



## PATIENT

Coco Forgey

## SPECIES

Feline

## BREED

DSH

## SEX

MN

## AGE

8Y

## WEIGHT

13

## INTERPRETED BY

Nele Eley (Ondreka),  
DVM Dr. med. vet.,  
DipECVCI

## IMAGING PERFORMED BY

Lyndsey/Vanessa

## HOSPITAL NAME

Tempe Lake Veterinary  
Hospital

## REFERRING VET

Dr. Lockhart

## INVOICE

74567

## DATE

4-13-26

## PRESENTING CLINICAL SIGNS

8-year-old MN feline (Coco) presented for concerns of possible urinary obstruction versus constipation with a 2-day history of decreased appetite; duration of illness otherwise unknown. On presentation, abdominal effusion was identified and approximately 600 mL of yellow-brown fluid was removed. Patient has a history of asthma and is currently managed on Fluticasone with good clinical control. Clinical concern is for inflammatory abdominal effusion (modified exudate) with differentials including septic versus non-septic peritonitis, pancreatitis with secondary effusion, neoplasia, and less likely FIP.

Abnormal PE/Chem/CBC/UA Results: Abdominocentesis revealed a high protein effusion (TP ~4.0 g/dL) with fluid creatinine comparable to serum, making uroabdomen unlikely. CBC shows marked leukocytosis (WBC ~29.5) with severe neutrophilia and lymphopenia. Chemistry reveals mild BUN elevation (~35–36) with normal creatinine (~1.3), along with hypoproteinemia (TP 4.1), hypoalbuminemia (1.7), and hypoglobulinemia (2.4); electrolytes are within normal limits without hyperkalemia. Urinalysis shows USG >1.060.

## COMPUTED TOMOGRAPHIC STUDY OF THE ABDOMEN

Early and late post contrast studies are available for review.

## COMPUTED TOMOGRAPHIC FINDINGS

Severe abdominal effusion is seen within the peritoneal cavity with peripheral rim enhancement and uneven distribution. Mild peritoneal soft tissue attenuation is present. There is no evidence of contrast leakage within the peritoneal cavity.

The liver margins appear to be rounded and “corticated.” No dominant hepatic mass is identified.

Mild extrahepatic biliary stasis is noted without evidence of mechanical obstruction.

The abdominal lymph nodes present within normal limits.

Focal irregular wall thickening of the urinary bladder is noted at its cranial pole in an area of approximately 2.5 cm diameter and 1.0 cm thickness. No evidence of urinary obstruction or rupture is identified.

Mild generalized enlargement of the pancreas is noted.

Both kidneys present age related changes.

The spleen presents corticated and otherwise within normal limits.

Multiple hyperattenuating small nodular structures appear to be concentrated in the ventral abdomen.

Pulmonary nodules are present within the imaged fields. Abdominal assessment requested only.

## COMPUTED TOMOGRAPHIC DIAGNOSIS

- Severe abdominal effusion with encapsulation/sclerosis.
- Focal cranial urinary bladder wall thickening: cystitis vs neoplasia.
- Mild pancreatic enlargement.
- Pulmonary nodules within field of view.
- Mild biliary stasis and hepatosplenic cortication.



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## INTERPRETATION OF FINDINGS & FURTHER RECOMMENDATIONS

The constellation of the findings suggest a severe chronic inflammatory process with potential neoplastic involvement. Most important differentials include infectious peritonitis primary or secondary to gastrointestinal disease, pancreatopathy, and less likely urinary tract disease; second, pancreatitis with secondary peritonitis; third, neoplasia such as peritoneal tumor seeding/ carcinomatosis (pulmonary nodules significantly raise the concern for metastatic disease or systemic neoplasia); fourth, feline infectious peritonitis; fifth, encapsulating/sclerosing peritonitis.

Recommendations: Abdominal fluid analysis with cytology, culture, and triglycerides/protein comparison (already partially performed), traumatic catheterization of the bladder, fPLI monitoring, assessment of thoracic CT. Consideration of infectious workup vs oncologic staging depending on cytology.





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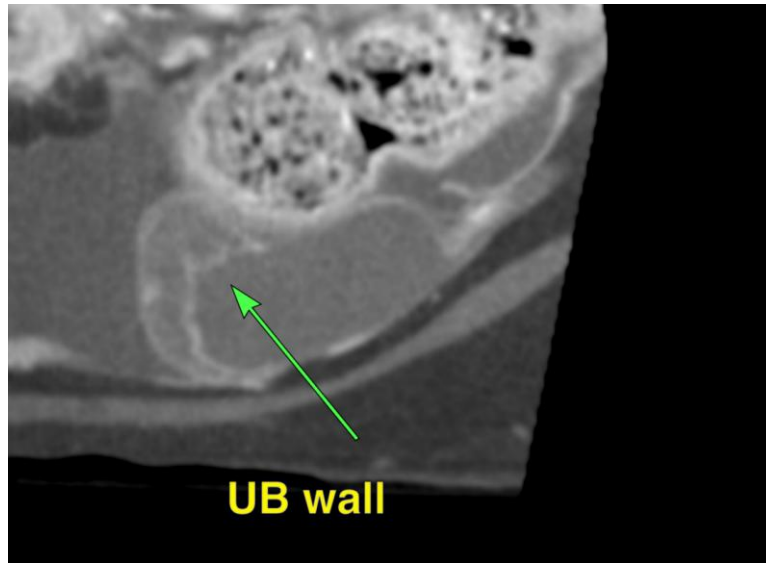
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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