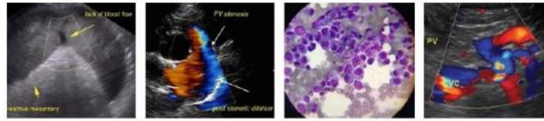


PATIENT

Oreo Ruser

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6 Years

WEIGHT

4.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Beattie PH Stoney Creek

REFERRING VET

Salib

INVOICE

23885

DATE

8/11/23

PRESENTING CLINICAL SIGNS

History: ddx blood loss, Destruction of red blood cells, fiv/flv/fip, bone marrow supp, kidney dis, neoplasia others Assessment: mild tense/painful cranial abdomen on palpation right eye looked infected yesterday lethargic last few days has new kitten- thought lethargic was just that not eating or drinking no bm growling- not normal talked to smart vet- given eye drops vomited green bile stomach felt soft last night- now feels hard on lower left side Current Medications Gabapentin, Metronidazole, Sucralfate, Mirtazapine

Abnormal PE/Chem/CBC/UA Results: RBC 6.94 x10^12/L 6.54 - 12.20, HCT 29.6 % 30.3 - 52.3 LOW, HGB 9.3 g/dL 9.8 - 16.2 LOW- mild Anemia without reticulocytosis - Likely non-regenerative anemia Radiographic Findings There is mild peritoneal effusion, of uncertain etiology. Peritonitis is possible. There is no evidence of pneumoperitoneum to suggest gastrointestinal perforation, and no signs of gastrointestinal obstruction are seen. There are degenerative changes of the left kidney.

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. Primarily anechoic urine was present in the lumen. Mild primarily dependent lumen 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 bladder was otherwise normal. Aortic trifurcation was normal.

Both kidneys were normal in size and margination with maintained 1:3 cortex to medulla ratio. Adequate corticomedullary border demarcation was noted. No pyelectasia was noted. No evidence of left or right retroperitoneal inflammation. Subjective areas of nonspecific increased renal medullary echogenicity. The left kidney measured 3.8 cm. The right kidney measured 4.0 cm.

Adrenal Glands

No overt pathology in the area of the left or right adrenal glands.

Spleen

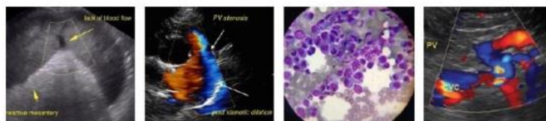
The spleen exhibited borderline enlargement (1.0 cm width). Finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma was noted. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver revealed subjective borderline to possible mild enlargement and maintained symmetrical capsule contour. Mild nonuniform hepatic parenchyma, exhibiting subtle areas of decreased parenchyma echogenicity compared to the spleen and falciform fat. No visualized hepatic masses or nodules.

The gallbladder was non distended in size with anechoic content and mild echogenic gallbladder sediment. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal



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The stomach exhibited overtly normal intact wall layering in the fundus and gastric body with possible mildly thickened wall layering in the area of the pylorus. The gastric lumen was empty without gastric distention secondary to retained ingesta, fluid or foreign material. The pylorus wall potentally measured 0.4 cm wall width.

The small intestine presented generalized intact segmental mildly prominent wall layering. The lumen of the small intestine was empty with no evidence of mechanical/metabolic ileus, loss of intestinal wall layering or intestinal masses. The duodenum wall measured 0.28 cm. The jejunum wall measured 0.28 cm.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

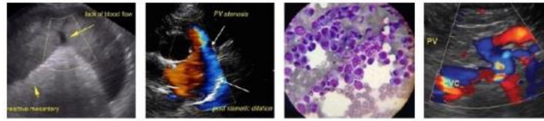
Pockets of mild volume primarily anechoic peritoneal free fluid were noted. Generalized mild increased omental echogenicity was noted. No overt visualized or significant omental lymphadenopathy. No visualized omental masses were noted.

