SonoPath
Clinical Sonography & Telecytology
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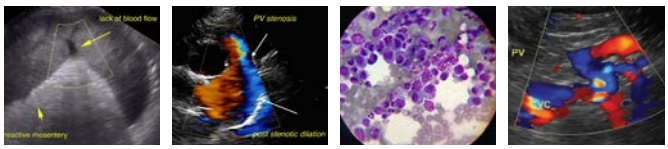

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Luna Lovegood Brown

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10 Years

WEIGHT

8.9 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Vet Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

42236

DATE

10/20/22

PRESENTING CLINICAL SIGNS

Presented 10/19/2022 for lethargy and hyporexia of about 2 days duration. Indoor only. No other past medical problems per owner. Has not been to a vet in years.

Abnormal PE/Chem/CBC/UA Results: Temperature was 105.2 F on presentation. Caudal abdominal pain noted. New grade 1/6 parasternal systolic HM. 6-8% dehydrated. 10/19/2022 cbc/chem white Blood cell high 22.3 Lymphocytes low 0.42 Neutrophils high 20.21 Eosinophils 0.67 Platelet low 88 Albumin low 2.1 globulins high normal Amylase high 1106 Glucose high 171 Remainder CBC/Chem wnl FeLV/FIV SNAP 10/20/2022 neg/neg Abdominal rads 10/20/2022 CONCLUSIONS: 1. The heterogeneous soft tissue gastric luminal material may represent retention of ingesta due to gastric hypomotility (gastritis, pancreatitis), however could also represent a trichobezoar or foreign material of soft tissue opacity (textile/fabric, plastic). 2. Apparent thickening of the gastric wall along the greater curvature may be artifactual due to silhouetting with luminal contents, however true wall thickening due to gastritis or gastric neoplasia cannot be ruled out. 3. Ovoid soft tissue opacity in the craniodorsal abdomen may be a summation artifact, however a small mass in this region should also be considered, with possible origins including spleen, liver, pancreas, adrenal gland, intestine, mesentery, or lymph node. 4. Equivocal hepatomegaly. Rule out normal variant versus mild enlargement due to a diffuse hepatopathy (hepatic lipidosis, hepatitis/cholangiohepatitis, vacuolar hepatopathy, and hepatic neoplasia. 5. There is no overt evidence of cardiomegaly or congestive heart failure. Possible causes for the reported murmur would include compensated hypertrophic cardiomyopathy, dynamic right ventricular outflow tract obstruction, valve insufficiency, or extra cardiac disease (hypothyroidism, anemia). UA 10/20/2022 USG 1.049 Protein 3+ Trace occult blood Slightly cloudy appearance Quite sediment otherwise

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 (3.9 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (3.82 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.37 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.27 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.

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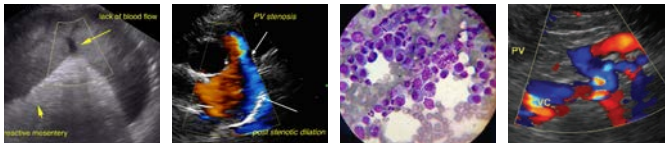

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Spleen

The spleen is subjectively normal in size (0.71 cm in width at the level of the hilus), 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 normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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. Duodenum wall measures 0.21 cm. Jejunum wall measures 0.24 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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.

Pancreas

The pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic prominent pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The significance of this is unclear with normal liver enzymes. This could be within normal limits for this individual.

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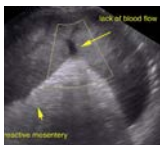
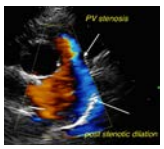
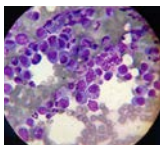
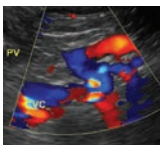

