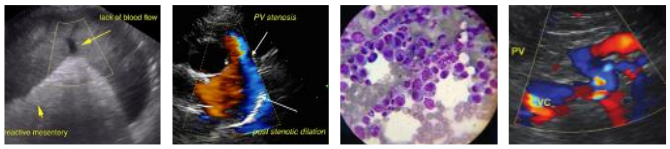
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Smokey Rosario

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

10yr

WEIGHT

5lb 7oz

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Suciu

HOSPITAL NAME

Animal Clinic of Queens

REFERRING VET

Dr. Suciu

INVOICE

13470ag

DATE

04/14/2023

PRESENTING CLINICAL SIGNS

Smokey vomited several times in the last two days (clear liquid), the last episode was 2 days ago after she drank water and some tuna juice. She stopped eating five days ago, there was no change in the diet (Royal Canin SO for history of urinary crystals). Her energy level is low, she lost weight.

Abnormal PE/Chem/CBC/UA Results: CBC: normal WBC, RBC, hemoglobin, and hematocrit (27.4%) low platelets (76) – R/O clumping vs true thrombocytopenia CHEM: normal BUN (18), low creatinine (0.5) – R/O low body mass low Ca (7.8) high globulin (6.1) – R/O infection vs inflammation vs neoplasia high glucose (159) – R/O stress high total bilirubin (1.9) – R/O hepatobiliary vs hemolysis high ALP 108 (0-90) – R/O hepatobiliary vs open EPOC: low Na (140), low Cl (105) – R/O secondary to vomiting low potassium (3.2) low ionized calcium (1.03) low hematocrit 27% (28-50%) mild stress hyperglycemia (142)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.8 cm in length. The right kidney measured 3.9 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The bilateral adrenal glands were overtly normal in size, position and shape. The left adrenal gland measured 0.50 cm width. The right adrenal gland measured 0.51 cm width.

Spleen

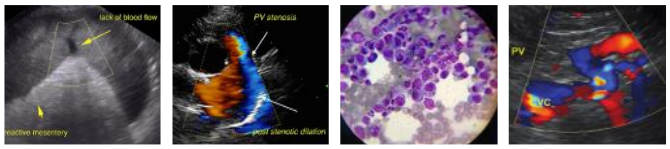
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.75 cm in width at the level of the hilus.

Liver/Gallbladder

The liver exhibited generalized enlargement and symmetrical capsule contour. Mild non-uniform hypoechoic hepatic parenchyma was present. Possible subtle congested hepatic vasculature with subjective mildly prominent cranial abdominal caudal vena cava was present. No evidence of caudal vena cava thrombus. The caudal vena cava measured 0.6 cm in width at the level of the hilus.

The gallbladder was subnormal in size with thin walls and primarily anechoic luminal content with minor echogenic non-organized debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. The common bile duct was not definitively visualized.

Gastrointestinal



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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate retained primarily anechoic fluid and luminal gas with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The jejunum wall measured 0.21 cm width. The ileocolic wall measured 0.32 cm width.

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

Pancreas

The pancreas base and right pancreatic limb was mildly prominent in size with mild capsule asymmetry and isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Generalized mild non-uniform hyperechoic omentum and mild to moderate volume anechoic peritoneal free fluid was present.

Intermittent enlarged mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. Possible abnormal width: length ratio was present (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 1.2 cm in diameter.

ULTRASONOGRAPHIC FINDINGS

- Mild urinary bladder sediment- cellular debris / protein, crystalline debris, lipid, or mucus.
- Age related renal changes.
- Hepatomegaly exhibiting possible mild congested vasculature.
- Sonographically unremarkable/subnormal gallbladder.
- Hypomotile stomach, structurally unremarkable small bowel.
- Prominent non-homogenous pancreas.
- Generalized non-uniform mild hyperechoic omentum, intermittent mesenteric lymphadenopathy and peritoneal effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the peritoneal effusion may include hepatopathy with possible emerging hepatic congestive criteria, pancreatitis, non-specific peritonitis or lymphatic obstruction potentially owing to carcinomatosis, lymphomatosis or similar. FIP is technically a potential yet considered less likely given the age of the patient.

