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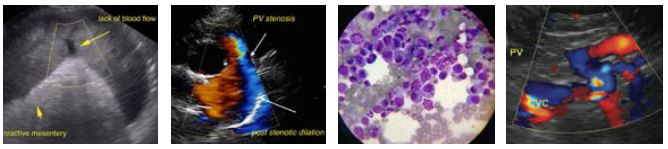


PATIENT

Clement Dreyer

SPECIES

Feline

BREED

Devon Rex

SEX

Neutered male

AGE

10 years

WEIGHT

8 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Dr. Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Mengine

INVOICE

95390

DATE

1/19/22

PRESENTING CLINICAL SIGNS

Presented to rDVM on 1/14/22 for a recent history of abdominal swelling. On exam patient was icteric with marked ascites. Chem performed - ALT 408, ALP 267, GGT 31, TBili 6.6, else unremarkable. Prior history - Pet was seen for wt loss and vomiting in 4/21, had an Eosinophil count of 11k, a SpecFPL was elevated at 6.7, and otherwise normal CBC/ Chem / T4 / U/A and retroviral testing. Treated with cerenia, signs resolved. Pet next seen for coughing and diagnosed with asthma in 9/21, and a CBC/ Chem / U/A / T4 at that time was normal except for a 3.8k eos. Retroviral testing & a fecal O&P + antigen test were negative. Pet was started on prednisolone daily for 2 months.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.57 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.65 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

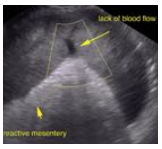
The right adrenal gland is normal in size measuring 0.5 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

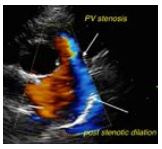
Spleen

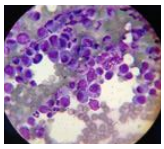
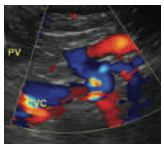
The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively large in size, with irregular margins and rounded liver lobes. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. While the parenchyma is diffusely heterogenous, there are additionally numerous, small, hypoechoic, slightly cystic lesions/moth eaten lesions. They varied in size





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from 0.25-1.0 cm. The gallbladder is difficult to visualize. A small structure consistent with the gallbladder is seen with a mild amount of biliary debris. There is no inflammation surrounding this structure.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm 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.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal and the jejunum measured as normal. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. The small intestine is normal at 0.24 cm.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering. The large intestine is normal and measured 0.15 cm.

Pancreas

The region of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation.

Free Abdomen

A large amount of echogenic free fluid was noted. No lymphadenomegaly is noted. The omentum is uniformly hyperechoic and somewhat irregular and there is the appearance of an irregular peritoneal surface on all of the abdominal organs with fibrin stranding and irregularity.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Large, irregular, heterogenous liver with hypoechoic cysts/nodules. Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Large volume of echogenic free abdominal fluid with irregular peritoneal surfaces and fibrin stranding with an abdomen. The findings are concerning for a chronic inflammatory process. I recommend fluid analysis, cytology +/- culture.

SECONDARY FINDINGS:

- Small contracted gallbladder. The significance of this is unclear.

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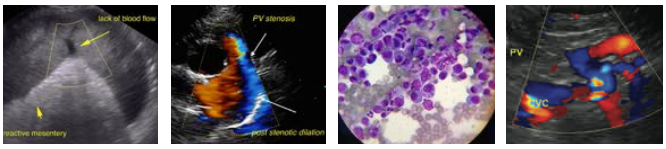

