



**PATIENT PRESENTING CLINICAL SIGNS**

Seraphina Donovan

Seraphina is a 7y FS Persian presenting for anorexia and inappropriate urination. The patient has not been eating/drinking for the past few days (up to a week per O). She has always had a history of inappropriate urination and after BW/urinalysis, rDVM believed it was behavioral. There has been no vomiting or diarrhea. Nothing that she could have gotten into per O, no change in diet. P is indoor only has otherwise been historically healthy.

**SPECIES**

Feline

Abnormal PE/Chem/CBC/UA Results: The stomach contains a mild amount of heterogeneous soft tissue and gas opacity. The small intestines contain homogeneous soft tissue opacity with interspersed gas and are normal in diameter. The colon contains formed feces and gas. The urinary bladder is mildly distended. The kidneys are normal in size and shape. There is adequate peritoneal serosal detail. There is an ovoid soft tissue opacity in the caudal ventral thorax, on midline, caudal to the cardiac silhouette. The cardiac silhouette is mildly enlarged. The pulmonary vasculature is within normal limits. Conclusion 1. Gastric food and/or foreign material. This is inconsistent with the reported history of not eating. 2. Otherwise relatively unremarkable abdomen. 3. Soft tissue opacity in the caudal ventral thorax may represent a peritoneal pericardial diaphragmatic hernia. A caudal mediastinal mass (cyst, neoplasia, granuloma, etc.) is not ruled out. 4. Mild cardiomegaly. Consider altered shape created by the caudal thoracic opacity. Cardiomyopathy is also considered. There is no evidence of heart failure.

**BREED**

Persian

**SEX**

FS

**AGE**

7 Years

Recommendations Baseline blood work and urinalysis could be considered if not already performed. An abdominal ultrasound to be considered to further evaluate the abdominal viscera; also consider thoracic ultrasound to evaluate the caudal mediastinum. Imaging the caudal thorax through the abdominal side of the diaphragm may be easiest. Read By: Kimberly Mulligan DVM, Diplomate ACVR CBC: mild neutropenia COMP: mild hypocalcemia EPOC: mild inc pO<sub>2</sub>/cSO<sub>2</sub>, mild dec pCO<sub>2</sub>/BUN PCV/TS: 40%, 7.4 g/dL

**INTERPRETED BY**

Sebastian Schaub, DVM  
Dr. med. vet. DipECVDI

**COMPUTED TOMOGRAPHY OF THE THORAX AND ABDOMEN**

A high resolution pre- and post-contrast CT study of the thorax and abdomen are provided for review.

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**COMPUTED TOMOGRAPHIC FINDINGS**

Thorax

Multifocal mild spondylosis formation is seen along the caudal thoracic spine.

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The sternal, cranial mediastinal and tracheobronchial lymph nodes are small elongated with a normal short-to-long-axis-ratio is < 0.5, the attenuation and contrast enhancement pattern is uniform and considered within normal limits.

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The cardiovascular structures including the pulmonary vasculature are within normal limits.

The bronchial tree presents with regular branching and tapers uniformly towards the periphery as expected, the bronchial walls are thin and smooth. The bronchus-to-artery ratio is within normal limits.

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The lung parenchyma presents the expected architecture and attenuation behavior.

Small incidental gas pockets are seen within the esophageal lumen, there is no evidence of abnormal dilation.



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In the center of the diaphragm, a defect measuring approximately 7 x 20 mm in size is visible and the left lateral & medial hepatic lobe are seen in the mid caudal aspect of the thoracic cavity – between the diaphragm and the heart. The herniated fat appears to be continuous with the pericardial sac and the prolapsed liver lobes are in contact with the caudal surface of the heart.

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Abdomen

The serosal fat presents normal attenuation behavior. There is no evidence of peritoneal effusion or peritonitis.

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Both kidneys present within normal limits for size, shape and organ architecture. The renal pelvis is accentuated by a thin rim of mineral attenuating material. After contrast administration a bilaterally symmetric and uniform nephro- and pyelogram is noted. Moderate thickening of the dorsal and right urinary bladder wall is appreciated, measuring approximately up to 3.5 mm in width and presenting mild irregular mucosal lining. No mineral attenuating calculi are seen along the ureters or in the urinary bladder.

