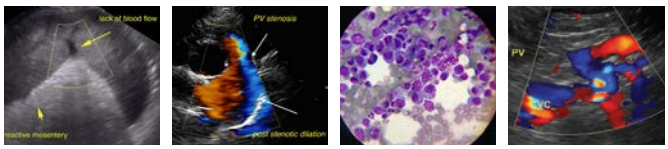
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Mars Sebastian

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
2 Years

WEIGHT
8.01

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

IMAGING PERFORMED BY
Elaina Petrone

HOSPITAL NAME
Long Branch AH

REFERRING VET
Dr. Jose Pla

INVOICE
46378

DATE
4/4/23

PRESENTING CLINICAL SIGNS

Presumptive FIP; Ascites

Abnormal PE/Chem/CBC/UA Results: Ascites; fluid analysis; transudate Chem: increase globulin, decease calcium, increase TP CBC: mild neutrophilia Toxo: IgG/IgA neg FELV/FIV neg Fecal: neg FCV positive 1:1600

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 (4.15 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 (4.34 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

Spleen

The spleen is subjectively normal in size. The spleen echotexture is heterogenous and mottled, 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.

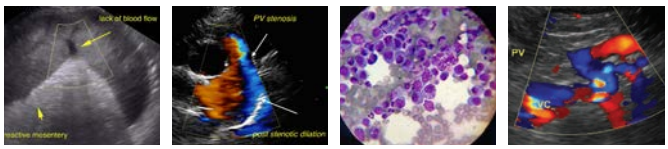
Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. 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.



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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. Jejunum wall measures 0.19 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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

Free Abdomen

There is a scant amount of free abdominal fluid. There is a mild lymphadenopathy present with mesenteric lymph nodes measuring 0.40 cm and 0.49 cm. The omentum is mildly hyperechoic, particularly around the pancreas.

ULTRASONOGRAPHIC FINDINGS

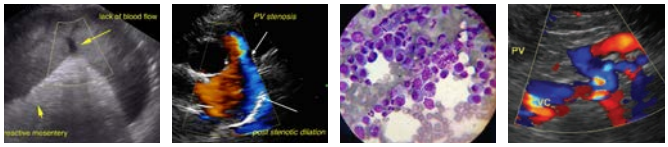
- Prominent, hypoechoic pancreas with mild surrounding hyperechoic mesentery – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Significantly mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Prominent/mildly enlarged mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Scant free abdominal fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

While the changes observed could be consistent with a diagnosis of FIP, the changes are relatively mild, and other differentials such as inflammatory disease, pancreatitis, etc. exist. If not already done, recommend cytology on the abdominal fluid collected. Additionally, consider a quantitative fPLI to further evaluate the pancreatic changes observed. The mesenteric lymph nodes are enlarged, but relatively mildly. Fine needle aspirate could be considered, but may be challenging due to the lack of significant enlargement.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

Diagnosing or excluding FIP in some individuals can be very challenging, particularly if they do not have a “classic” presentation. I would strongly recommend a fine needle aspirate of the spleen in this individual, as it does appear significantly mottled, and treatment for pancreatitis with a PLI level in addition to chest radiographs, and if possible cytology on the abdominal fluid. Consider treatment for



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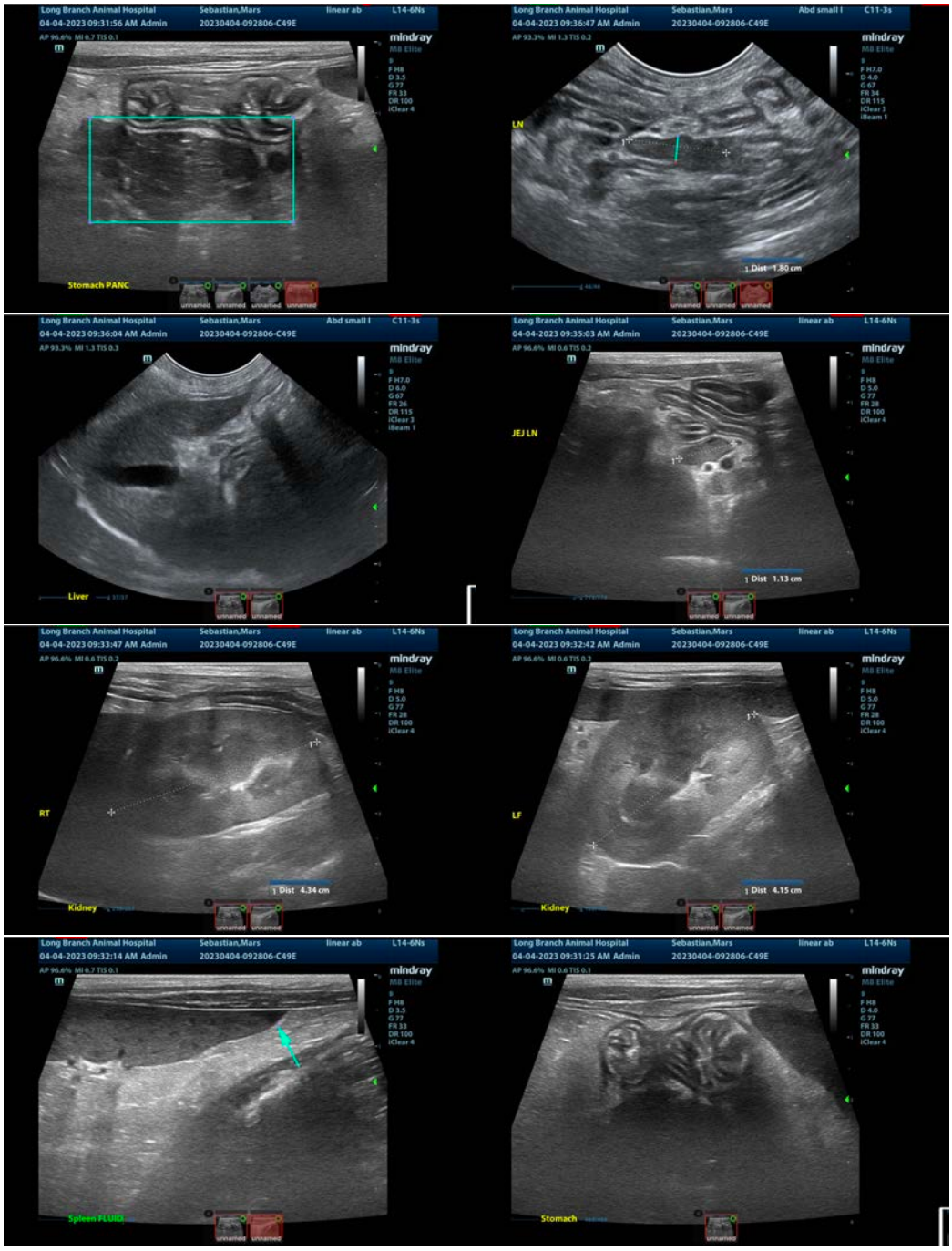
pancreatitis and reevaluation. Additionally, you could consider an FIP PCR to Auburn University, as this may be slightly more sensitive than an ELISA, although there still is no definitive premortem test.



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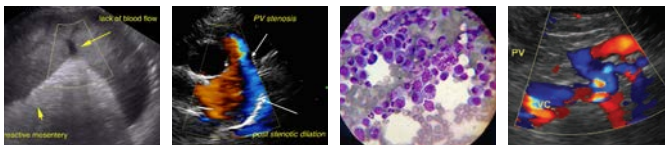

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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