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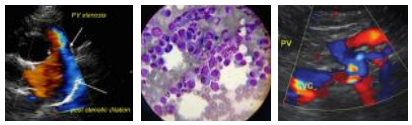

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

1/20/2022

PATIENT

Panther Mullen

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

6-21-2007

WEIGHT

11.69 Lbs.

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Everhart Veterinary Center

REFERRING VET

Not Provided

INVOICE

10174

PRESENTING CLINICAL SIGNS

History: O feels pet is not doing well on call in. 1-12-2022. Pet had history of anemia with CMD where full sedation needed to workup/get labs. I was able to do a recheck lsa600 on pet with no medications oral or injectable on board that showed early renal but anemia resolved. O
feels that U/S may be needed to try and determine sickness based on previous discussions here.

Current Medications: renal diets if e is eating them, pet had Cerenia recently as well.
Lab Results: Attached separately.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Gabapentin PO.
Stat Report: Not requested.
Patient has chronic renal disease, is mildly azotemic. Urine Specific Gravity 1.020. Normal T4

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with mostly anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (3.65 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. The cortex is mildly hyperechoic relative to the liver. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is small in size (3.04 cm in length); with a slightly irregular shape. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A cortical infarct is suspected at the caudal pole. Trace pyelectasia is present. There is no evidence of, nephroliths or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.49 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.42 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.81 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal

Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal wall is diffusely thickened (up to 0.49 cm) with apparent retention of the normal layering pattern. There is disruption in the normal 1:3 muscularis to mucosal ratio, with a >1: 1 ratio in most segments. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

Trace free fluid is observed. One to two prominent lymph nodes are observed at the aortic trifurcation, the largest measuring 1.62 cm in length. A 1.96 cm hypoechoic lymph node is also observed in the right cranial quadrant. At least 2 severely enlarged hypoechoic to slightly heterogenous rounded-to-irregular lymph nodes are observed adjacent to the ileocecocolic junction, the largest measuring 4.04 cm. Surrounding mesentery is hyperechoic. A hyperechoic wall measuring up to 0.42 cm appears to be surrounding the two largest lymph nodes.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

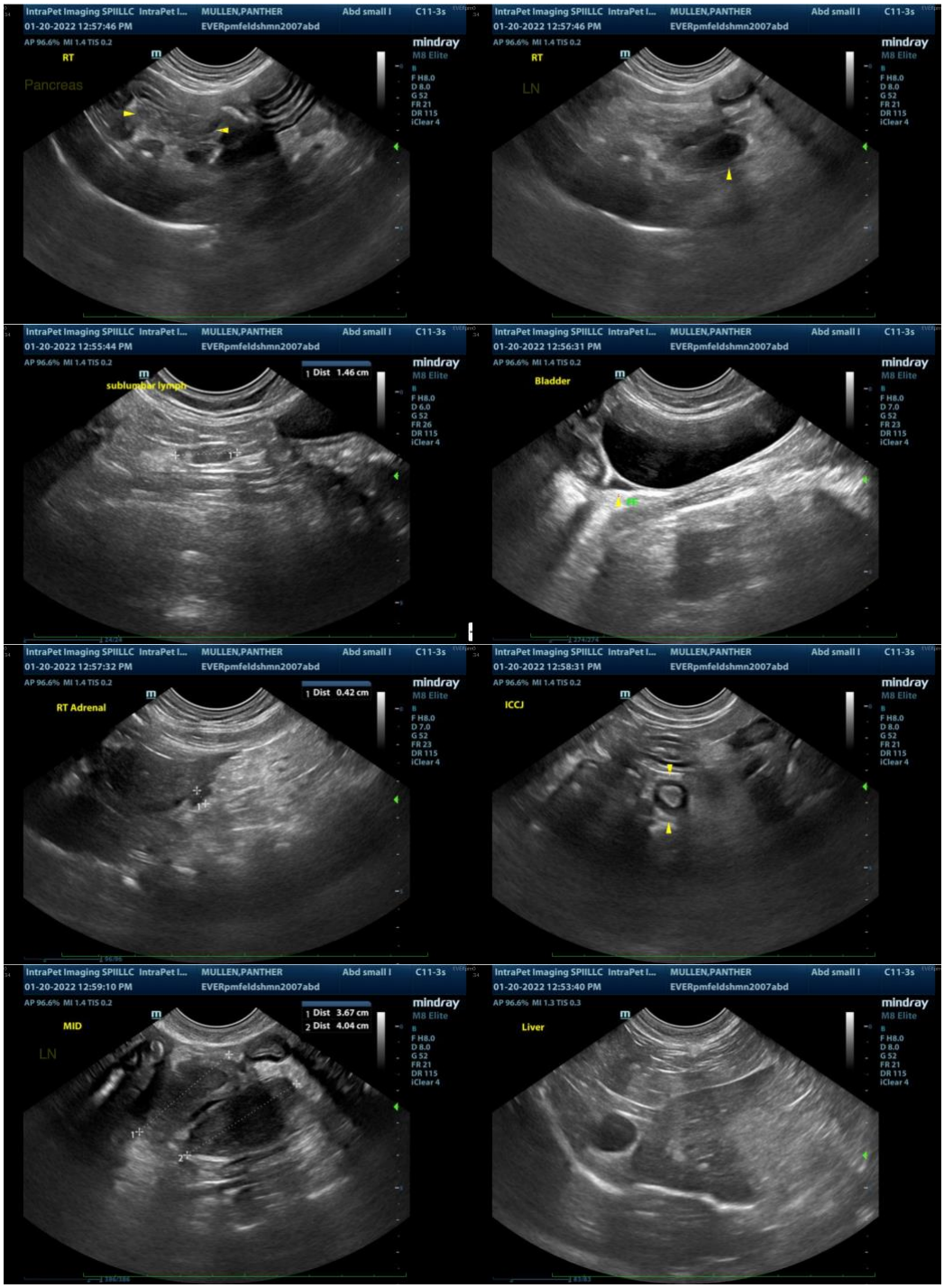
- The enlarged abdominal lymph nodes are concerning for infiltrative neoplasia. Lymphoma is the top differential. Regional peritonitis is present in the midabdominal cavity.
- The small intestinal wall changes are also concerning for emerging lymphoma with a possibility of severe inflammatory bowel disease.