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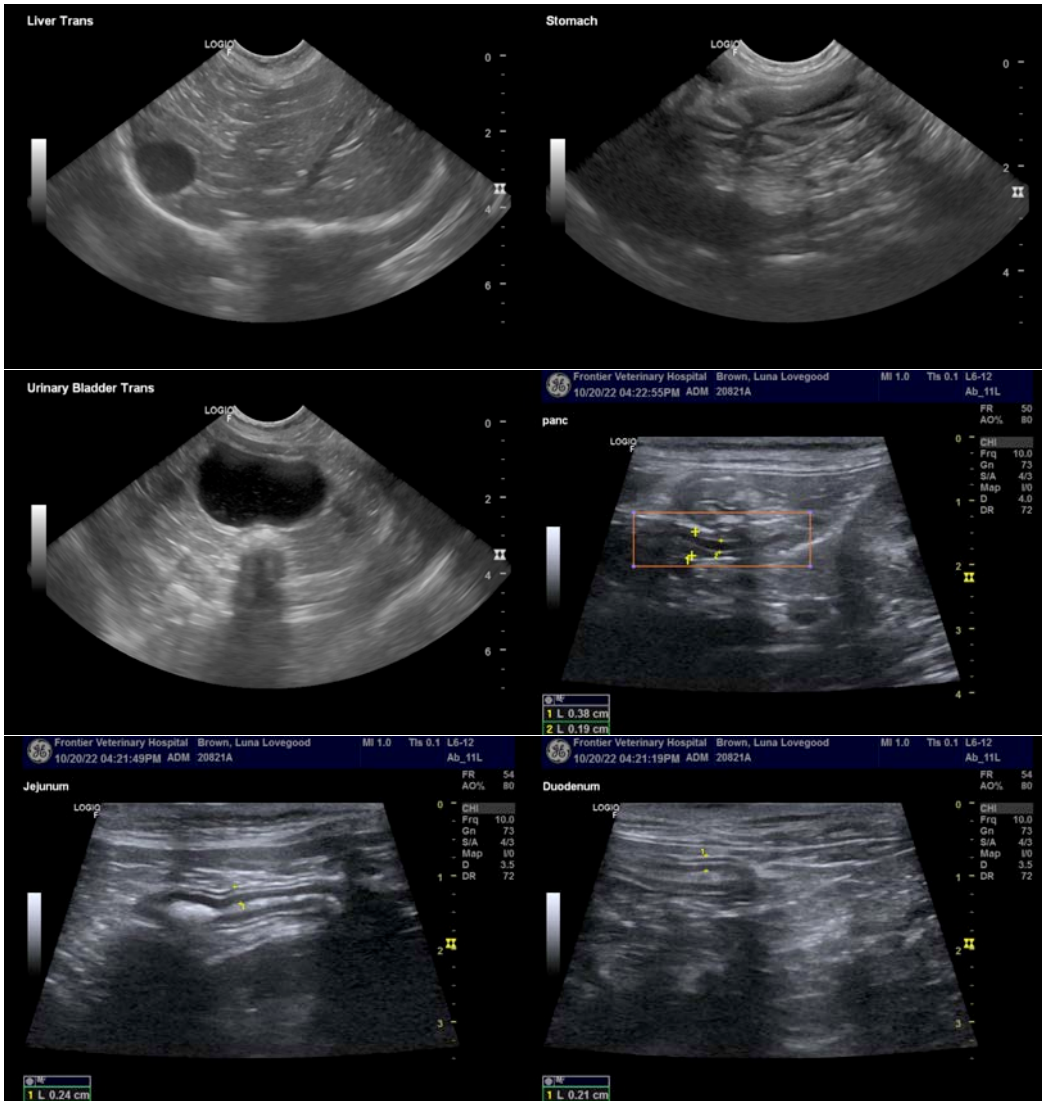
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed on today's scan are relatively mild and non-specific. The pancreas appears somewhat prominent. This could be associated with mild current inflammation or a previous episode of inflammation. Correlate findings with a quantitative fPLI level. Additionally, the mildly heterogeneous liver is of questionable significance without concurrent liver enzyme elevations. Depending on the degree of globulin elevation, you could consider a protein electrophoresis to further delineate a possible cause for the globulin elevation. Additionally, the low albumin could be compensatory, or could be associated with liver, GI, or renal disease. Recommend a urinalysis, culture, and urine protein to creatinine ratio. Additionally, you could consider a liver function test and a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to look for evidence of underlying GI disease.

If the fever is persistent, continue looking for possible infectious causes with the aforementioned urine culture. You have screened the thorax with radiographs. No obvious source is evident in the abdomen. Consider infectious disease testing if appropriate (consider a feline comprehensive panel to NC State's vector borne disease lab). Additionally, this could be inflammatory/autoimmune. With the globulin elevation you could consider screening for FIP and consider a PCR to Auburn University (still not a definitive test, but possibly helpful).



