



**PATIENT**

Hank Baldic

**SPECIES**

Feline

**BREED**

DSH

**SEX**

MN

**AGE**

15 months

**WEIGHT**

13.2 lbs.

**INTERPRETED BY**

R. McKenzie Daniel, DVM,  
DABVP (Canine and  
Feline)

**IMAGING  
PERFORMED BY**

Pamela Harrigan, RDCS

**HOSPITAL NAME**

Falmouth AH

**REFERRING VET**

Lilan Hauser, DVM

**INVOICE**

13021

**DATE**

1/10/22

**PRESENTING CLINICAL SIGNS**

New patient presents with lethargy, tachycardia, thin body. Normal temperature, hypotensive (systolic 43, 43, 50 mmHg). HR 180 bpm. CBC - HCT 22% TP 11.2; T globulin 8.4; WBC 24K. Urine is brown. Grade III/VI systolic murmur; abnormal proBNP (quick echo showed HOCM vs mitral valve dysplasia with outflow obstruction). ? FIP or other cause of increased protein, anemia. FNA taken of lymph nodes at time of ultrasound exam

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild, primarily nondependent, particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the aortic trifurcation was free of pathology.

The bilateral kidneys were mild enlarged in size with asymmetrical margination. Subtle cortical hypertrophy exhibiting nonuniform cortex echogenicity with similar medullary echogenicity and loss of corticomedullary border demarcation were present. Evidence of retroperitoneal inflammation and potential effusion around both kidneys was evident. The left kidney measured 4.6 cm in length. The right kidney measured 4.7 cm in length.

**Adrenal Glands**

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.40 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.40 cm width.

**Spleen**

The spleen exhibited mild prominent size yet not overtly enlarged, measuring 0.90 cm width at the level of the hilus. Medial folding of the caudal spleen was present.

**Liver/ Gallbladder**

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild echogenic, nonmineralized biliary sludge. The gallbladder was otherwise normal. The cystic duct and common bile ducts were normal without evidence of dilation.

Transdiaphragmatic view revealed a mild comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation.



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***Gastrointestinal***

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The visualized gastric walls were sonographically unremarkable. The lumen of the stomach contained moderate, retained, ingesta exhibiting progressive acoustic shadowing. The ventral gastric body wall width measured 0.22 cm.

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The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A segmental to diffuse ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present without obstruction or foreign material. The jejunum wall width measured 0.26 cm. The ileocolic wall width measured 0.35 cm. The duodenum wall width measured 0.2 cm.

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The colon walls presented intact yet mildly prominent wall layering with mild thickened to echogenic submucosa. Nonformed to liquid fecal matter was present in the colon lumen with lumen dilation. The descending colon wall width measured 0.25 cm.

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***Pancreas***

The pancreas was mildly prominent in size with mildly swollen contour and hypoechoic parenchyma compared to the adjacent echogenic peripancreatic omentum.

***Free Abdomen***

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Midabdominal mesenteric lymph nodes were present. The lymph nodes exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). The enlarged lymph nodes were bordered by echogenic to reactive mesentery. An example of a lymph node measured 1.76 cm in diameter. Generalized reactive mesentery along with mild volume peritoneal to retroperitoneal free fluid was present.

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**ULTRASONOGRAPHIC FINDINGS**

***Primary Findings***

- Mild urinary bladder sediment - cellular or crystalline debris or potential mucus
- Bilateral mild renomegaly exhibiting indistinct corticomedullary demarcation
- Mesenteric lymphadenopathy - reactive / inflammatory, granulomatous or neoplastic lymphadenopathy possible
- Prominent spleen with folding
- Mild enterocolitis pattern
- Hypoechoic to prominent pancreas - potential for reactive pancreatic changes or mild pancreatitis
- Generalized reactive to echogenic mesentery and small volume peritoneal to retroperitoneal free fluid
- Mild transdiaphragmatic comet tail artifact