**SEX**

FS

The adrenal glands are within normal limits for size, shape and organ architecture.

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The spleen presents with normal shape, even surface, uniformly attenuating parenchyma and homogeneous contrast enhancement, unremarkable.

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The pancreas is evenly contoured, the pancreatic parenchyma is homogeneous and presents uniform contrast enhancement.

The position, delineation and content of the gastrointestinal tract are considered within normal limits throughout. Post contrast administration, the outer layer of the small intestinal loops is prominent.

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The bony and surrounding soft tissue structures reveal no abnormalities.

**COMPUTED TOMOGRAPHIC DIAGNOSIS**

- Peritoneo pericardial diaphragmatic hernia with prolapse of parts of the liver – suspect left medial & lateral liver lobe
- Generalized mild to moderate mural thickening urinary bladder wall – maintained wall layering
- Mild nephrolithiasis without evidence of obstruction
- Suspect mild mural thickening of the outer layer of the small intestinal tract
- Normal thorax but mild spondylosis formation

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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The CT study is consistent with peritoneo pericardial diaphragmatic hernia with prolapse of parts of the left division of the liver. Surgical repair and repositioning the parts of the liver is the therapy of choice. Although this is likely an incidental finding at this point.

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The thickened urinary bladder wall is compatible with underlying cystitis and is compatible with the presenting clinical signs.

The prominent muscular layer of the small intestinal loops can be caused by inflammation (e.g.



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lymphocytic plasmocytic, eosinophilic), hyperthyroidism or neoplastic invasion (round cell tumor). Ultrasound can be used to confirm the diagnosis. Full thickness biopsies can be used for further definition.

