



**PATIENT**

Minga Gawlas

**SPECIES**

Feline

**BREED**

Siamese X

**SEX**

Spayed Female

**AGE**

10.5 Years

**WEIGHT**

8 Pounds

**INTERPRETED BY**

Lisa Carioto, DVM,  
DVSc, Diplomate  
ACVIM

**IMAGING PERFORMED BY**

Dr. Meghan Myers

**HOSPITAL NAME**

Hershire AH

**REFERRING VET**

Dr. Meghan Myers

**INVOICE**

37708

**DATE**

5/17/22

**PRESENTING CLINICAL SIGNS**

Pet is on chemotherapy (carboplatin) overseen by oncologist for Merkel cell carcinoma. Anorexia for last 7 days, lethargic, - cbc at that time showed neutropenia - started on clavamox, sq fluids, cerenia and mirtazipine. Not much improvement. Returned Monday- cbc normal (neutropenia resolved), chest rads normal (onco recc'd looking for mets), continued supportive - hospitalized during daytime hours on iv fluids, continued cerenia, added elura, returned today- chemistry panel showed increased alt, alpk, ggt, t.bili, pet is jaundice, only eating bites of food at this time. Plan is to transfer to 24 hour er for fluids and treatment based on ultrasound findings.

Abnormal PE/Chem/CBC/UA Results: ALT 413, ALP 815, GGT 19, Tbili 4.7 lipase normal (did not run pli snap test yet)

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is well distended with anechoic contents. The wall is smooth and regular. No abnormalities are noted with the trigone or proximal urethra, and there is no evidence of sediment, cystoliths, polyps or a mass.

**Kidneys**

The **left** kidney measures 2.90 cm (3.80-4.40 cm). The shape is mildly rounded, however, the capsule is smooth. A mild loss of the normal definition of the cortico-medullary junction is present.

Mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. An accumulation of intrapelvic fat is noted. The surrounding mesentery is mildly hyperechoic.

The **right** kidney measures approximately 2.90 cm (3.80-4.40 cm), i.e. gas is affecting the ability to obtain a precise measurement. Findings are similar to the left kidney.

**Aortic bifurcation/trifurcation**

No abnormalities observed.

**Adrenal Glands**

The **left** adrenal gland measures 0.29 cm in diameter. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

The **right** adrenal gland is not visualized due to gas in the surrounding GI tract.

**Spleen**

Mild splenomegaly at 11.7 mm (normal = 10 mm). It appears mildly "swollen". No abnormalities are observed with its overall echotexture, echogenicity or vasculature, i.e. congestion and thrombi are not identified. The capsule is smooth. Surrounding mesentery is mildly hyperechoic.

**Liver**

Mild to moderate hepatomegaly is suspected. The liver's borders are smooth, but mildly rounded, and scalloping of the liver lobes is observed. A diffuse, mildly coarse or granular echotexture is observed, with occasional hypoechoic ill-defined nodules. The liver is diffusely hyperechoic i.e. it is isoechoic to the spleen, however it is hypoechoic to the surrounding mesentery. The mesentery medial to the liver is severely hyperechoic. A trivial amount of anechoic fluid is visualized amongst the liver lobes. No obvious abnormalities are noted with the hepatic vessels.



