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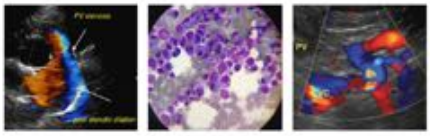

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PATIENT
Clyde Pohl

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
15 years

WEIGHT
6 lbs

INTERPRETED BY
Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY
Sarah Pender CVT

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Dr. Glispie

INVOICE
31621

DATE
7/11/22

PRESENTING CLINICAL SIGNS

Was seen 7/7 for vomiting, losing weight, lack of appetite, had loose stool once. Hx of urinary blockage Abnormal PE/Chem/CBC/UA Results: SDMA-28 ALT-332 ALKP-334 GGT-9 TbiI-2.8 Na-166 RBC-6.15 Mono-0.93 PLT-55 PCT-0.09

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is well distended. The wall is smooth and regular. No abnormalities are present with the trigone or proximal urethra. A small to moderate amount of free floating and gravity dependent sediment is present, in addition to possible mucus strands. There is no evidence of cystoliths, polyps or a mass.

Kidneys

The **left** kidney measures 3.52 cm (3.80-4.40 cm). The capsule is mildly irregular. The cortex is hyperechoic and a moderate loss of the normal definition of the cortico-medullary junction is present. Mineralizations of the pelvis are noted. There are no signs of nephroliths or clinically significant pyelectasia (0.93 mm). An accumulation of intrapelvic fat is noted. The kidney is surrounded by a moderate to marked amount of anechoic effusion.

The **right** kidney measures 3.58 cm (3.80-4.40 cm). The capsule is deformed by a depression at the antimesenteric border. A large triangular shaped, hyperechoic, cortical lesion is observed where the capsule is deformed. This is in addition to diffuse hyperechogenicity of the cortex. A moderate to loss of the normal definition of the cortico-medullary junction is present. Mineralizations of the pelvis are observed, without signs of nephroliths or pyelectasia. The kidney is surrounded by a marked amount of anechoic effusion. An infarct and subsequent fibrosis of the capsule is suspected.

Adrenal Glands

The adrenal glands are not visualized due to the large amount of ascites present.

Spleen

Mild splenomegaly 13.3 mm (normal = 10 mm). The spleen is within normal limits in echotexture, and echogenicity. The capsule is smooth. Occasional pinpoint hyperechoic foci are scattered haphazardly throughout the parenchyma. They are most consistent with mineralizations, and not considered clinically significant. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

Liver

Hepatomegaly is suspected, however, the size and echogenicity of the liver are difficult to evaluate due to the severe amount of ascites present, i.e., the lobes are separated by the ascites, however, they appear "swollen" and liver lobes extend past a depth of 4 cm. The borders are smooth, but vary between sharp to mildly rounded. Its echotexture is homogeneous. A number of pinpoint hyperechoic foci are scattered haphazardly throughout the parenchyma. They are most consistent with mineralizations, and not considered clinically significant. Occasional anechoic to hypoechoic nodules are noted in the liver parenchyma, for example 3.3 mm x 3.5 mm. Hepatic vessels are not easily evaluated due to ascites.

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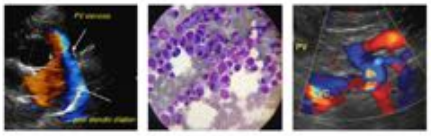

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The gallbladder (GB) is moderately distended. The wall is mildly thickened at 1.3 mm. It is also mildly hyperechoic. The latter may be due to inflammation, as well as ascites. A small to moderate amount of echogenic material is present within the GB. The cystic and/or common bile ducts are not visualized, however, there are no obvious signs of an obstruction.

Gastrointestinal

A small amount of fluid is present within the lumen of the stomach. The gastric wall is within normal limits in thickness and the wall layers are well defined despite the history of vomiting. No obvious abnormalities are observed with its peristalsis.

The duodenum is mildly thickened and fogging of the mucosa is present.

