



PATIENT

Beatrix Meyers

SPECIES

Feline

BREED

Nebelung

SEX

FS

AGE

13 years

WEIGHT

5.9 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

VCA Westmoreland

REFERRING VET

Dr Bugarovich

INVOICE

13927

DATE

5/20/22

PRESENTING CLINICAL SIGNS

Weight loss, not interested in food, Chronic diarrhea Dehydration 10%, formed stool in colon, muscle atrophy

ALT 286, AST 153, TBili 1.4, Na:K 30, WBC 42.3 with neutrophilia and monocytosis, Urine specific gravity 1.045, 2+protein, 1+bilirubin

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 changes was noted.

The area of the aortic trifurcation was free of pathology.

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 3.5 cm in length. The right kidney measured 3.7 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 0.33 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.28 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 0.55 cm width. No evidence of splenic neoplastic criteria was noted.

Liver/ Gallbladder

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was subnormal in size with overtly normal gallbladder walls containing minimal anechoic content. No overt evidence of peripheral gallbladder Inflammation was noted. The



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common bile duct was not visualized yet no evidence of post hepatic common bile duct stasis, dilation, or obstructive pattern.

Gastrointestinal

The gastric walls were sonographically normal. The lumen of the stomach contained mild to moderate retained nonshadowing ingesta/chyme most consistent with post prandial presentation without signs of ileus, obstruction or foreign material. The gastric body wall width measured 0.21 cm.

The small intestine presented intact wall layering and subjective maintained 1:3 muscularis/mucosa ratio with segmental to generalized propensity for mildly echogenic small intestinal mucosa layer. No overt evidence of loss of intestinal wall layering or intestinal masses. The jejunum wall width measured 0.25 cm.

The descending colon walls presented intact yet 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 0.34 cm.

Pancreas

The left limb of the pancreas was mildly prominent in size with capsule asymmetry and heterogenous to mildly hypoechoic parenchyma.

Free Abdomen

Moderate volume peritoneal free fluid and generalized hyperechoic mesentery was present. No overt evidence of concurrent intraabdominal lymphadenopathy was noted.

Rapid view of the heart revealed subjective normal cardiac structure without overt evidence of left or right heart chamber enlargement, as well as subjective normal contractility. Concurrent pleural effusion was present. Overt evidence of pericardial or cranial mediastinal masses was not visualized in the visible window.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy with subnormal gallbladder - no evidence of post hepatic obstruction
- Retained gastric ingesta / chyme
- Subjective segmental to generalized mild Increased small bowel mucosa echogenicity - nonspecific
- Heterogeneous to mildly hypoechoic left pancreas - potential for chronic to chronic active pancreatitis, no evidence of pancreatic neoplastic criteria
- Chronic descending colitis pattern
- Bicavitary effusion with generalized hyperechoic mesentery - subjectively noncardiogenic



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's weight loss, underlying chronic gastroenterocolonopathy, i.e., IBD / eosinophilic enteritis or other is possible. Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate +/- diarrhea PCR panel. Concurrent potential for chronic to chronic active pancreatitis, often seen concurrently with underlying chronic gastrointestinal disease is possible, yet subjectively the degree of pancreatic inflammation was not consistent with the degree of pancreatic pathology generally associated with bicavitary effusion.

Abdominocentesis for fluid analysis, cytospin cytology +/- culture and sensitivity, as well as screening hepatic FNA, assuming normal clotting status and using a 25-gauge needle, is warranted for further clarification.

Given that no subnormal albumin levels that would diminish oncotic pressure the point of causing free fluid, and no obvious evidence of passive hepatic congestion or significant to diffuse hepatic disease, as well as no evidence of intestinal perforation or other significant mural pathology that would be responsible for bicavitary effusion, potential nonobvious lymphatic obstruction owing to underlying neoplastic process i.e., lymphomatosis, carcinomatosis, or similar cannot be definitively excluded.

