IMAGING PERFORMED BY

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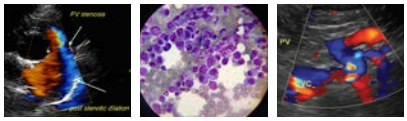

SonoPath
Clinical Sonography & Telecytology
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DATE

4/6/23

PATIENT

Simba Silvestri

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3/20/17

WEIGHT

10 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Unger

INVOICE

46468

PRESENTING CLINICAL SIGNS

Patient presented 1 week ago for 2 week history of not behaving normally. Simba has not been to a vet since he was neutered and had kitten vaccines. He is an indoor cat. He has been hiding in the bedroom for about 2 weeks and urinating inappropriately. O placed a litterbox in the room and he started using it. He is eating as long as food is brought into the room. Exam was unremarkable other then a grade 2/6 murmur. Bloodwork revealed a non-regenerative anemia. Presumptive diagnosis
IMHA.

Current Medications: Zenequin 25mg 1/2 T sid started 4/4, to start pred 10 mg bid today
Lab Results: Hct 3/31 - 19.6% dropped to 12.9% by 4/5. increased platelet count, felv/fiv neg, anemia panel pending, path review showed agglutination and ghost cells
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Declined at this time.
Imaging Performed By: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (4.08 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 (4.33 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 0.68 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. Pinpoint mineralizations are noted.

The right adrenal gland is normal in size measuring 0.45 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. Pinpoint mineralizations are noted.

Spleen

The spleen is large (1.3 cm in width at the level of the hilus). 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 a large amount of shadowing ingesta. 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. Jejunum wall measures 0.18 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 mottled 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.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

PRIMARY FINDINGS

- Echogenic debris visualized in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Large, 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, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Large, shadowing ingesta visualized within the gastric lumen – Findings are most consistent with a nonfasted patient.

SECONDARY FINDINGS

- Pinpoint mineralizations visualized in both adrenal glands – This is likely an incidental finding.

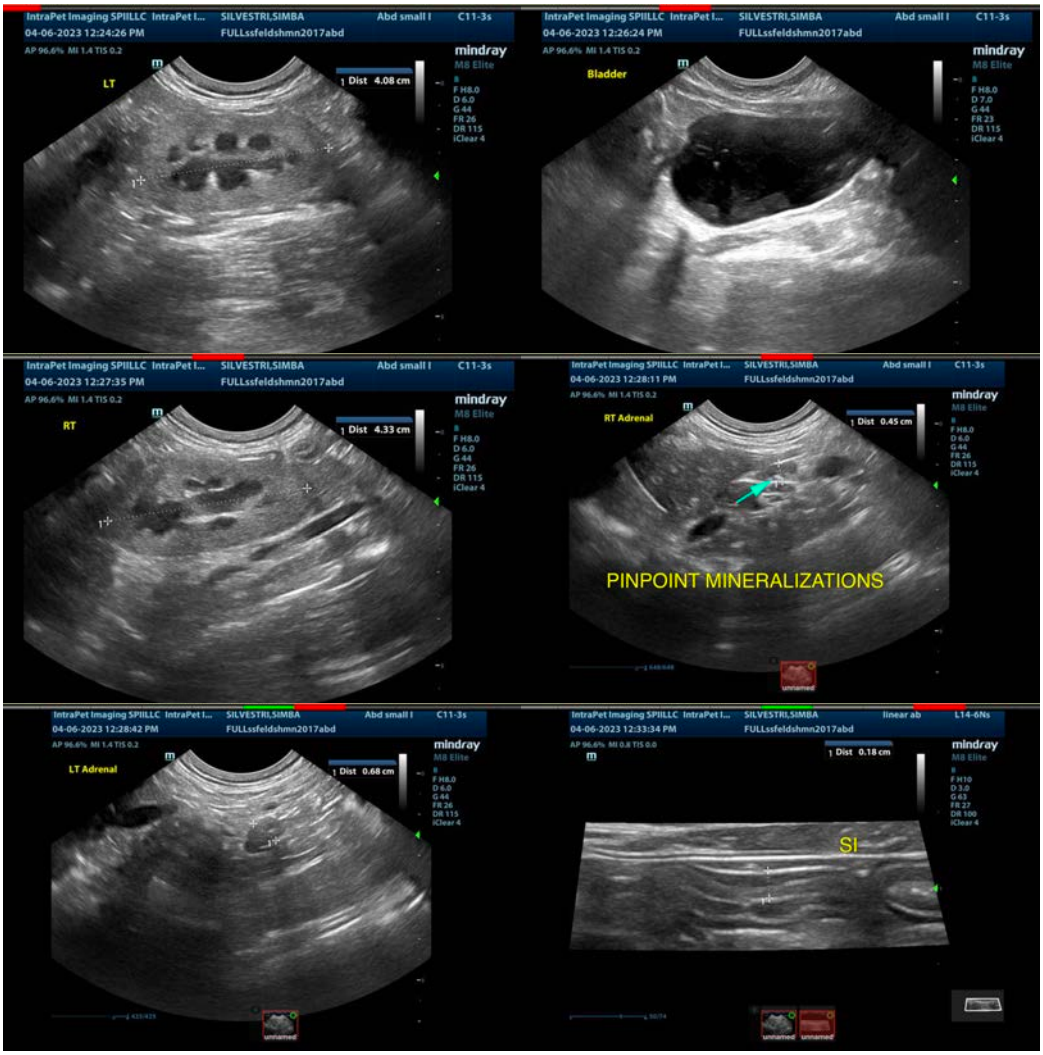
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