Small intestinal wall thickness is increased diffusely (0.34 cm – 0.38 cm). Fogging of the mucosa is present, and the submucosa is more prominent than usual. The serosa is also prominent, however, this is attributed to the ascites. Fluid and gas are present within the lumen of the jejunum. The submucosa of the jejunum is prominent in the mid-abdomen, where the enlarged lymph node is noted.

The colonic wall is not thickened and mural detail is considered normal.

Pancreas

The pancreas is heterogeneous with hypoechoic nodules of variable size. It is hypoechoic with signs of edema as well as a "hazy" appearance. A well-defined mass is not visualized.

Other

Lymph nodes

Multiple lymph nodes are mildly to moderately enlarged.

Mesenteric lymph node, measuring 0.54 cm in diameter x 2.22 cm in length, is noted amongst the gastrointestinal tract and mesentery.

Two round, enlarged lymph nodes, with smooth borders, are present mid-abdomen amongst the jejunum and mesentery. The larger of the two measures 1.02 cm in diameter x 1.31 cm in length.

Abdominal effusion

A marked amount of anechoic effusion is present throughout the abdomen. Fibrin is also observed floating within the effusion. The effusion in the right cranial quadrant is cellular or high in protein based on the free floating echogenic material noted in the ascites.

Mesentery

Small, well-defined, hypoechoic nodules are noted throughout the mesentery.

ULTRASONOGRAPHIC FINDINGS

- **Liver**: Cholestasis, cholangitis/cholangiohepatitis and secondary hepatic lipidosis are suspected. Suppurative cholecystitis cannot be excluded based on the appearance of the gallbladder and blood work results. Neoplasia, such as lymphoma, or other round cell tumour, cannot be excluded.

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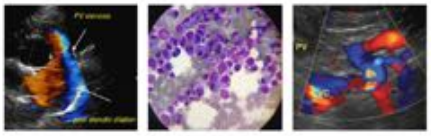

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- **Gallbladder**: Cholecystitis may be present, including a suppurative form. Obvious signs of an obstruction are not appreciated.
- **Gastrointestinal tract**: Changes are non-specific and somewhat subjective (i.e. mucosal fogging). Although there is no loss of definition of the wall layers, neoplasia, such as lymphoma or other round cell tumour, must be considered. However, a chronic enteropathy, such as inflammatory bowel disease, cannot be excluded. Biopsies and additional immunodiagnostic tests are often required to differentiate the two diseases.
- **Spleen**: Splenomegaly without concomitant parenchymal changes may occur due to splenitis, reactive hypersplenism and extramedullary hematopoiesis. Infiltrative disease, such as lymphoma or other round cell tumour, may also be present.
- **Pancreas**: Active pancreatitis cannot be excluded.
- **Lymph nodes**: Although the lymphadenomegaly is mild and is likely due to reactive hyperplasia, infiltration with neoplastic cells must also be considered.
- **Mesentery**: Diffusely hyperechoic mesentery, likely a result of the severe ascites, however, a diffuse intra-abdominal inflammatory process (pancreatitis, cholangitis/cholangiohepatitis, pancreatitis, etc.) may be contributing to the changes observed.
- **Ascites**: Differential diagnoses include extravasation/increased permeability, vasculitis, carcinomatosis, lymphomatosis, as well as lymphatic obstruction. The latter is not evident intra-abdominally, however, an intrathoracic cause is possible.
- **Kidneys**: Bilateral age-related degenerative changes, in addition to previous infarcts and fibrosis, particularly of the right kidney.
- **Urinary bladder**: The *free floating sediment* within the lumen of the urinary bladder is most likely composed of mucus, crystalline material and exfoliated cells. The debris is likely clinically insignificant.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following are suggested/recommended

Repeat the platelet count in a citrate tube and evaluate a blood smear to confirm the severity of thrombocytopenia.