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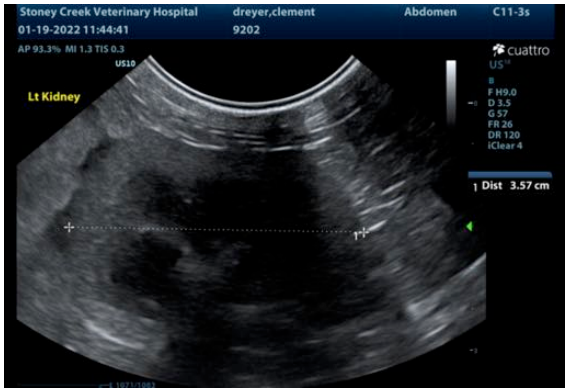
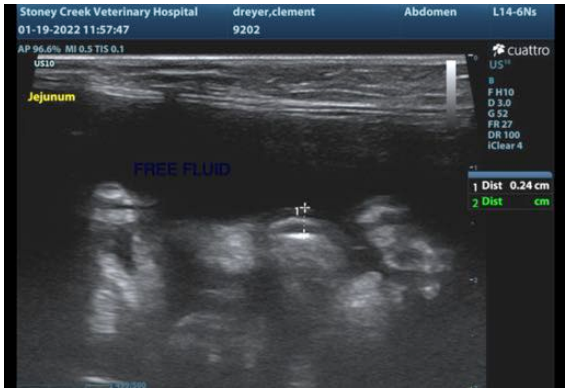
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is the perception of generalized inflammation in the abdomen and all the peritoneal surfaces appear somewhat irregular with fibrin strands indicating a level of chronicity to the fluid present. I recommend fluid analysis, cytology, +/- culture. With the icterus present there is likely either a primary hepatopathy or biliary disease present. The gallbladder is very difficult to visualize. I suspect it has contracted down, but cannot rule out the possibility of a previous rupture, etc. (there is no inflammation to suggest this). My suspicions are that there is a systemic problem largely involving the liver.

- Recommend a FNA of the liver provided coagulation parameters allow this.
- Consider pathologist review of a blood smear to evaluate the peripheral eosinophilia.
- Consider testing for Toxoplasmosis and FIP specific PCR to Auburn University.
- Recommend three view thoracic radiographs to look for concurrent intrathoracic disease.

If infectious disease testing and cytology is unsuccessful in obtaining a diagnosis I would consider surgical evaluation of the abdomen with biopsies of the liver and any abnormal tissue, peritoneal tissue, etc. If the patient is not eating consider placing a feeding tube and continue supportive therapy.





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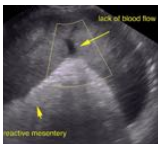
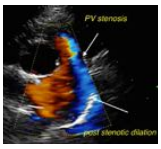
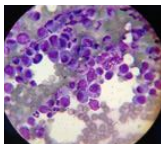
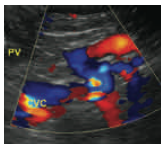

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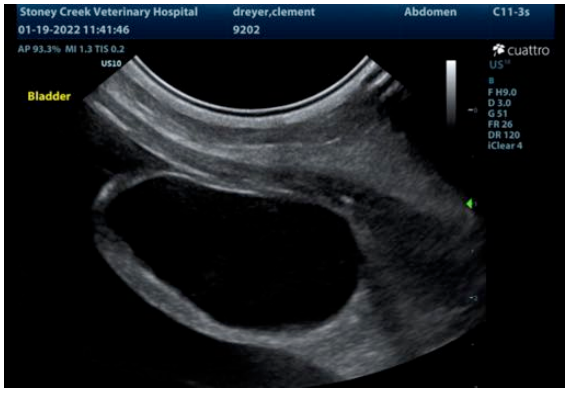

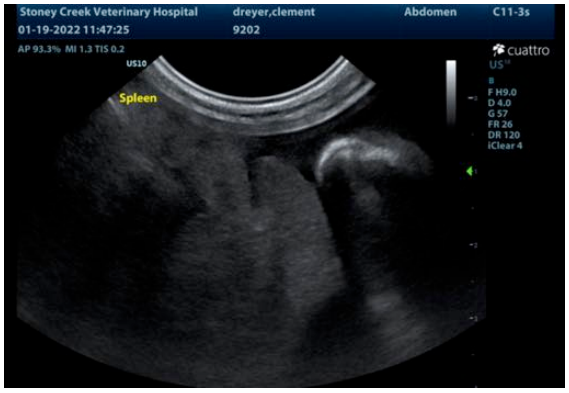

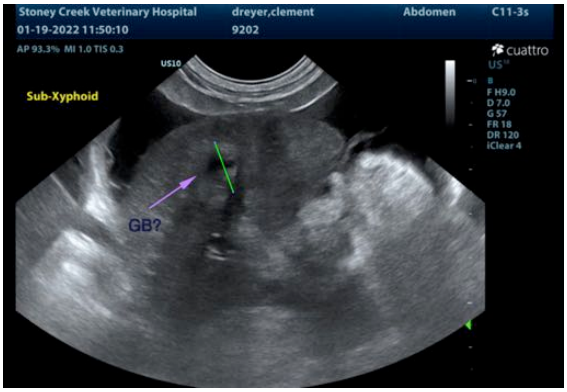

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com