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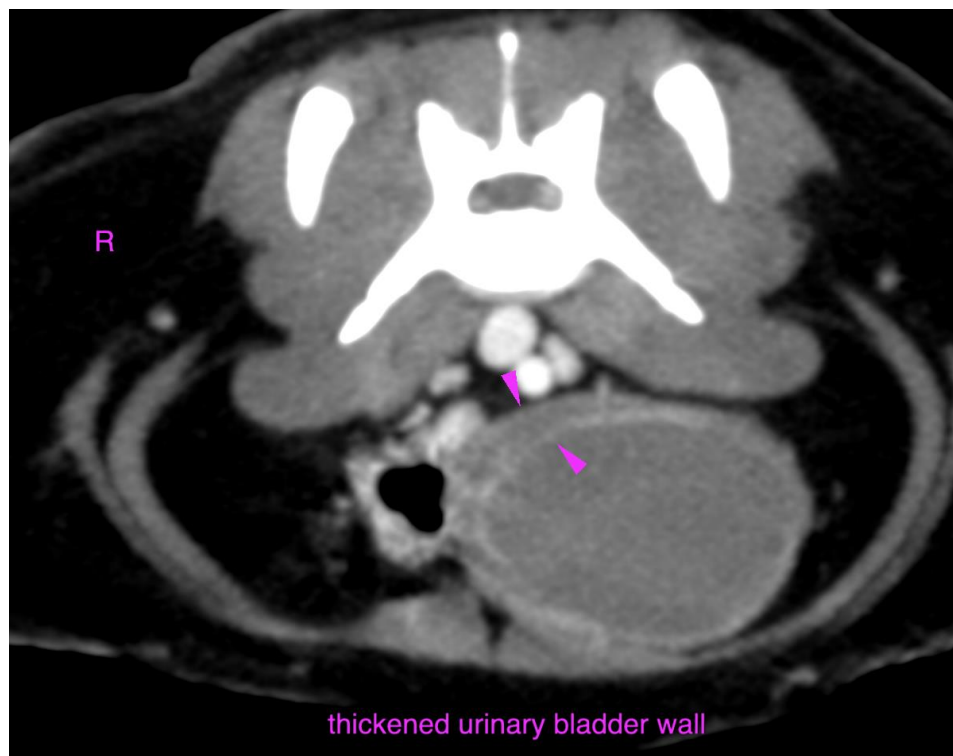
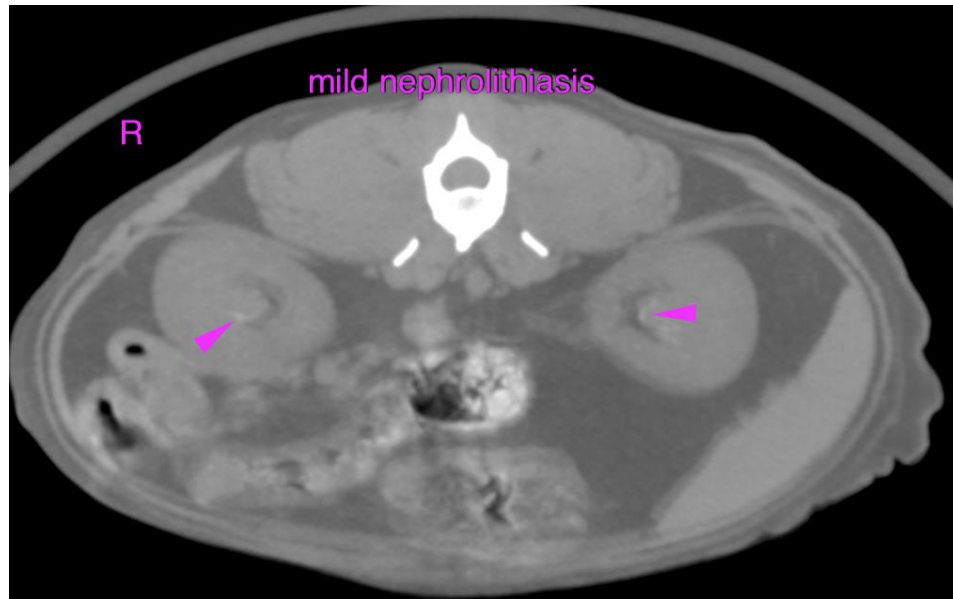
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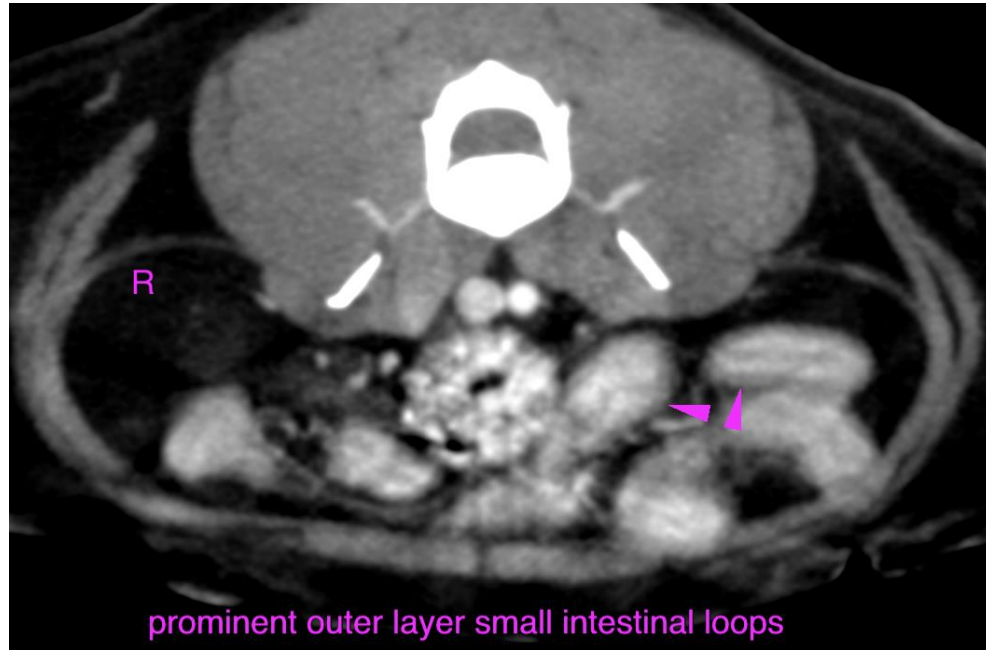
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Sebastian Schaub**, Sebastian Schaub, DVM, Dr. med. vet. DipECVDI  
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