Hospitalization would be ideal for intravenous fluids and administration of analgesics

If not possible, subcutaneous fluids and analgesia (buprenorphine 0.005-0.01 mg/kg q8-12 hours sublingually)

vitamin K (0.5 mg/kg SQ for one dose, i.e., cholestasis likely

Ultrasound-guided fine needle aspirates (FNA) of the liver, spleen and ascitic fluid would normally be recommended to obtain a definitive diagnosis, however, this will depend on whether the

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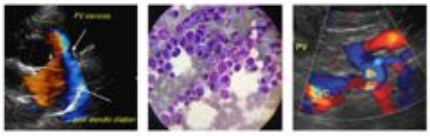

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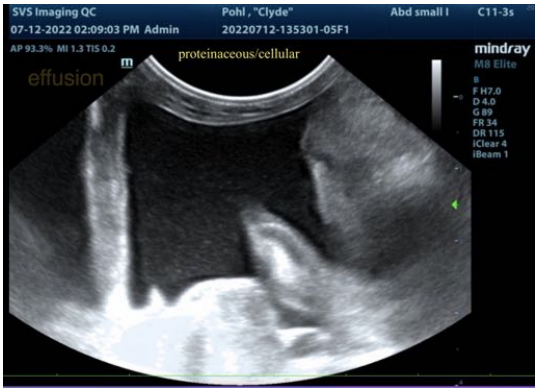
thrombocytopenia is confirmed. There is a risk of hemorrhage with a platelet count less than 30-50 x 10^9/L.

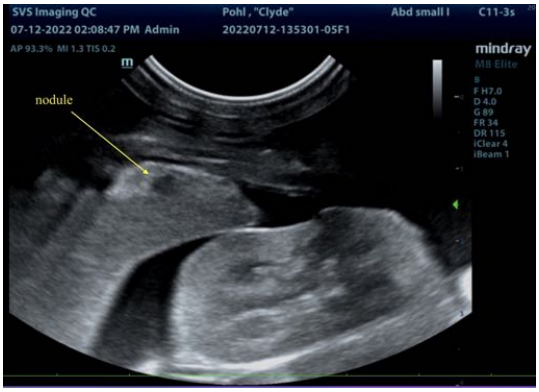
Coagulation profile if FNA are pursued, with administration of vitamin K, even if results are within the normal reference range.

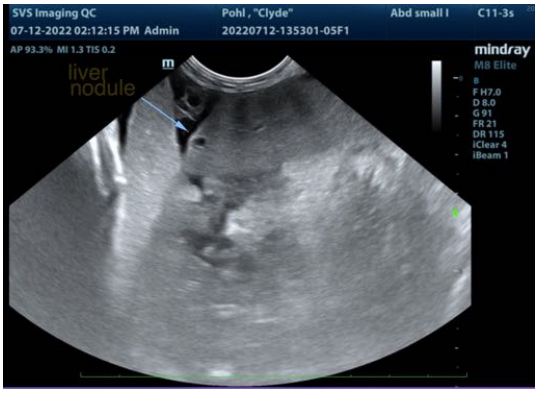
Empirical therapy may be tried if clients do not want to pursue further diagnostics, for example, an initial dose of dexamethasone SQ or IV may be administered, followed by oral dexamethasone or prednisolone.

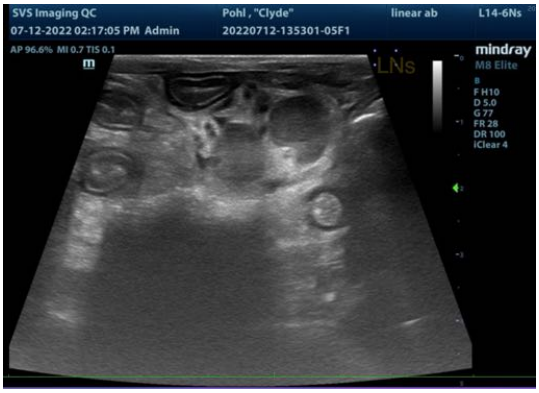
If prednisolone is used, 1-2 mg/kg/day once a day for 14 days, then tapered to minimum effective dose.

If no improvement with steroids, differential diagnoses include cholangitis/cholangiohepatitis, cholecystitis, and secondary ascending bacterial infections. Although indiscriminate use of antibiotics is not recommended, once could consider broad-spectrum antibiotic.









