



PATIENT

Hank Sanborn

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

9 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Chaley Hunt, LVT

HOSPITAL NAME

Columbia AC

REFERRING VET

Dr. Michelle Engel

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DATE

2/9/22

PRESENTING CLINICAL SIGNS

Has not been eating for an unknown period of time. Has a history of GI upset/IBD that is usually treated with steroids once a year. Last dose was either October or January. He has been treated since Monday with Mirtzapine, Convenia, and Buprenorphine, and B12 last night. SQ fluids Monday, force feeding i/d pate 2-3 times/day.

Abnormal PE/Chem/CBC/UA Results: Labs on 2/9/22 fPL: Abnormal RBC - 6.17 HCT - 26.8 WBC - 23.67 Creat - 0.7 BUN - 8 Calcium - 7.3 Sodium - 146 Potassium - 3.3 Albumin- 2.1 GGT - 16 Total Bili - 5.2

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is not clearly visualized, possibly to lack of urine distention.

The left kidney has a normal shape and size (4.35 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 (4.18 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 0.48 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 large in size, and normal in 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 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.



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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 (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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Pancreas

The pancreas appears prominent and hypoechoic in areas with ill-defined margins, and it is surrounded by hyperechoic mesentery and free fluid. In some areas, the pancreas almost appears nodular, but this is difficult to differentiate from enlarged lymph nodes in the area. Findings are most consistent with moderate to severe pancreatitis or pancreatic neoplasia.

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Free Abdomen

There is a large amount of free abdominal fluid. There is a large amount of inflammation of the omentum in the cranial abdomen in the area around the pancreas, and there is abnormal tissue in this area as well, which is difficult to differentiate from enlarged lymph nodes or a nodular pancreas.

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Other

On some images, there is the suspicion of pleural effusion.

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PRIMARY FINDINGS

- Large volume free abdominal fluid
- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Prominent, hypoechoic pancreas surrounded by hyperechoic mesentery – The pancreatic changes are most consistent with moderate/severe pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Severe cranial abdominal inflammation with possible lymphadenopathy versus nodular pancreas

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SECONDARY FINDINGS

- Suspect pleural effusion. Recommend radiologist review of 3-view thoracic radiographs and cardiac ultrasound.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The general impression of the scan is severe cranial abdominal inflammation with fluid, a large liver and pancreas, and possible cranial abdominal lymphadenopathy. It is somewhat difficult to determine if there is inflammation associated with the pancreas and liver, which is causing the fluid, or if there is another process causing congestion, fluid accumulation, etc. (such as heart disease), but with the low albumin levels and the elevated bilirubin, hepatic disease would have to be high suspicion, such as

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neoplasia or hepatic lipidosis.

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- Recommend 3-view thoracic radiographs reviewed by a radiologist.
- Recommend echocardiogram.
- Recommend ionized calcium level and PTH
- Recommend a fine needle aspirate of the liver, fluid analysis and cytology on the free abdominal fluid, and an aspirate of either the cranial abdominal lymph node/nodule or pancreas (provided coagulation parameters are ok).

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Primary differentials at this point would have to be severe hepatic lipidosis, round cell neoplasia, +/- pancreatitis, but concurrent intrathoracic disease needs to be considered.

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Consider a GI panel with a quantitative fPLI, TLI, cobalamin and folate (Texas A&M University).

A feeding tube may need to be considered if anorexia persists, provided coagulation parameters will allow this.

