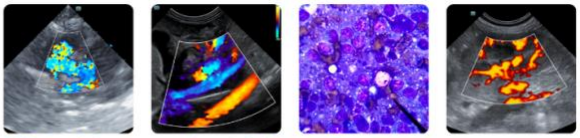

PATIENT

Slade Bargo

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years 6 Months

WEIGHT

11 pounds

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Farview Animal Clinic

REFERRING VET

Dr. Mosaad

INVOICE

13544

DATE

02/03/26

PRESENTING CLINICAL SIGNS

- Decr. appetite, pale mm, fluid wave in abd. neur signs when eating. Rads show loss of detail cranial abd.

Abnormal PE/Chem/CBC/UA Results: RBc-5.89 HGB-8.6 HCt-28.64 PLT-41 RDW-24.7 Amy-1944 TP-9.2 Glob-6.5

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Loss of corticomedullary distinction was also present. The left kidney measured 4.2 cm in length. The right kidney measured 4.2 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized with no obvious pathology.

Spleen

The spleen presented mildly enlarged with mild asymmetrical medial capsule contour and mild heterogeneous parenchyma. No mass or nodules were evident. The spleen measured 1.2 cm width level of the mid spleen.

Liver & Gallbladder

The liver was subjectively mildly enlarged. 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 thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented borderline to mild thickened wall with maintained 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The small intestine wall measured 0.27 cm wall width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

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The left pancreatic limb presented mildly prominent in size with mild asymmetrical capsule contour and mild nonhomogenous hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

Generalized mild nonhomogenous hyperechoic omentum and mild volume of mildly echogenic peritoneal effusion was present. No visualized significant omental lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mild asymmetrical splenomegaly.
- Mild non-congested hepatomegaly.
- Intact mildly thickened small intestine wall.
- Mildly prominent nonhomogenous hypoechoic left pancreas.
- Generalized nonhomogenous hyperechoic omentum and mild volume echogenic peritoneal effusion.

Secondary Findings

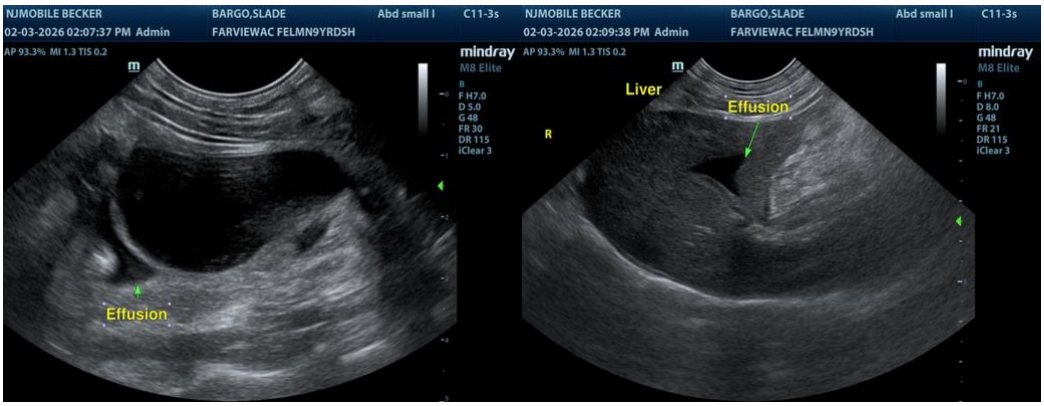
- Bilateral chronic renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given no reported subnormal albumin levels or evidence of hepatic congestion, considerations for the effusion may include nonspecific peritonitis, FIP, or neoplastic effusion such as carcinomatosis, lymphomatosis, or similar. Chronic to chronic active pancreatitis pattern is possible yet did not overtly meet significant active pancreatitis criteria as a definitive cause of the peritonitis. Underlying enteropathy likewise is possible yet no evidence of significant gastrointestinal mural pathology.

Further assessment may include abdominal effusion analysis, cytology +/- culture and sensitivity if evidence of inflammatory component or FIP titers/PCR. If concern for FIP, screening hepatosplenic FNA cytology using a 25-gauge needle, and if normal clotting status, three view chest radiographs and albumin globulin ratio.

FIP or neoplasia, given clinical presentation in conjunction with abdominal effusion, are primary considerations.