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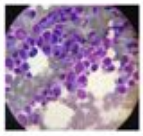


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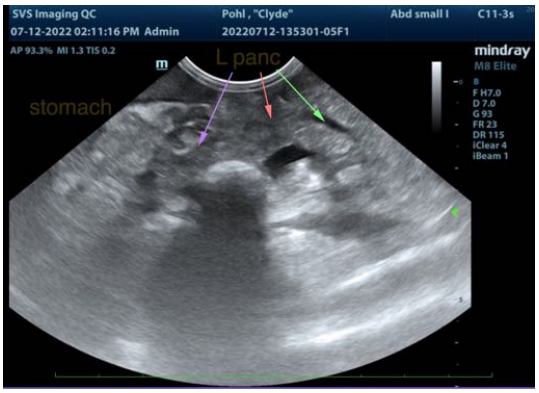

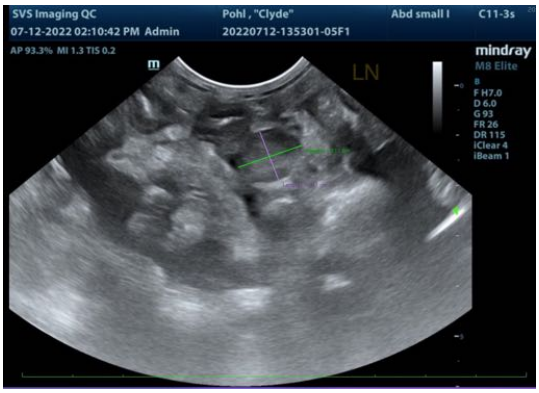

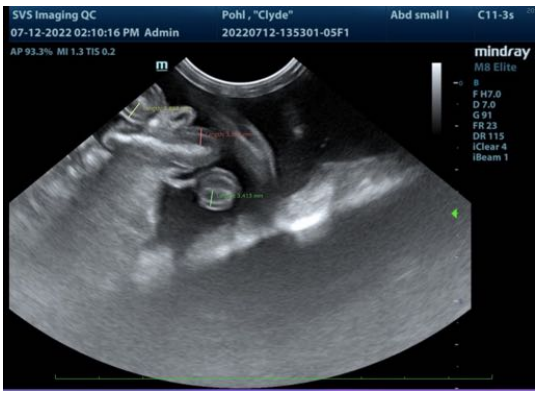

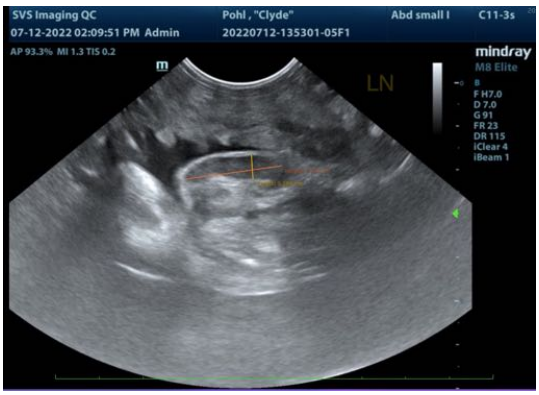