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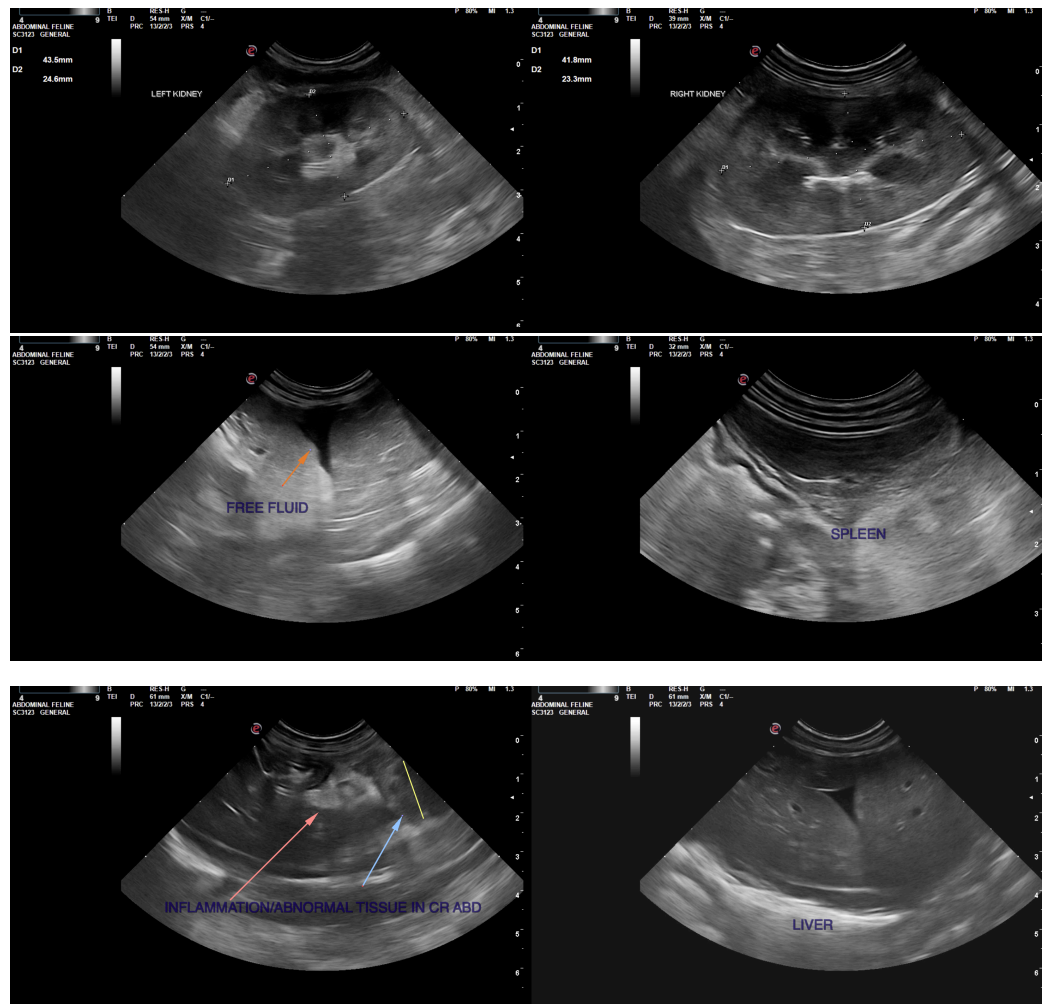
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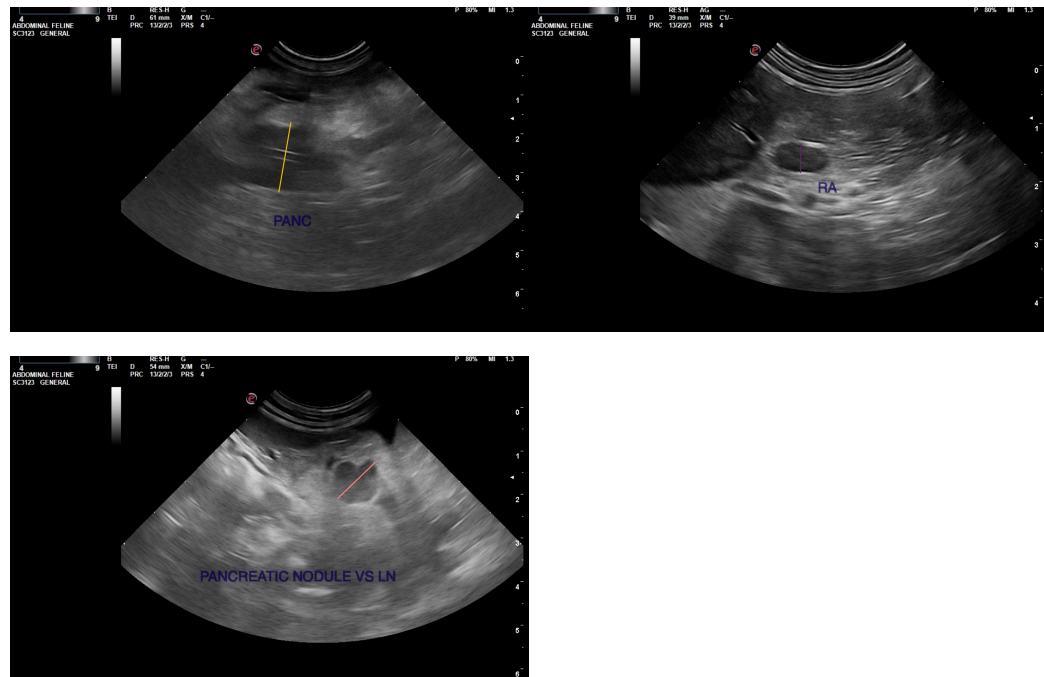
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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