<b>PATIENT</b>	
Minga Gawlas	The gallbladder wall is thicker than usual (2.5 mm) and hyperechoic. A small amount of echogenic material is present within the GB. A trivial amount of anechoic fluid is visualized lateral to the gallbladder. The cystic duct is mildly dilated and tortuous, however, there are no signs of an obstruction.
<b>SPECIES</b>	<b>Gastrointestinal</b>
Feline	Gas and a small amount of fluid are present within the lumen of the stomach. The gastric wall is within normal limits in thickness and the wall layers are well defined. No obvious abnormalities are observed with its peristalsis.
<b>BREED</b>	
Siamese X	The duodenum is within normal limits in thickness and the definition of wall layers is preserved.  The small intestinal wall thickness, including the duodenum, is within normal limits and the definition of the wall layers is preserved. No abnormalities are observed with the ileocecal colic junction. Abnormally dilated loops of bowel are not observed.
<b>SEX</b>	
Spayed Female	Gas is present within the transverse colon.  The colonic wall is not thickened and mural detail is considered normal.
<b>AGE</b>	
10.5 Years	<b>Pancreas</b>  No overt abnormalities are observed with the echogenicity or echotexture of the left or right limbs. The mesentery surrounding the pancreas is hyperechoic, however, it is hyperechoic throughout the entire abdomen.
<b>WEIGHT</b>	
8 Pounds	<b>Other</b>
<b>INTERPRETED BY</b>	<b>Lymph nodes (LNs)</b>
Lisa Carioto, DVM, DVSc, Diplomate ACVIM	Mildly enlarged, hypoechoic sublumbar LN lymph node, 7.5 mm in diameter x 7.9 mm in length. The mesentery surrounding the lymph node is mildly hyperechoic.
<b>IMAGING PERFORMED BY</b>	<b>Abdominal effusion</b>
Dr. Meghan Myers	A trivial amount of anechoic fluid is visualized lateral to the gallbladder.
<b>HOSPITAL NAME</b>	<b>Mesentery</b>
Hershire AH	The mesentery is moderately to markedly hyperechoic throughout the abdomen.
<b>REFERRING VET</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
Dr. Meghan Myers	<ul style="list-style-type: none"> <li>• Splenomegaly possibly due to splenitis, including immune-mediated induced inflammation. However, neoplasia, cannot be excluded.</li> <li>• Differential diagnoses for the hepatomegaly and diffuse hyperechogenicity, in conjunction with the gallbladder changes include, cholestasis, cholangitis/cholangiohepatitis and cholecystitis. Suppurative forms of the latter diseases are likely. Hepatic lipidosis is also likely present. Neoplastic infiltration cannot be excluded, however, target lesions are not visualized. Note, hepatotoxicity secondary to medications is possible, including the administration to carprorelin (Elura).</li> <li>• The renal changes may be secondary to age-related degeneration, however, pyelonephritis cannot be excluded.</li> <li>• Steatitis and ascites may be due to diffuse inflammation and vasculitis.</li> </ul>
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- Mild lymphadenomegaly of the sublumbar lymph node is noted, however, no other lymph nodes are enlarged. Reactive hyperplasia remains a possible cause of the mild lymphadenomegaly, i.e. neoplastic infiltration is not the only possibility.

**SPECIES**

Feline

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

A spec fPL may be considered to exclude pancreatitis, i.e. the absence of sonographic abnormalities does not exclude a diagnosis of pancreatitis.

**BREED**

Siamese X

Intravenous fluids, analgesics, antibiotics and other supportive therapy are recommended. vitamin K (0.5 mg/kg SQ q8-12h for 1-3 doses) for treatment of cholestasis.

**SEX**

Spayed Female

A nasogastric tube and "trickle feeding" may be considered to help support Minga.

**AGE**

10.5 Years

Although not ideal, cefovecin (Convenia) may be tried, i.e., avoids GI tract. Discussion with the client that this is not necessarily an ideal drug. If improvement observed, at least 2 additional doses 10-12 days apart recommended.

