



# IT'S YOUR CASE

Species: Feline      Breed: Domestic Shorthair (DSH)      Sex: Male Neutered      Age: 10 years

## Clinical History:

He has seemed lethargic and had intermittent vomiting for the last 2 weeks. He seems to be more distant than normal. He has no major medical history of note per owner.

CBC reveals significant lymphocytosis (appears to be banded neutrophils on blood smear)

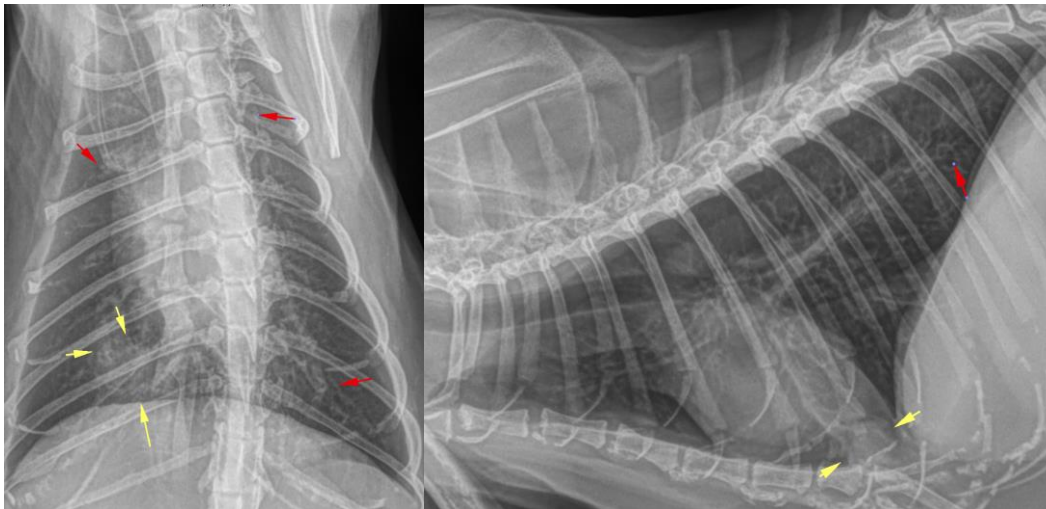
**Anatomic regions:** Thorax, Abdomen

## Diagnostic interpretation:

### THORAX:

The patient has a thin body habitus. The cardiac silhouette is normal in size and position; there is no specific chamber enlargement. The pulmonary vasculature is normal in diameter and tapers as it extends to the periphery. Mild bronchial pattern is diffusely distributed (red arrows). In the ventral periphery of the right middle lung lobe, irregular soft tissue is bronchocentric (yellow arrows). No nodules are seen. The trachea and mainstem bronchi are patent. The pleural space and mediastinum are unremarkable.

The thoracic vertebral column is unremarkable without evidence of fracture, luxation or osteolysis.



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## ABDOMEN:

There is reduced central abdominal serosal contrast where soft tissue opacity is closely associated with the gas filled intestinal segment. There is increased soft tissue opacity that is ill-defined medial to the spleen (orange arrows) and along the right lateral body wall (pink arrows). In the left caudal peritoneal space, a smoothly margined thinly mineral walled structure (light blue arrow) is consistent with the Bates body.