Effusion analysis cytology +/- C/S if evidence of inflammatory cells is recommended. Assuming normal clotting status and using a 25g needle, a hepatic FNA for screening cytology is warranted for further assessment. Three view chest radiographs are recommended if not done to assess for occult thoracic pathology. As needed GI support is recommended. Protein electrophoresis may be considered if persistent/progressive hyperglobulinemia.

An extremely guarded prognosis is indicated.

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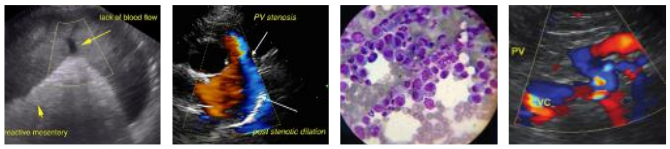

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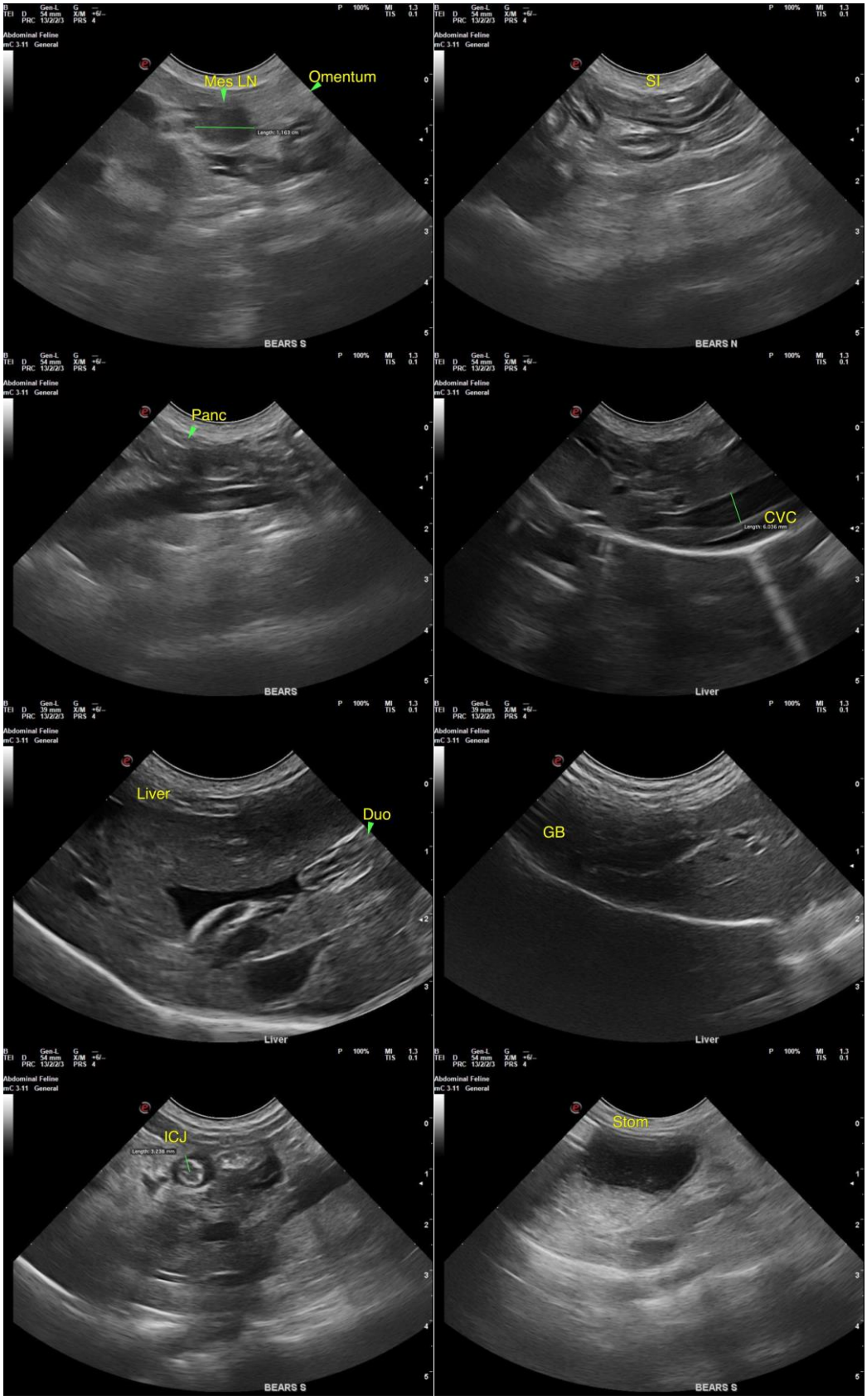