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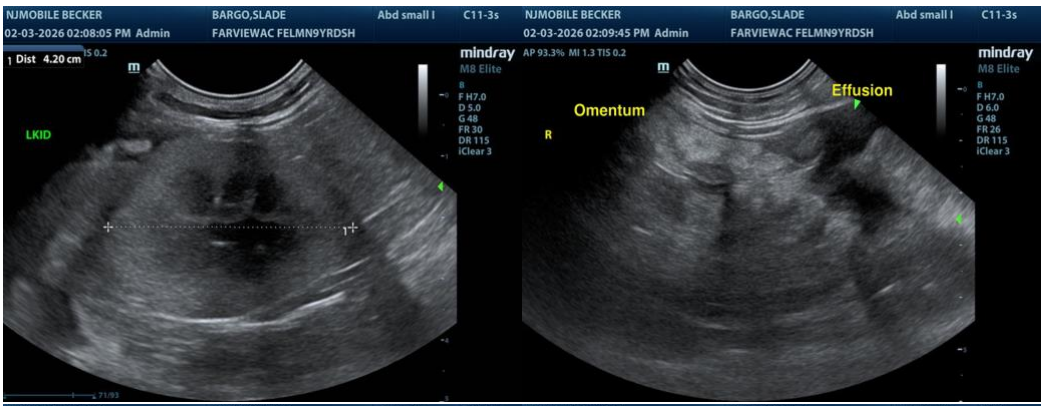

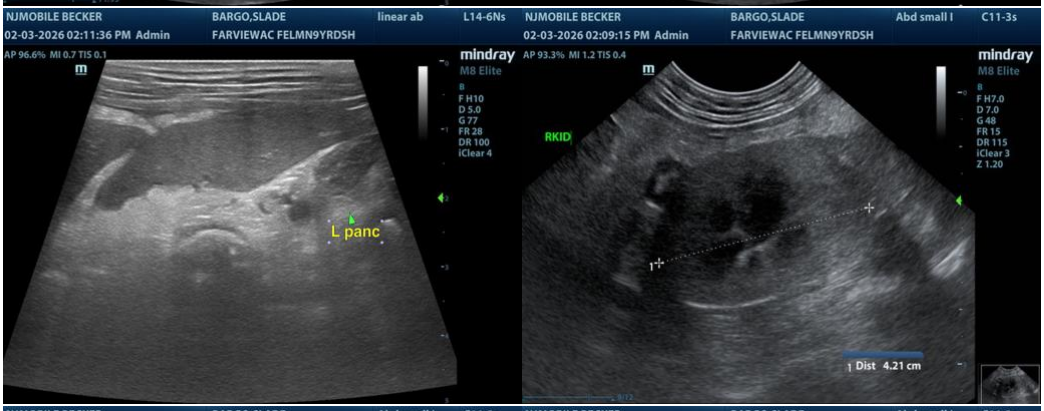

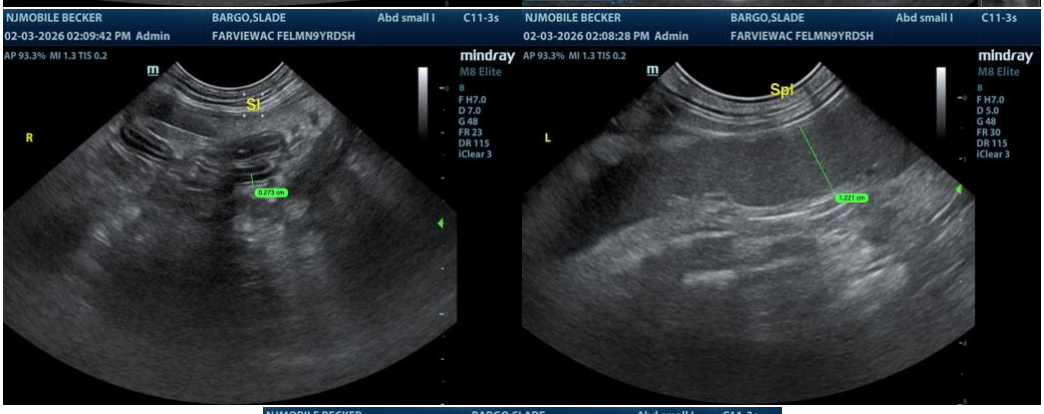

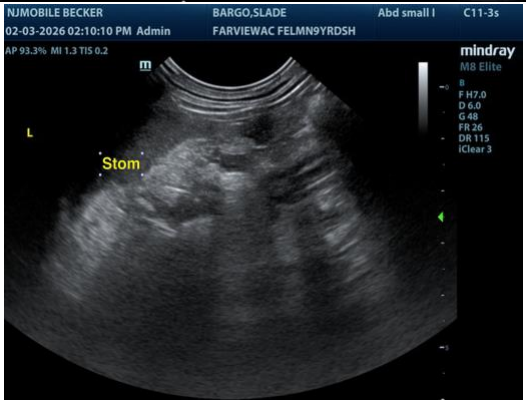

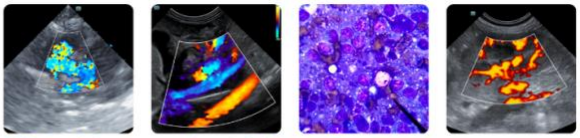

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com