



PATIENT

Elton Romeo

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Months

WEIGHT

4.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Lupole

INVOICE

38714

DATE

6/15/22

PRESENTING CLINICAL SIGNS

Presented at our hospital for couple weeks ago appetite changed, interested in food but not eating much, ate Friskies gravy easily today, scabs on ears and one on neck, rDVM said allergic reaction
Previous Health Concerns: maybe digestive issues- from shelter so unsure
Abnormal PE/Chem/CBC/UA Results: Abdominal: thickened bowel and painful in cranial abdomen
Cbc: hct 26 rbc 5.28 Chem: alb 2.0 alp 174 bun 8.9 crea 0.4 ca 7.8 glob 6.2 t bili 2.1 tp 8.2 Epcoc: bun 9 ca 1.16 creat 0.45 hct 24 K+ 3.5 na 147 Rads: ground glass appearance in abdomen; Felv/fiv/hw: neg X 3

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 is borderline large at 4.31 cm with normal corticomedullary distinction and corticomedullary rim sign. 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 is normal/borderline large in size at 4.36 cm. Normal corticomedullary distinction and prominent corticomedullary rim sign noted. 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 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.

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 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. Jejunum wall measured 0.18 cm. 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 is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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Free Abdomen

There is a moderate amount of free abdominal fluid. No lymphadenopathy. The omentum appears generally of increased echogenicity.

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ULTRASONOGRAPHIC FINDINGS

- Moderate volume free abdominal fluid – recommend fluid analysis and cytology +/- culture.
- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Borderline large kidneys with corticomedullary rim sign – Clinical significance uncertain, can be seen in normal patients and in cases of ethylene glycol toxicity, FIP, chronic interstitial nephritis, and leptospirosis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a moderate volume of free fluid in the abdomen as well as a large, heterogeneous liver. The history reports a low albumin. Recommend liver function test as well as a urine protein to creatinine ratio and a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further try to identify the source for the low albumin levels (liver disease, protein losing nephropathy/enteropathy, etc.

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3-view thoracic radiographs should be obtained to evaluate for thoracic lesions, evidence of heart disease, etc.

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There are no obvious biliary changes observed, so the elevation in bilirubin could be secondary to primary hepatic disease or associated with the mild anemia reported. Recommend a fine needle aspirate of the liver.

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If an answer is not obtained based on fine needle aspirate of the liver and evaluation of the abdominal fluid, then it may be necessary to consider surgery to obtain biopsies of tissues. Possible differentials would include peritonitis (bacterial or inflammatory), FIP, infiltrative neoplasia, severe intestinal disease, etc.

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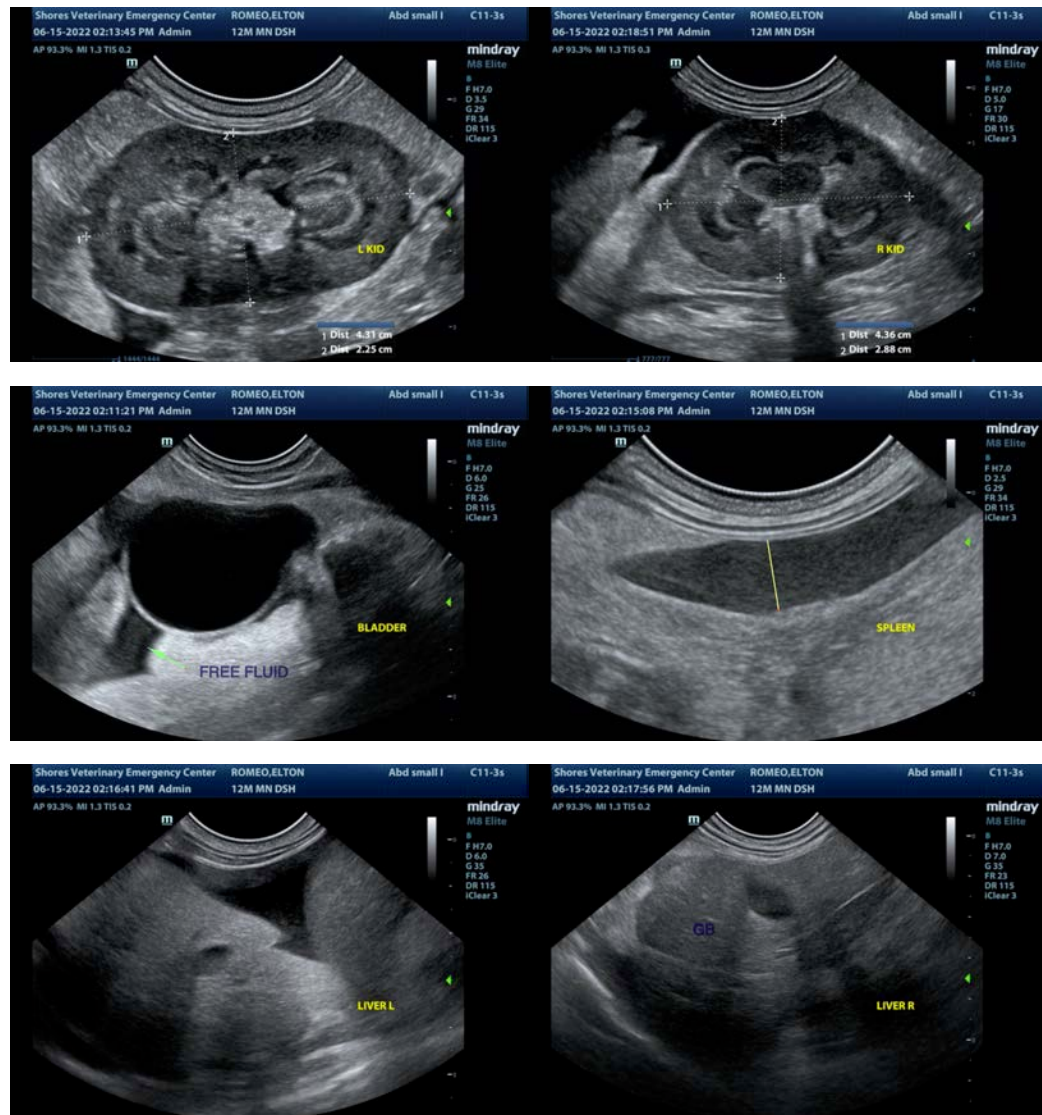
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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