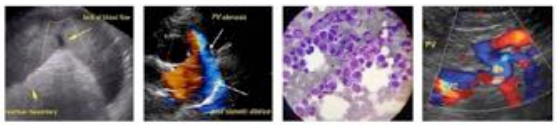


PATIENT

Henri Ranieri

SPECIES

Feline

BREED

Domestic Longhair

SEX

Neutered male

AGE

4 years

WEIGHT

4.86 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reshny, RVT

HOSPITAL NAME

Beatties East Hamilton PH

REFERRING VET

Dr. MacDonald

INVOICE

94893

DATE

12/24/21

PRESENTING CLINICAL SIGNS

Diarrhea, vomiting for 1 week Tennis ball sized firm lump palpated in cranial abdomen, painful. Clavaseptin, Buprenorphine
Abnormal PE/Chem/CBC/UA Results: very high WBCS AND LYMPHOCYTES- neoplasia, infection low neutrophils with band neutrophils chronic infection/inflammation reticulocytosis with anemia- possible blood loss/hemolytic anemia monocytosis -tissue necrosis/inflammation SDMA 26 (0-14)- possible impaired kidney function high wbcs with rbcs in urine- inf/inflammation

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 borderline large size (4.36 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 borderline large size (4.86 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 left adrenal gland is normal in size measuring 0.31 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.

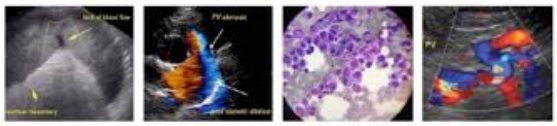
The right adrenal gland is normal in size measuring 0.44 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is large and measured 1.0 cm in diameter at the level of the hilus. The spleen echotexture is hypoechoic with rounded edges and it is surrounded by hyperechoic mesentery. Blood flow through the hilus and splenic parenchyma appears normal.

Liver

The liver is subjectively large in size, and echogenicity with smooth rounded peripheral margins. The parenchyma is hypoechoic and 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 gallbladder is not thickened



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and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <036cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

Many of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter and some have minimal fluid distension. More commonly there is moderate fluid distension and some areas have a corrugated appearance with some bunching and sharp turns. Additionally, most areas display a prominent muscularis layer that does not display the typical 1:3 muscularis to mucosal layer ratio. The duodenum measures 0.32 cm and the jejunum measures at 0.3 cm. There were no focal lesions consistent with obstruction or a mass effect observed, but diffuse enteritis was evident and severely patchy mesentery surrounding the bowel particularly in the mid to caudal abdomen. This is consistent with peritonitis.

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 the surrounding mesentery. There is no evidence of nodules or cystic lesions but the omentum is so abnormal it is difficult to distinguish between nodular pancreas and abnormal, inflamed abdominal tissue.. The findings are consistent with moderate to severe pancreatitis and severe peritonitis

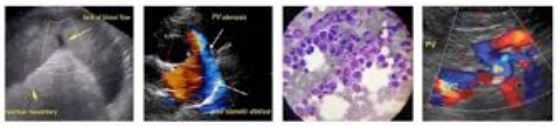
Free Abdomen

There is a small/moderate amount of echogenic free fluid visualized. No lymphadenomegaly was visualized. The omentum appears severely patchy and hyperechoic in the general abdomen not limited to surrounding the pancreas. There is a large ill defined hypoechoic speckled region mid abdomen which could be producing a mass effect on palpation.The bowel and the pancreas both appear very inflamed.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Severe, diffuse peritonitis. The diffusely hyperechoic mesentery and abdominal effusion are changes consistent with peritonitis (either infectious or inflammatory). Recommend fluid analysis and culture.
- Diffusely (but not uniformly) fluid dilated bowel with corrugation. The findings are consistent with diffuse enteritis. While no foreign material is observed this cannot be excluded as a possibility.



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- Severely, hypoechoic pancreas surrounded by hyperechoic mesentery. The pancreatic changes are most consistent with (moderate to severe) pancreatitis/pancreatic infiltration. I recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider FNA if not improving.
- Large, hypoechoic spleen The spleen likely appears hypoechoic in contrast to the surrounding hyperechoic mesentery, but is enlarged and irregular. I recommend an FNA.
- Large, expansile hyperechoic liver. Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. There is concern for possible LMA, FIP etc due the diffuse nature of this abnormal tissue.
- Moderate gastric distension with fluid/ingesta. Correlate with radiographs and feeding history. If the patient was adequately fasted consider differentials as delayed gastric emptying or partial outflow tract obstruction (none clearly visualized).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The abdomen is severely inflamed with patchy appearing heterogenous and hyperechoic mesentery. The pancreas is prominent, but the inflammation does not appear confined to the area around the pancreas. Additionally the bowel is fluid dilated appears somewhat corruated. I suspect that this is consistent with diffuse enteritis, but foreign material cannot be excluded as a possibility.