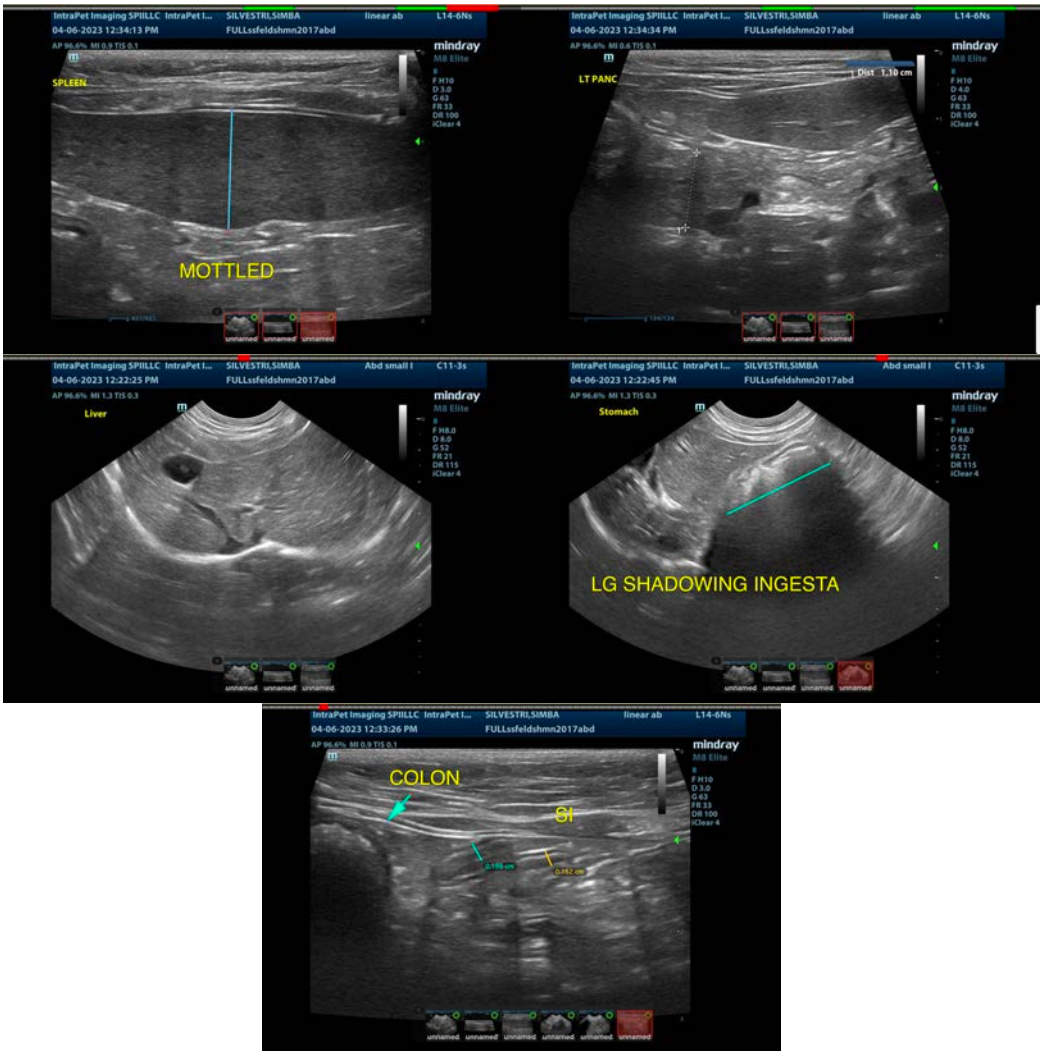
No lesions are visualized on today's exam to suggest hemorrhage as a source of the anemia reported. Additionally, no focal mass lesions are observed. The spleen does appear large and mottled. This could be due to neoplastic infiltration, red blood cell regeneration, immune mediated disease, or red blood cell parasitism. Consider a fine needle aspirate of the spleen.

Based on the path review findings, it is reasonable to start immunosuppression while awaiting on additional test results. Consider Prednisolone at 2.0 mg/kg once daily +/- an additional immunosuppressant, and a blood transfusion if clinically necessary.

Recommend urinalysis and culture to evaluate the echogenic debris in the urinary bladder, and three view thoracic radiographs.

If the anemia remains non-regenerative, consider a bone marrow aspirate.





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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