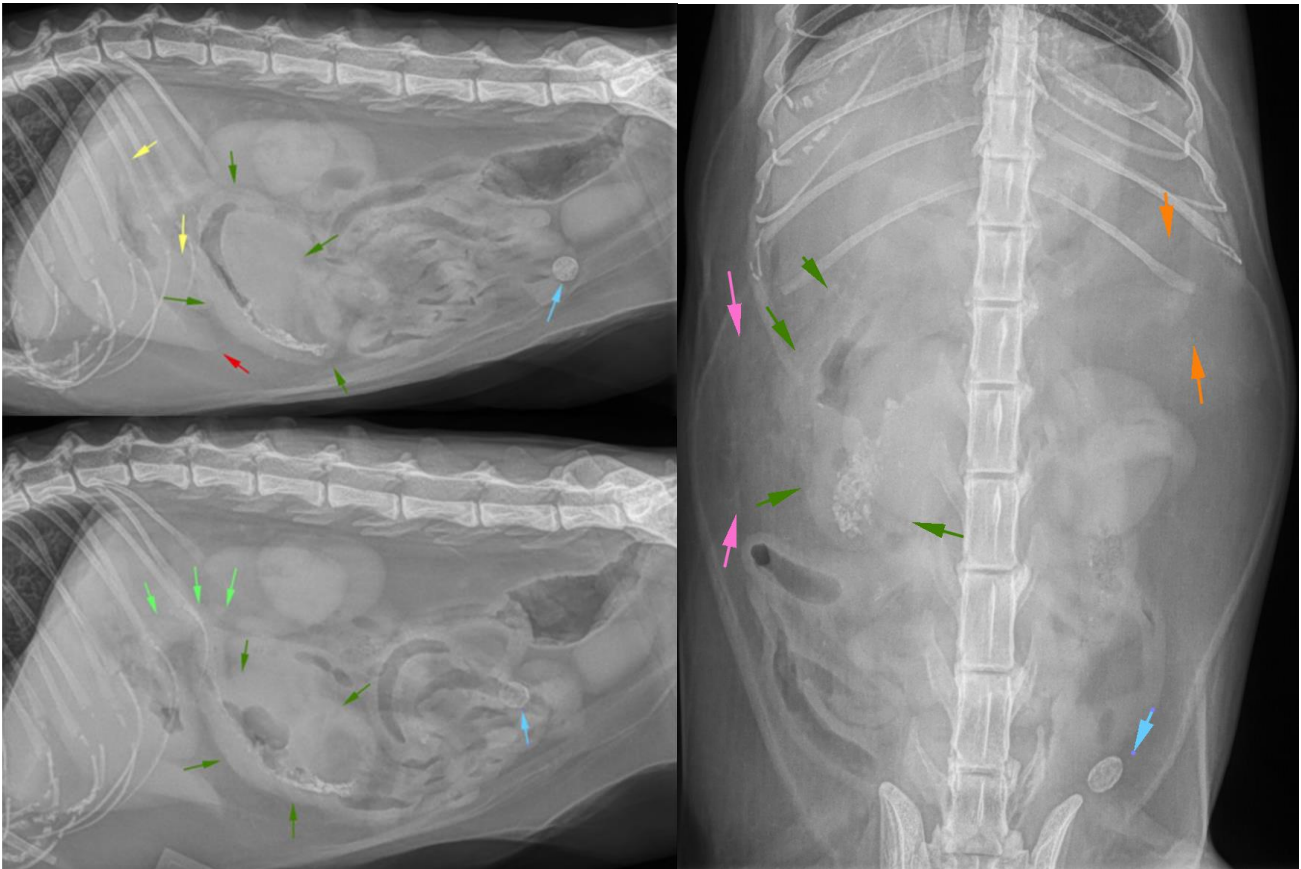
The liver is enlarged, extending beyond the costal arch, and has smooth margins (red arrow).

The visible margins of the liver and spleen are radiographically within normal limits.

The gastric silhouette contains gas and minimal heterogenous soft tissue (yellow arrows); it is normal in position. The duodenum is partially delineated in the left lateral view (bright green arrows). This is dorsally to the previously described central abdominal soft tissue. Eccentrically surrounding a gas and mineral filled lumen, lobulated soft tissue caudally displaces regional small intestinal segments. This structure spans three vertebral segments and occupies 1/3 of the height of the abdomen on the lateral views.

The renal and urinary bladder silhouettes are smoothly margined and within normal limits. There is mild asymmetry between the shape of the renal silhouettes. There are no radiopaque calculi.

The lumbar vertebral column is unremarkable without evidence of fracture, luxation or osteolysis.



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## Conclusions:

- Diffuse bronchial changes may represent chronic lower airway inflammation (i.e. feline asthma +/- fibrosis).
- Focal soft tissue in the periphery of the right middle lung lobe. Differentials include focal atelectasis, bronchopneumonia, or combination therein. Neoplastic infiltration is considered less likely.
- Small intestinal mass with gravel sign. Consider the potential for partial obstruction of the lumen. Primary consideration is given to neoplasia (i.e. Lymphoma or gastrointestinal adenocarcinoma). Infectious aetiologies (i.e. pythium) are uncommon in this geographic region and should be correlated to historical exposure.
- Peritoneal effusion +/- steatitis. Likely secondary inflammation however the potential for perforation should be considered.
  - Consider potential for concurrent pancreatitis.
- Hepatomegaly. This is nonspecific and differential include fat infiltration, hepatic lipidosis, neoplasia, cholangiohepatopathy versus less likely, vacuolar hepatopathy (i.e. metabolic or endocrine hepatopathy) versus nodular regeneration.

## Additional comments:

There are substantive changes evident in these radiographic could contribute to the patient's apathy and recent vomiting. The presence of a soft tissue mass in association with the small intestine is concerning for neoplastic infiltration. Further evaluation can be made with sonography and tissue sampling. Given the accumulation of mineral at the level of the mass, a gravel sign associated with partial obstruction should also be considered. This may be relevant if the patient has experienced recent weight loss.

The regional loss of contrast can represent inflammation associated with the mass. Gastrointestinal masses are at risk of perforation and the potential for septic effusion should be evaluated with fluid sampling and cytology.

The change in the region of the right middle lung lobe could be benign atelectasis associated with chronic lower airway inflammation however decreased clearance can potentiate bronchopneumonia. Quick screening can be made with sternal recumbency and repeated dorsiventral view of the thorax to assess for resolution of atelectasis. Further evaluation for bronchopneumonia can be made with bronchoalveolar lavage or response to empiric therapy.



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