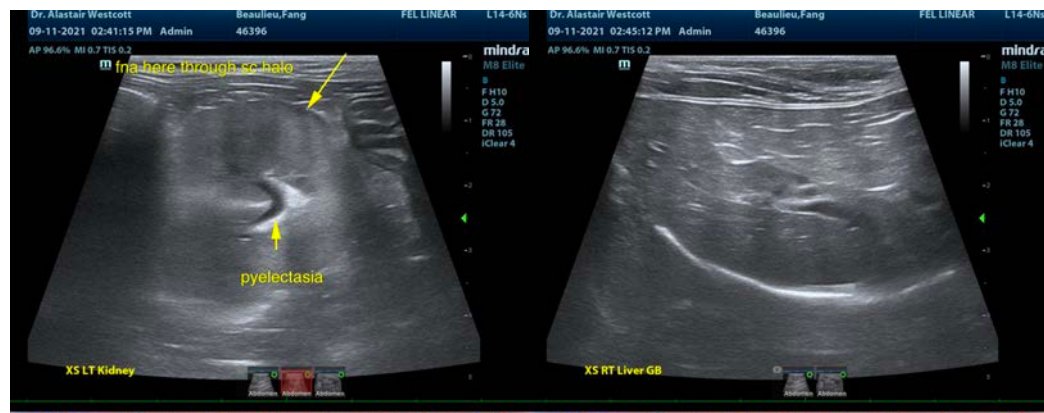
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ULTRASONOGRAPHIC FINDINGS

- Bilateral renomegaly with subcapsular halo
- Prominent irregular pancreas
- Minor reactive mesentery upon portions of small intestinal thickening
- Splenic enlargement

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I'm strongly concerned for underlying round cell neoplasia or FIP in this patient. Coagulation panel and 25-gauge FNA of either kidney (particularly in the subcapsular halo region) as well as the spleen would be indicated +/- pancreatic FNA. Round cell neoplasia, FIP, nephritis possible yet less likely. Sampling is essential in this patient. Prognosis is guarded. Full urinalysis, culture and sensitivity indicated.



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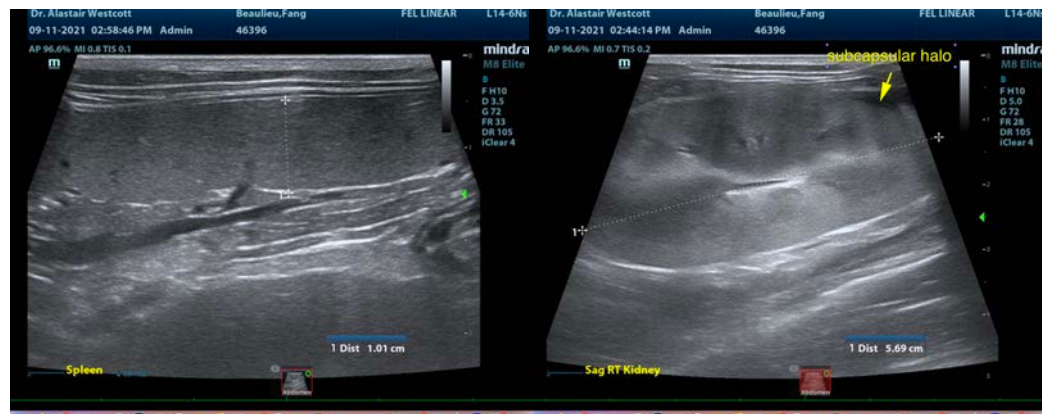
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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