ULTRASONOGRAPHIC FINDINGS

- Mild dependent urinary bladder sediment- possible pyuria
- Nonspecific minor chronic renal changes
- Borderline hepatosplenomegaly
- Mild gallbladder sediment
- Possible mild thickened pylorus wall with empty gastric lumen
- Intact segmental mildly prominent small bowel wall
- Heterogenous pancreas
- Intermittent pockets of mild volume peritoneal effusion

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinalysis with culture and sensitivity if evidence of inflammatory cells is recommended. The mild volume peritoneal effusion is nonspecific and may indicate non-septic vs septic effusion, while the possibility of emerging neoplastic effusion, i.e., carcinomatosis, lymphomatosis or similar cannot be excluded. Effusion analysis, cytology +/- culture and sensitivity, if evidence of inflammatory cells, as well as assuming normal clotting status, screening hepatosplenic FNA cytology, using a 25G needle is warranted. Recheck retroviral, status is recommended if not recently or already done. Sonographically, the appearance of the pancreas was not consistent with significant or active pancreatitis, although low grade pancreatitis could be possible. Correlation with a spec FPL or full gi panel to include PLI/TLI/Cobalamin/Folate to assess for occult intestinal disease may be considered.



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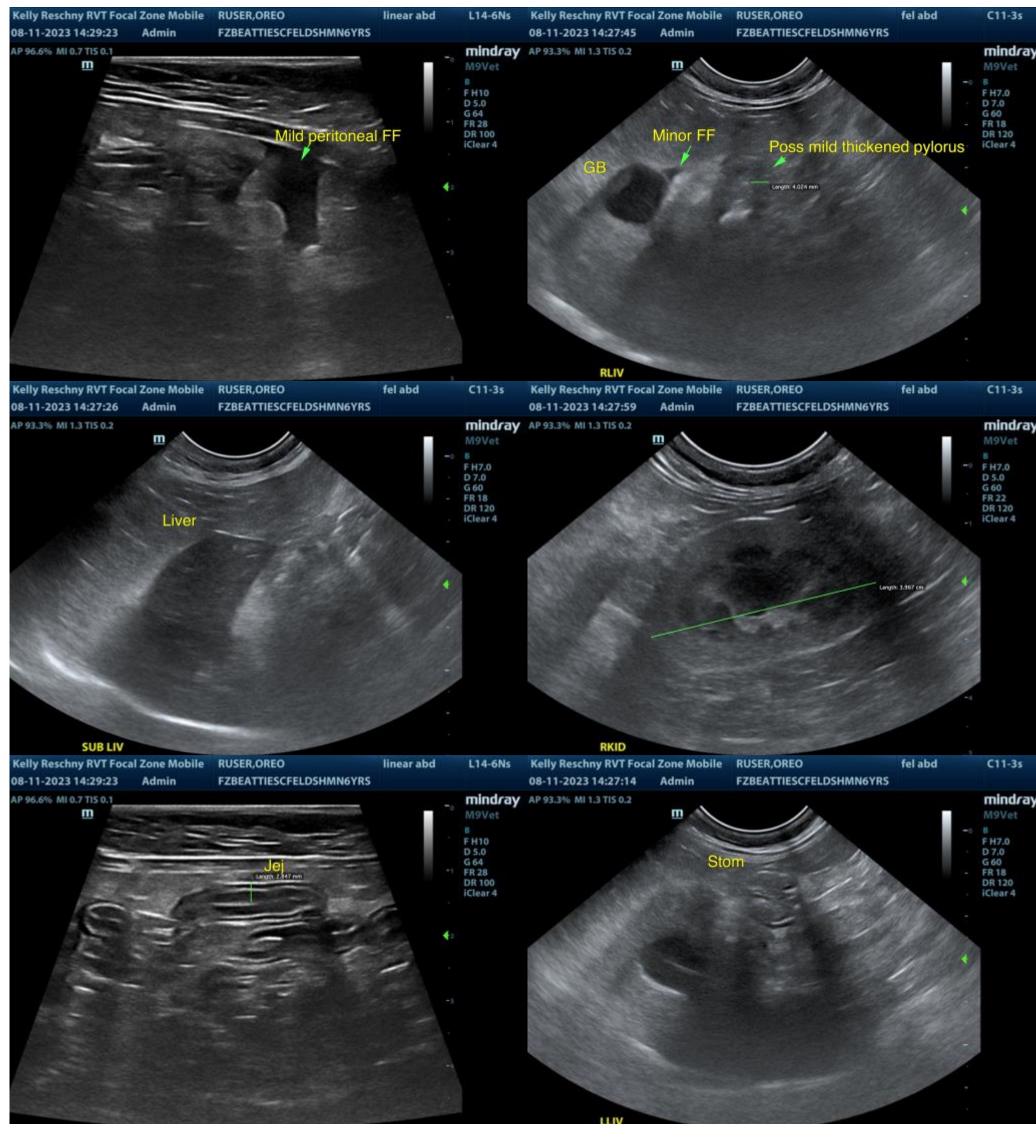
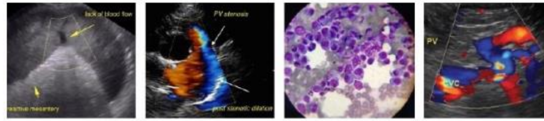
Empirically, as needed gastrointestinal support therapy for potential low grade pancreatitis, which may include gastroprotectants, antinausea medication, as needed analgesia, assessment of clinical response and potential sonographic reassessment if progressive peritoneal effusion and clinical signs or pending additional diagnostics.