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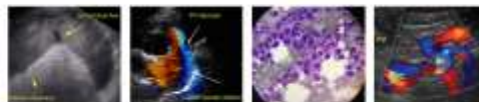
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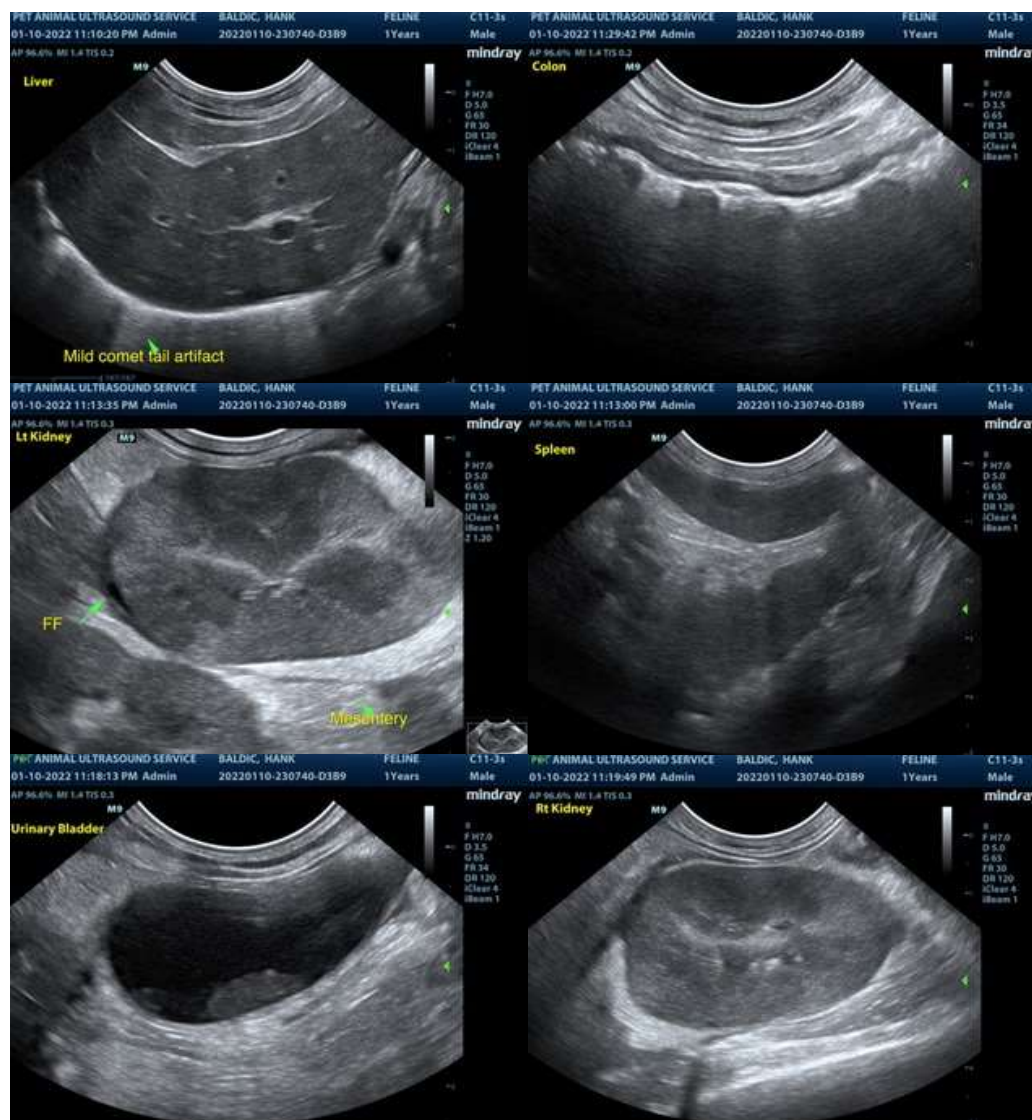
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Primary considerations in this case are significant intraabdominal nonspecific inflammatory disease, FIP, or potential round cell neoplasia such as lymphoma. Pending lymphatic cytology, additional sampling of renal cortex +/- spleen, assuming normal clotting status and using a 25-gauge needle, could be considered. Protein electrophoresis for further assessment of hyperglobulinemia may be considered.

Three view chest radiographs are recommended if not done. Urine culture and sensitivity on a sterile urine sample and CBC pathology review may be considered.





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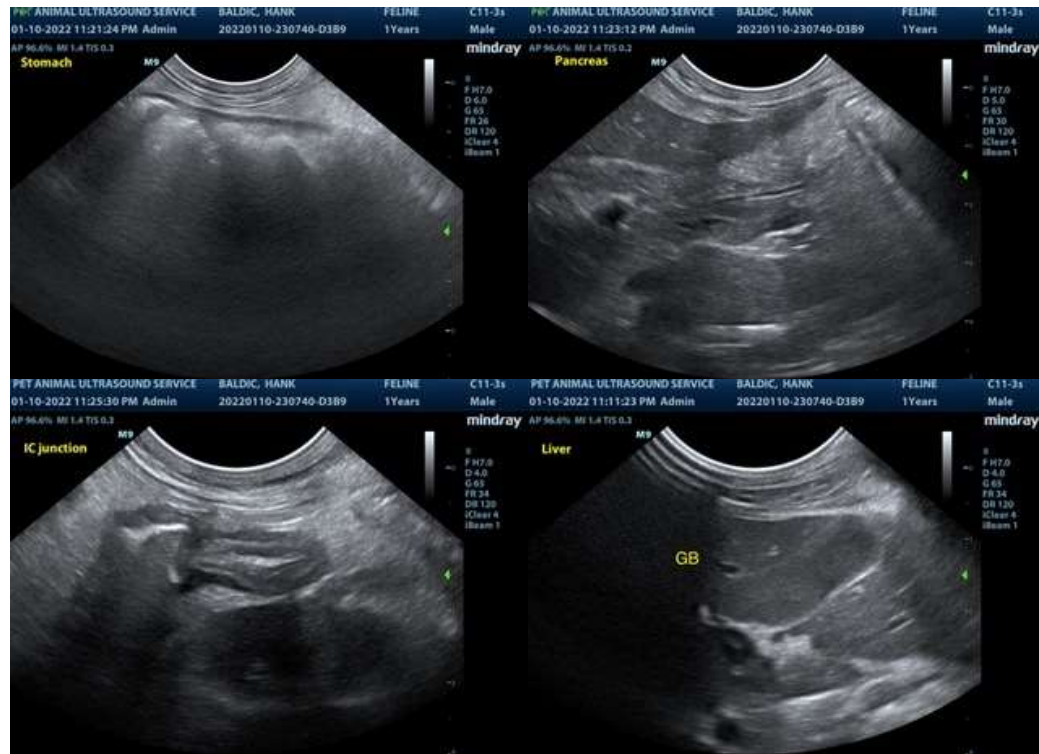
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)  
 info@SonoPath.com