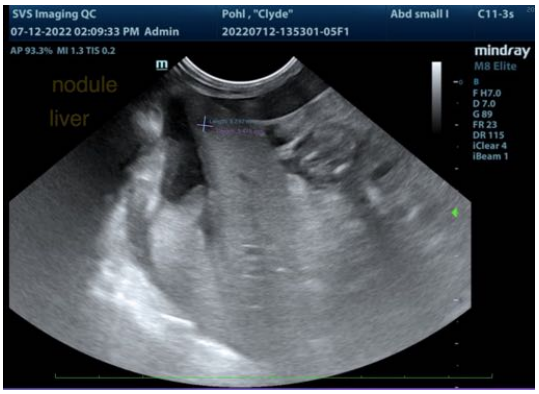

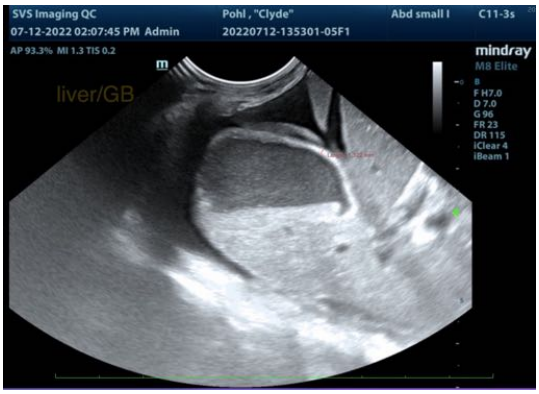

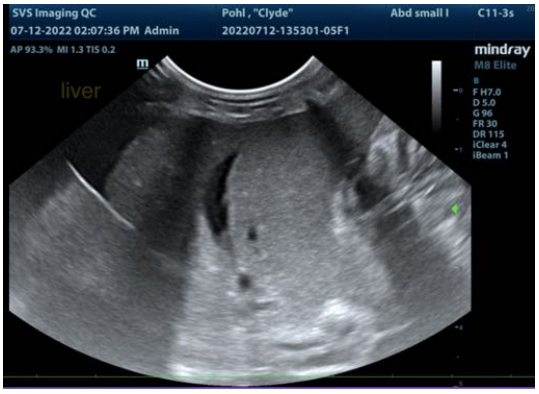

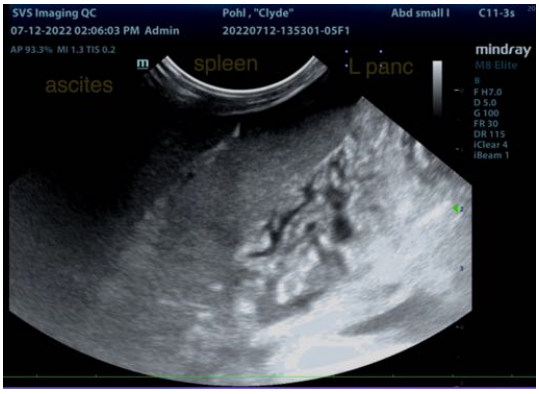

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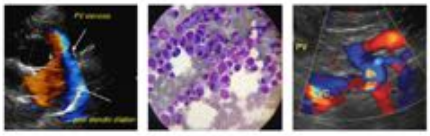

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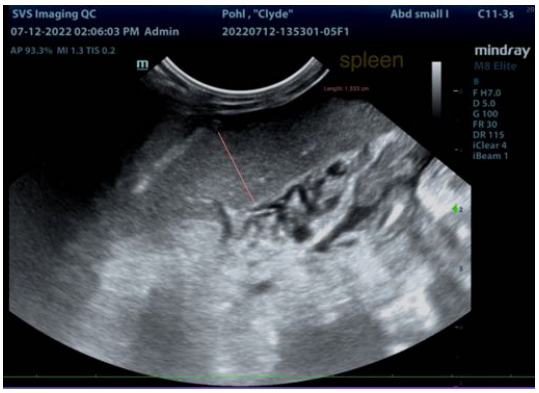