**WEIGHT**

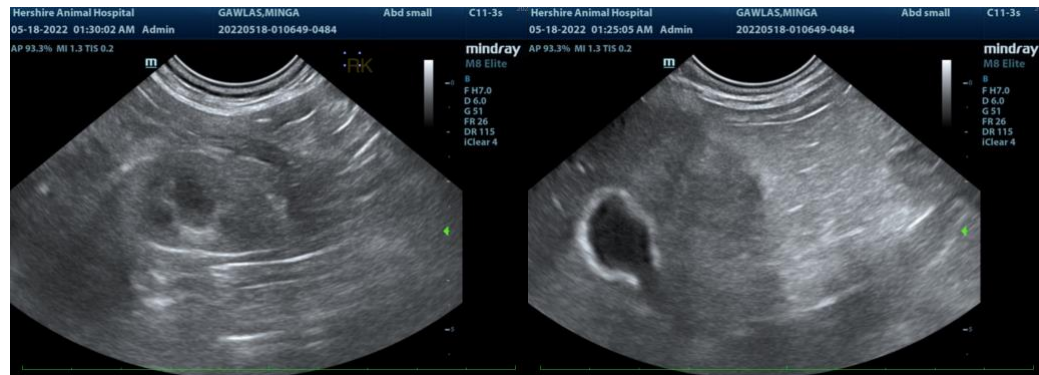
8 Pounds

A low dose of steroids (prednisolone 0.25-0.5 mg/kg/day or dexamethasone 0.03-0.05 mg/kg/day) may be necessary to decrease inflammation.

Fine needle aspirates of the spleen, liver and sublumbar lymph nodes may be considered. Performing a coagulation profile prior to the final aspirates would be prudent but is not a necessity. Administration of vitamin K (0.5 mg/kg SQ q8-12h for 1-3 doses) is strongly recommended even if the results of the PT/PTT are within normal limits.

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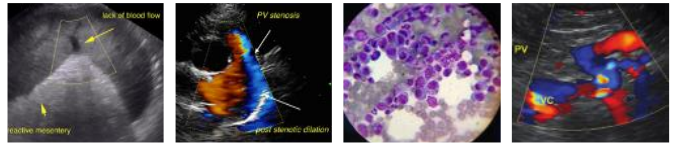
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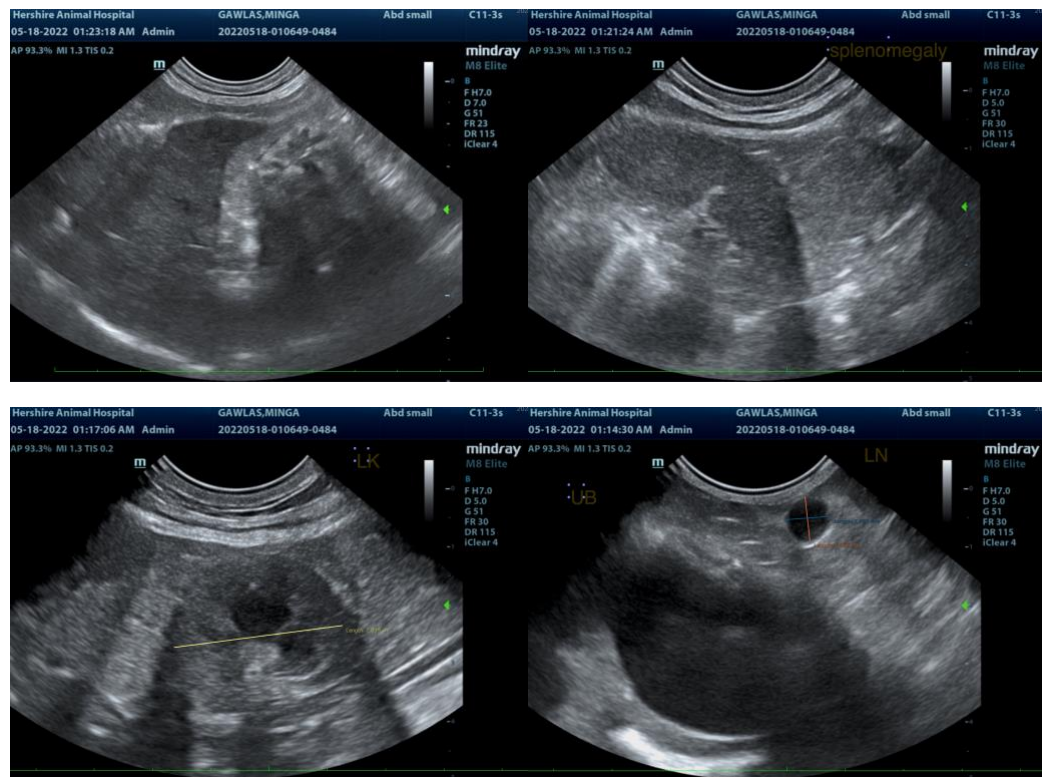
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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