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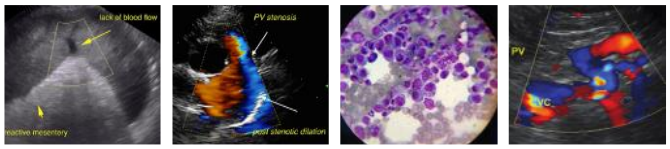

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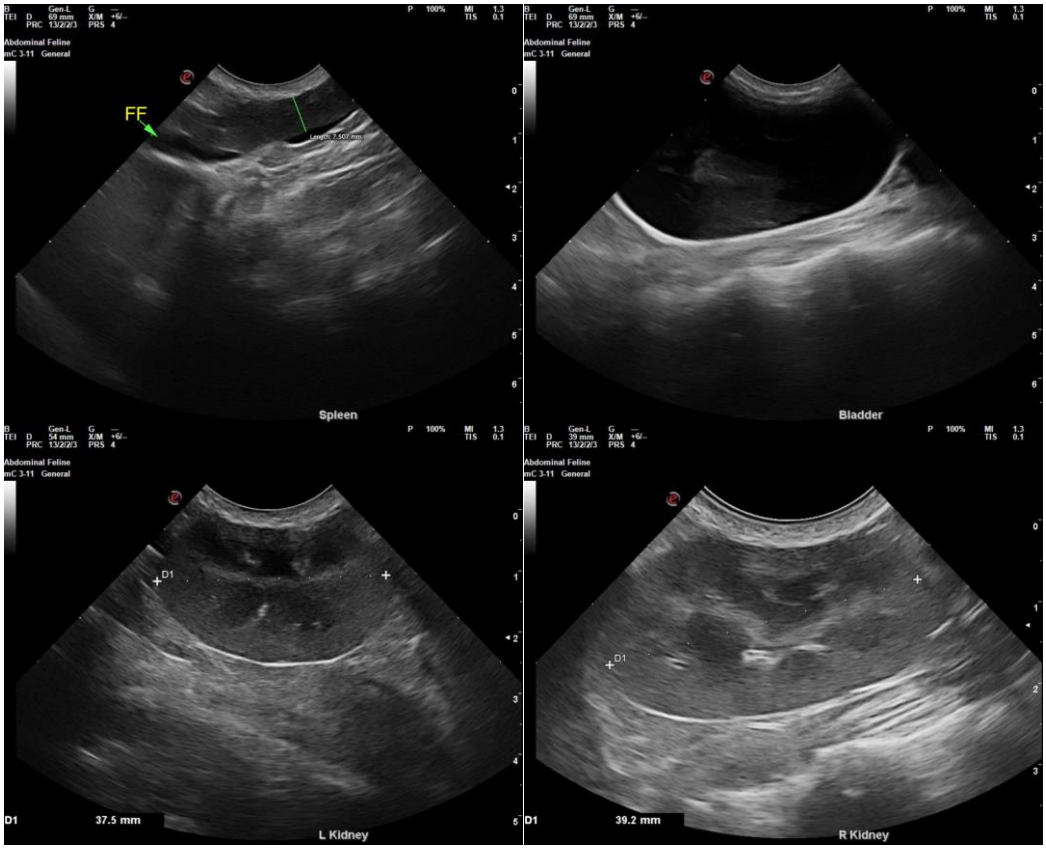

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
mac.daniel@sonopath.com