



**PATIENT**

Hunter Broderick

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

15 Years

**WEIGHT**

8 Pounds

**INTERPRETED BY**

Aubrey Hirsch, DVM,  
Practice Limited to  
Internal Medicine

**IMAGING  
PERFORMED BY**

Dr. Elaina Petrone

**HOSPITAL NAME**

Long Branch AH

**REFERRING VET**

Dr. Elaina Petrone

**INVOICE**

24722

**DATE**

8/16/21

**PRESENTING CLINICAL SIGNS**

15 yo MN DSH. History of vomiting and weight loss.

Abnormal PE/Chem/CBC/UA Results: Weight loss, decreased muscle mass, grade 3 heart murmur, severe dental disease T4: 3.2 Creatinine 1.7 SDMA: 18 USG: 1.018 Total bilirubin: 1.1 ALT: 189 ALP: 162 Monocytosis: 1260 Neutrophilia: 16485 Hct: 32% fT4 and UA pending R/O hyperthyroidism, CKD, GI LSA vs. IBD, chronic pancreatitis, pyelonephritis (possibly all of the above)

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately distended with anechoic urine. The bladder wall, trigone, ureteral papillae and visible urethra appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.7 cm in length). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction. There is no evidence of perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. There is mild renal pelvic dilation present (0.19 cm). Renal vasculature is normal.

The right kidney has a normal shape and size (3.9 cm in length). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction. There is no evidence of perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. There is mild renal pelvic dilation present (0.18 cm). Renal vasculature is normal.

**Adrenal Glands**

The region of left adrenal (cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

**Spleen**

The spleen is subjectively normal in size and shape, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

**Liver**

The liver is subjectively large in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed

The gallbladder lumen is mild to moderately distended. The wall of the gallbladder is mildly prominent at 0.15 cm. There is a mild amount of echogenic, gravity dependent sludge. The remainder of luminal content is anechoic. The common bile duct is not visible.

**Gastrointestinal**

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.



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The visualized areas of the jejunum and ileum have uniform diameter with minimal fluid distention. Wall thickness is normal to slightly increased with the jejunum measuring between 0.2-0.29 cm. The ileum measures 0.29 cm. There is segmental, moderate circumferential muscularis layer thickening. There are no focal lesions consistent with obstruction or mass effect.

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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

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**Pancreas**

The pancreas is prominent and is hypoechoic and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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**Free Abdomen**

Evaluation of the peritoneal cavity reveals a mild amount of effusion. There is a moderate lymphadenomegaly present. The lymph nodes appear heterogeneous with multifocal variably sized hypoechoic nodular regions throughout. A mesenteric lymph node measured 0.68 cm x 1.5 cm. A colic lymph node measured 0.58 cm x 0.87 cm. The Medial iliac nodes and aorta are not imaged. The omentum is slightly hyperechoic.

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**ULTRASONOGRAPHIC FINDINGS**

**WEIGHT**

8 Pounds

- Moderate circumferential bowel wall thickening – most consistent with infiltrative disease such as inflammation, infection, edema, or neoplasia.
- Moderate lymphadenopathy - The moderate mesenteric lymphadenopathy is most concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease (tick born disease-such as bartonealla, fungal infections, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.
- Mildly prominent pancreas - The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Hyperechoic liver - Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Gallbladder sludge, mild - The significance of the aggregated gallbladder debris is unclear. This could represent cholestasis, cholecystitis, or may be incidental. Incidental gall bladder debris is less common in cats.
- Pyelectasia, mild - Pyelectasia of the left and right kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Small volume free fluid

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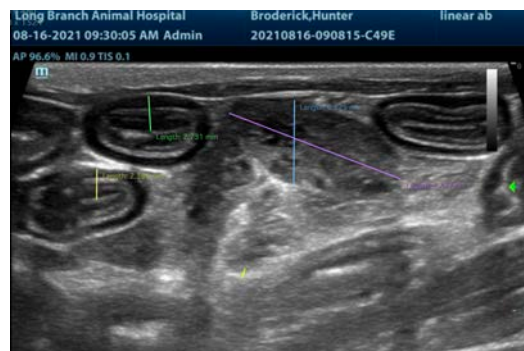
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The findings would warrant concern for more severe infiltrative disease such as lymphoma. However, cytology or biopsy would be required for definitive diagnosis. Severe inflammatory bowel disease cannot be ruled out. Fine needle aspiration with cytology of the lymph nodes would be recommended. Intestinal biopsies (surgical versus endoscopic) could also be considered.



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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