The liver is swollen and expansile. The combination of the severe diffusely abnormal, omentum, large swollen liver, prominent kidneys etc.. could be consistent with diffuse LMA, FIP etc..

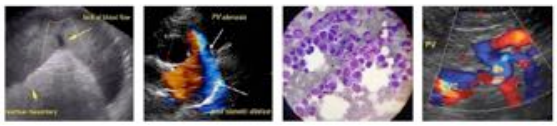
- Recommend fluid analysis and sampling in addition to an FNA of the inflamed omentum (large hypoechoic area) to look for any free bacteria, neoplastic cells etc. I recommend cytology and culture.
- I recommend an fPLI, TLI, cobalamin and folate to get more information on the small intestine and pancreas.

If there is no evidence of septic peritonitis based on radiographs and fluid analysis then I recommend aggressive therapy for pancreatitis.

I recommend close monitoring. If the patient is not improving consider exploratory to lavage the abdomen, take samples and look for evidence of foreign material.

I recommend three view thoracic radiographs.

Prognosis is guarded. There is concern for metastatic neoplasia in this young cat.



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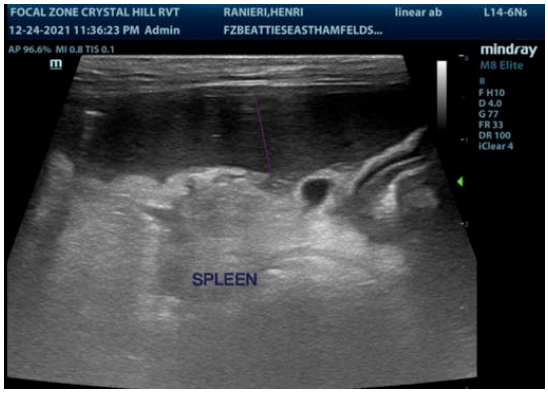