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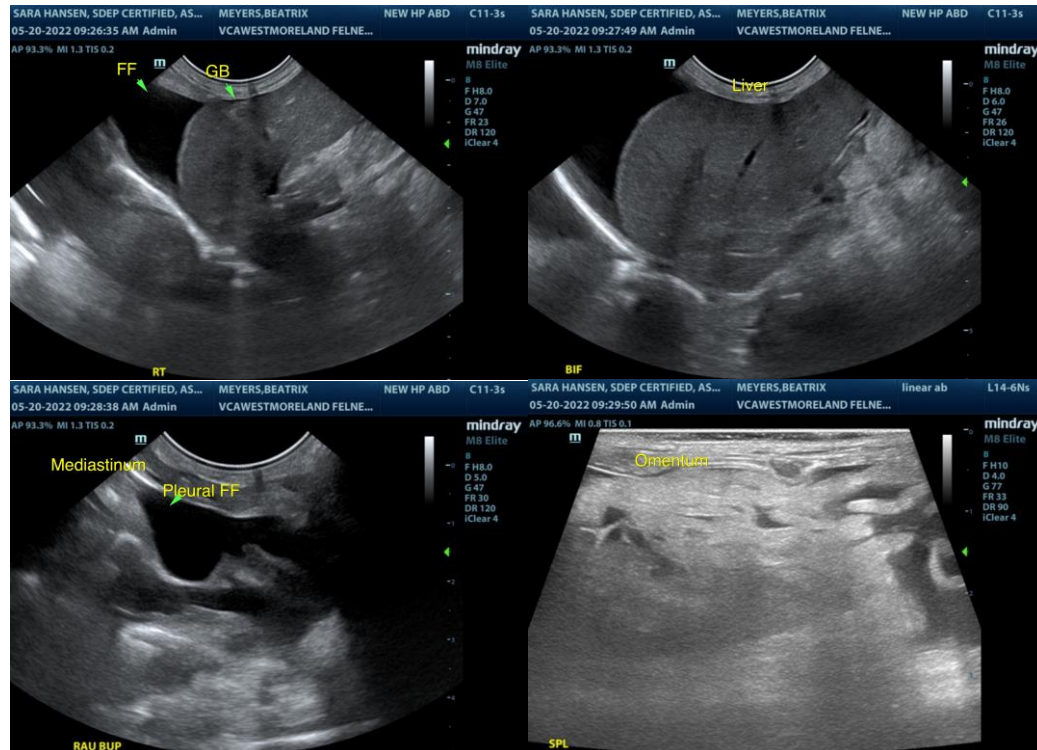
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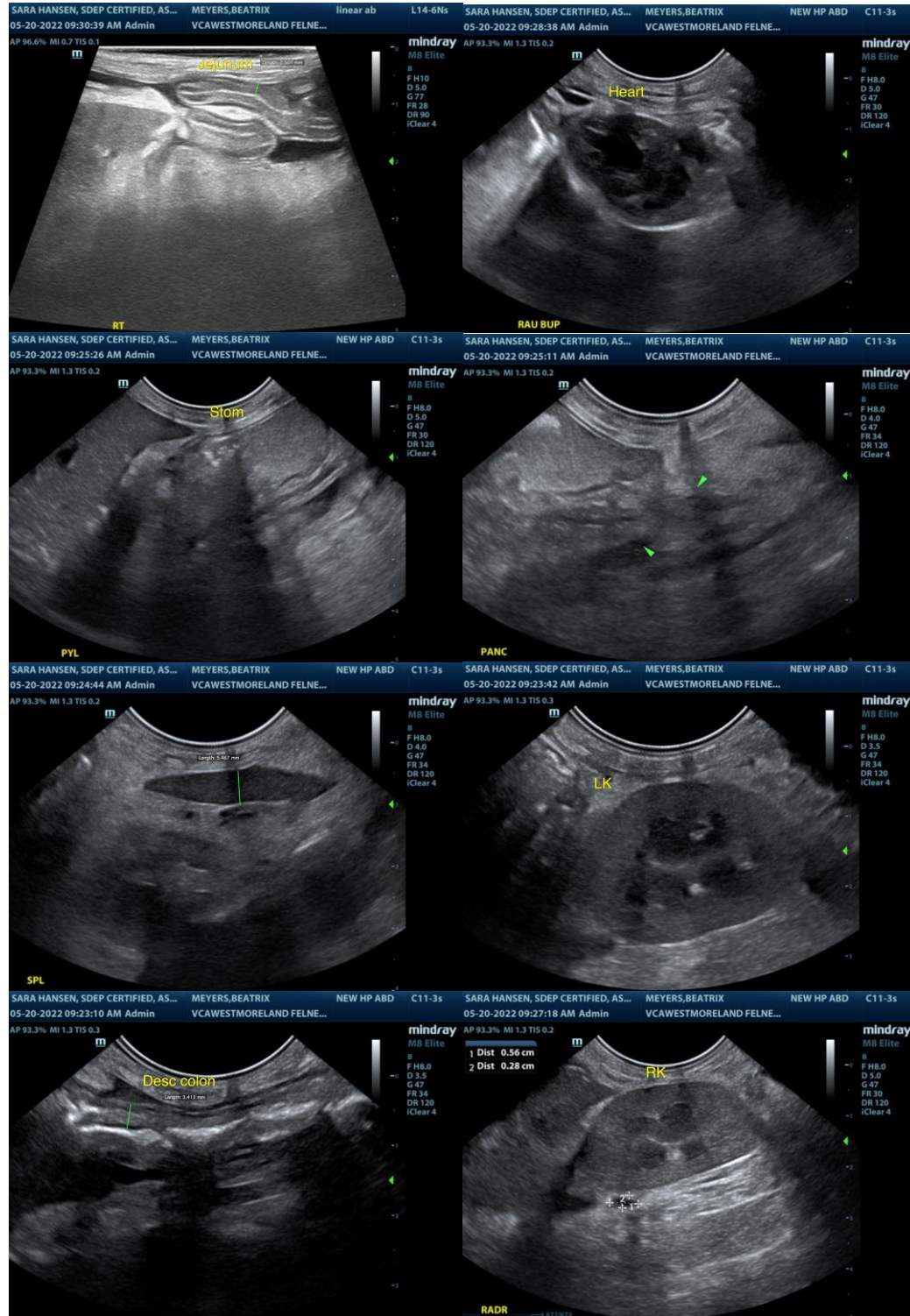
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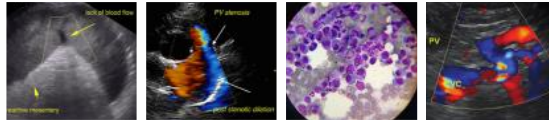
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com