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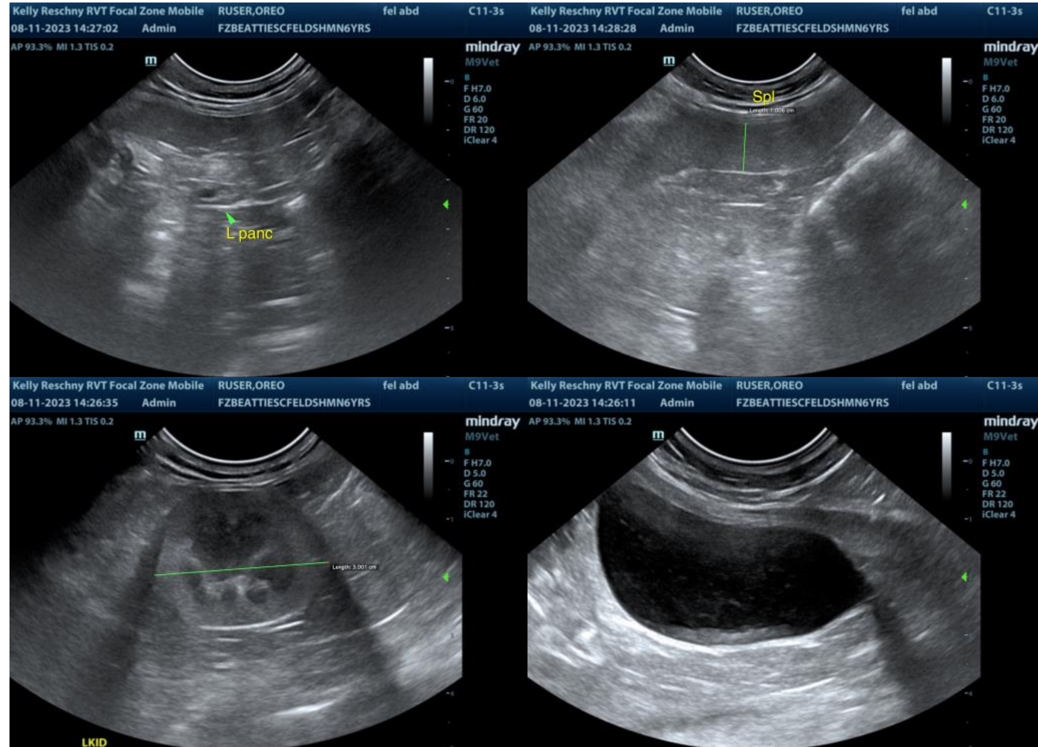

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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