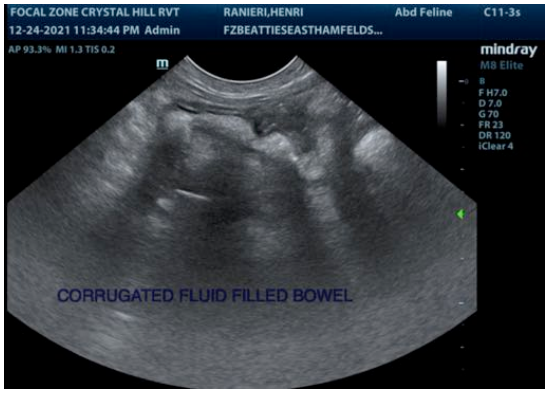

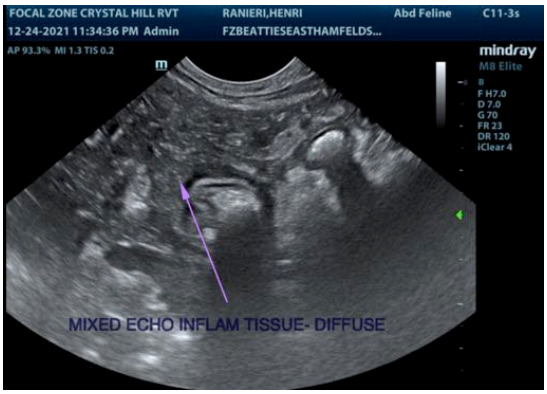

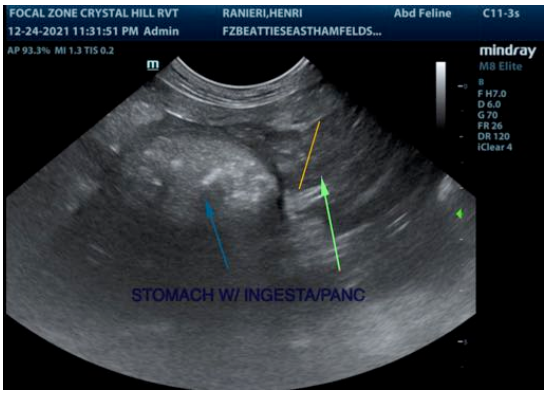

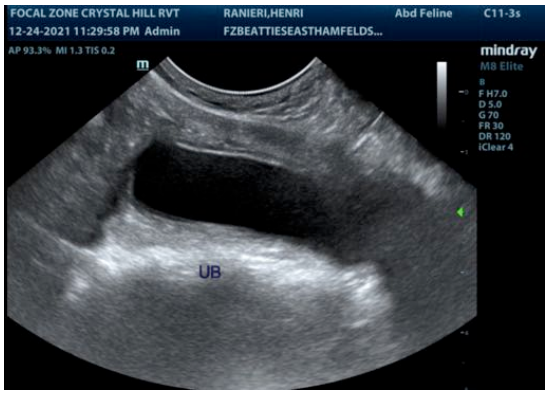

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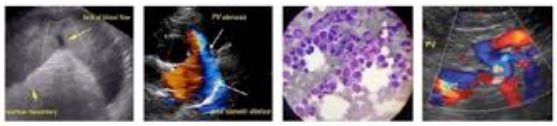

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289-808-2608 info@thefocalzone.com

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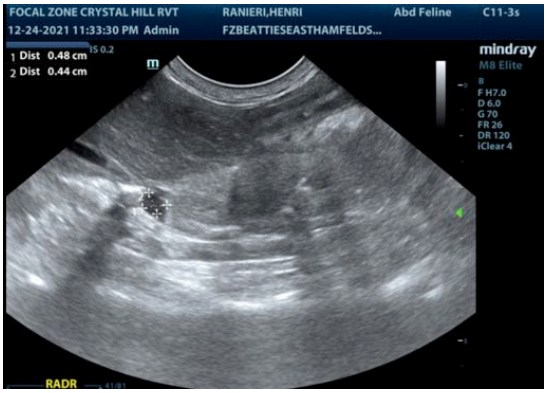

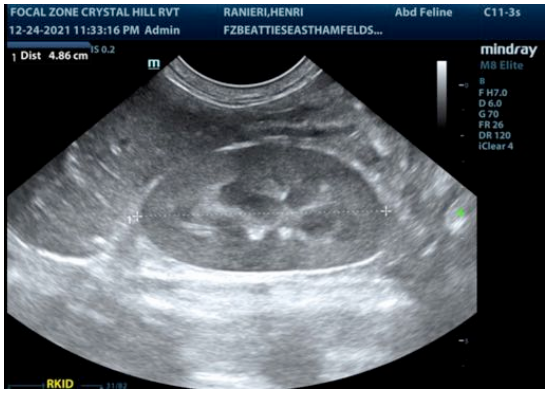

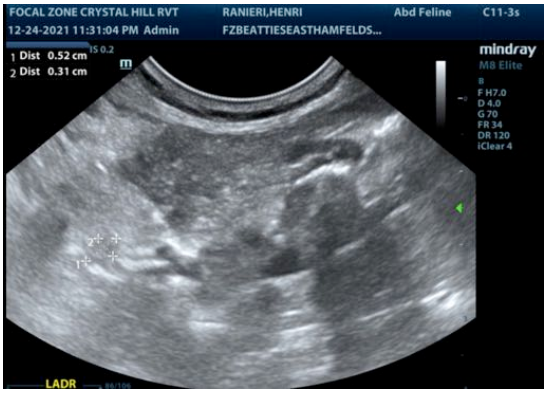

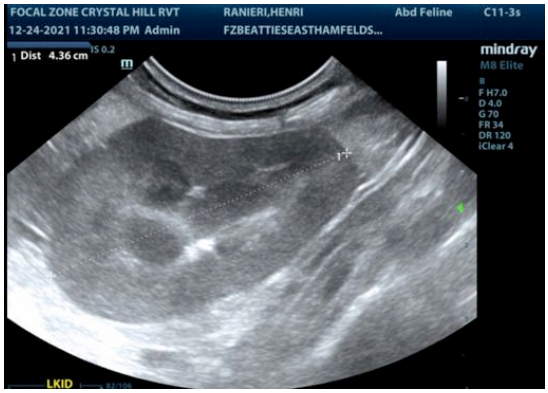

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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