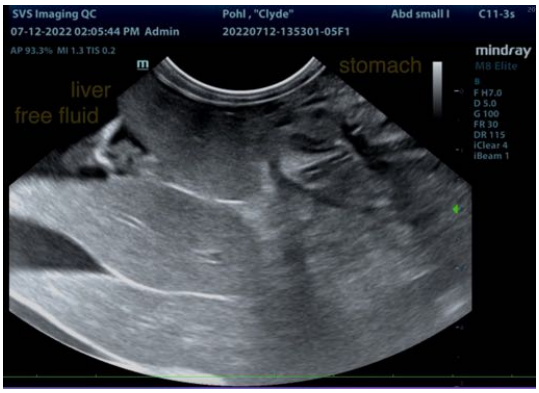

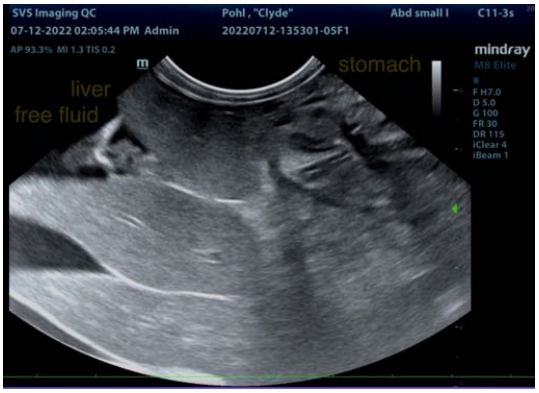

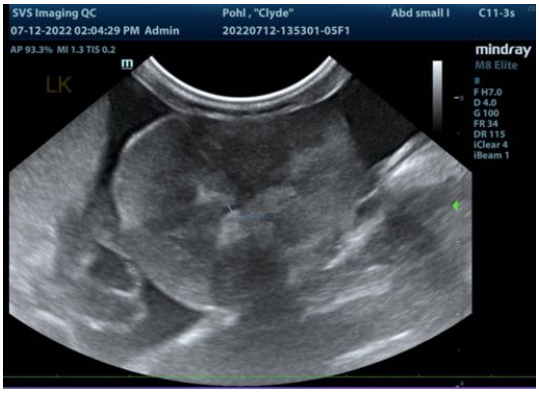

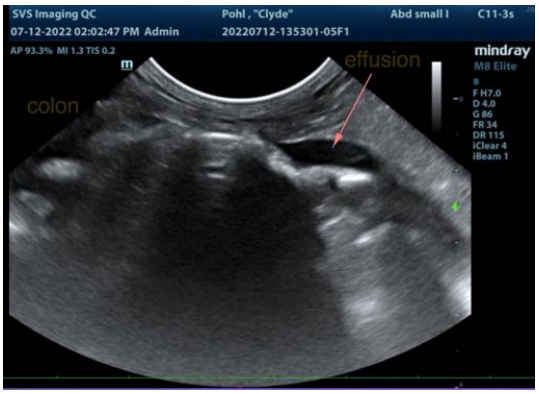

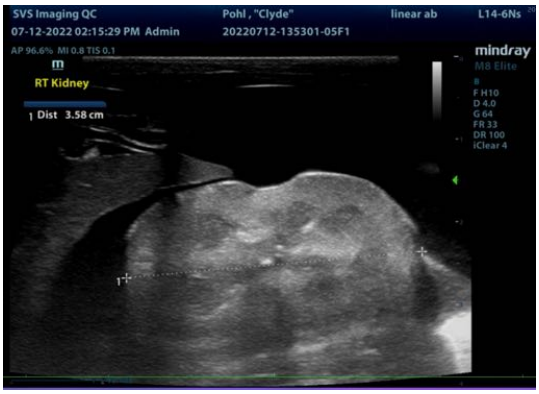

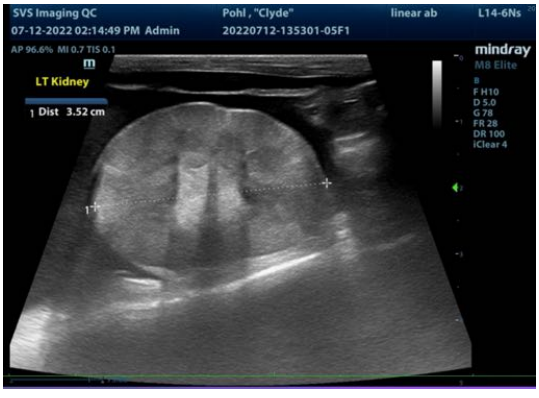

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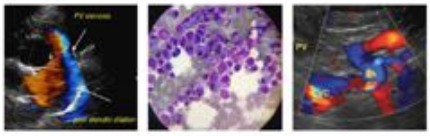

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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