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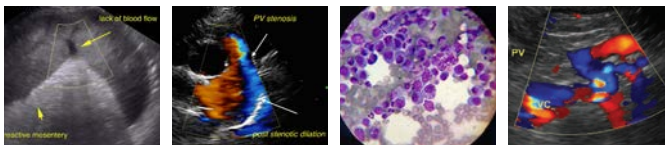

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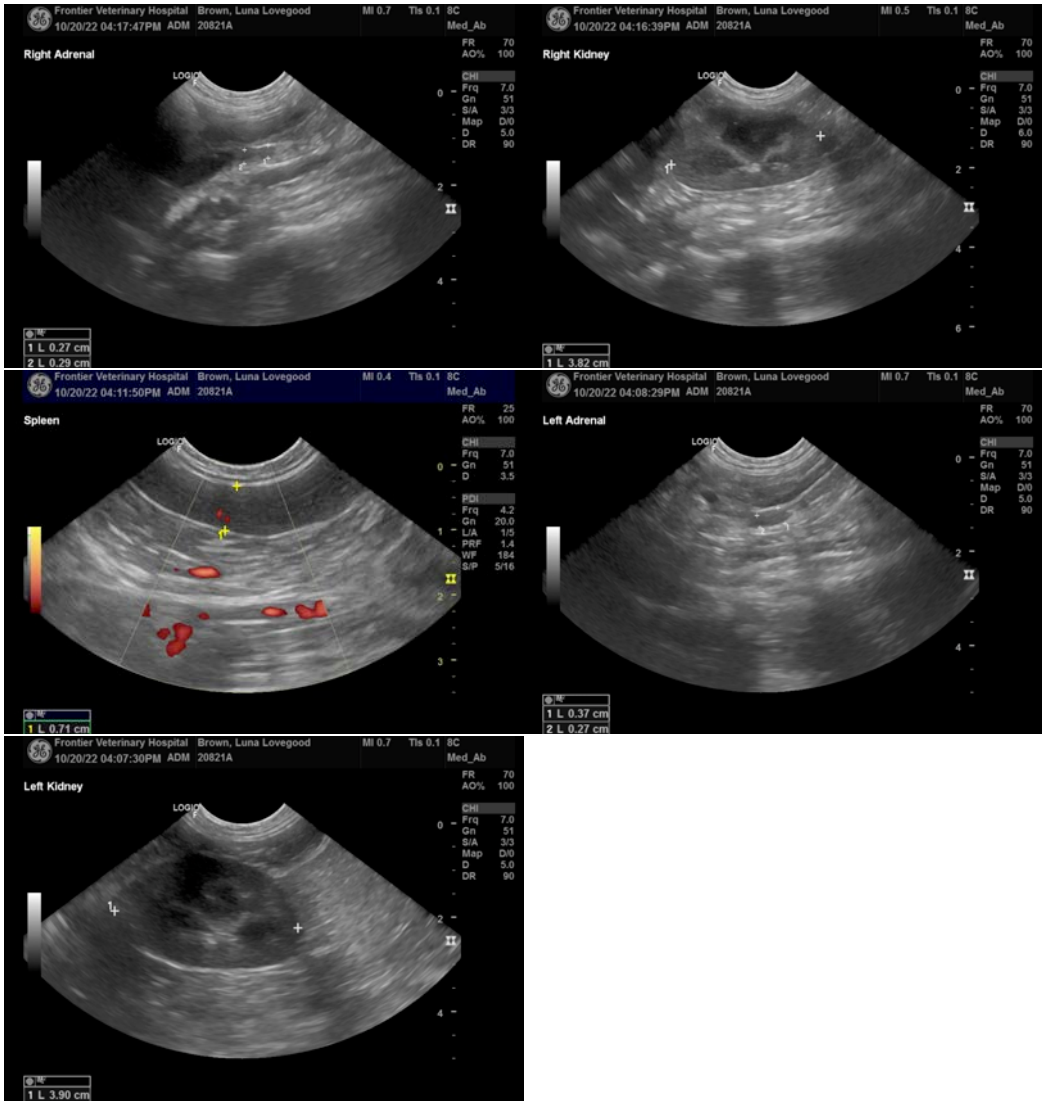

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com