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis, or chronic pancreatitis.
- Bilateral age-related renal changes with a suspected right cortical infarct.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for lymphadenopathy in the chest.
- A fine-needle aspirate of the enlarged midabdominal lymph nodes is recommended, if clotting status is appropriate. If cytology results are inconclusive, consider PARR or surgical abdominal lymph node and gastrointestinal biopsies to further assess for lymphoma.
- A malabsorption panel, including serum cobalamin and folate PLI and TLI is also recommended.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AP 96.6% MI 1.4 TIS 0.2
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2 Dist 4.04 cm
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AP 96.6% MI 1.3 TIS 0.3
Liver
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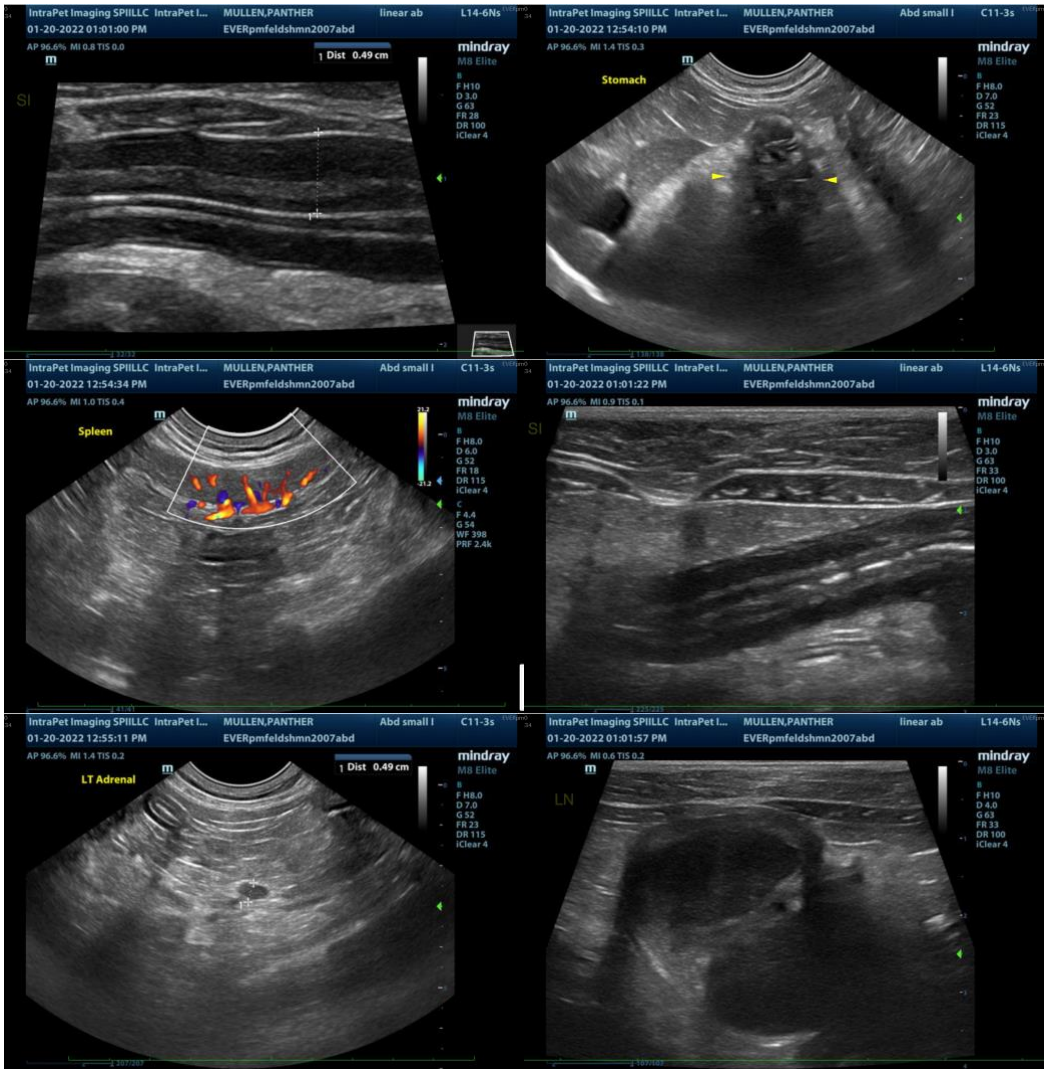
M8 Elite



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.

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