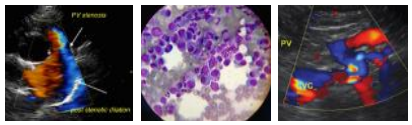
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Yaya Peeps Robinson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7-26-2004

WEIGHT

7.5 Lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brilhart, RDMS.

HOSPITAL NAME

Paradise Animal Hospital

REFERRING VET

Dr. Twardzik & Dr. King

INVOICE

10206

DATE

1/26/22

PRESENTING CLINICAL SIGNS

History: Patient had a carcinoma of the left maxilla that was treated with radiation therapy last summer and seems well controlled as of ~3weeks ago (U. Penn did tx, recheck). Suspected IBD based on U/S done at U Penn ~9 months ago. CKD stage II/IV non-hypertensive, non-proteinuric, stable-little change over last 3 weeks. Patient has had intermittent poor appetite. Owner gives Mirataz PRN. Thursday/Friday of last week, pt. seemed to have trouble passing very small BM, then started to have diarrhea. Appetite declined after diarrhea started Saturday, ate little; Sunday licked at gravy. Has not eaten since then.
BW Monday almost identical to BW done on 1/3 except mild leukocytosis, mild neutrophilia. Patient also gets sq fluids EOD at home.
Monday started on iv fluids, Cerenia 1 mg/kg iv SID, ondansetron 0.5 mg/kg iv SID and metronidazole 10 mg/kg iv BID. PE revealed very "plump" left kidney, dental disease, no other remarkable findings.

Current Medications: 50 ml sc fluids EOD, has been on 2X maintenance ~20 hours for last two days (Monday, Tuesday); Ondansetron 0.5 mg/kg iv SID (2 days), Cerenia oral on Sunday and iv Monday and Tuesday 1 mg/kg iv, Metronidazole started Monday 10 mg/kg iv BID.
Lab Results: Crea 2.4 mg/dl; BUN 37 mg/dl; WBCs 20K, neutrophils 17K; PCV 29%.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 mildly distended with 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 (3.49 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Trace pyelectasia is present (0.18 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.27 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

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

Spleen

The spleen is normal in size (0.58 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 prominent in size with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. There is an increase in portal markings. Hepatic vasculature is of normal volume with no evidence of congestion.

The gall bladder is moderately distended. A bi-lobed conformation is present with a normal wall thickness. The cystic ducts are prominent. The common bile duct is normal/not seen.

Gastrointestinal
The gastric lumen is severely fluid distended and hypomotile. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is diffusely dilated with fluid and chyme and is also hypomotile. The duodenal jejunal walls are normal in thickness with a normal layering pattern and appropriate mural detail. At the level of the ileocecocolic junction, a 3.05 x 2.04 cm mass effect is present and extending from the distal ileum into the proximal 2 cm of colon. The mesentery effacing the serosal surface of this region is hyperechoic. The wall in this region is severely thickened (up to 0.90 cm), hypoechoic with a complete loss of the normal layering pattern. The colonic wall tapers to a normal thickness as it extends distally. The colonic lumen contains granular-appearing fecal material.

Pancreas
The right limb is enlarged with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is borderline dilated (0.23 cm in diameter). The mesentery effacing the serosal surface is slightly hyperechoic.

Free Abdomen
Trace free fluid is observed. One to two prominent lymph nodes are observed at the ileocecocolic junction, the largest measuring 0.50. In addition, one to two prominent mesenteric lymph nodes are seen, the largest measuring 1.19 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

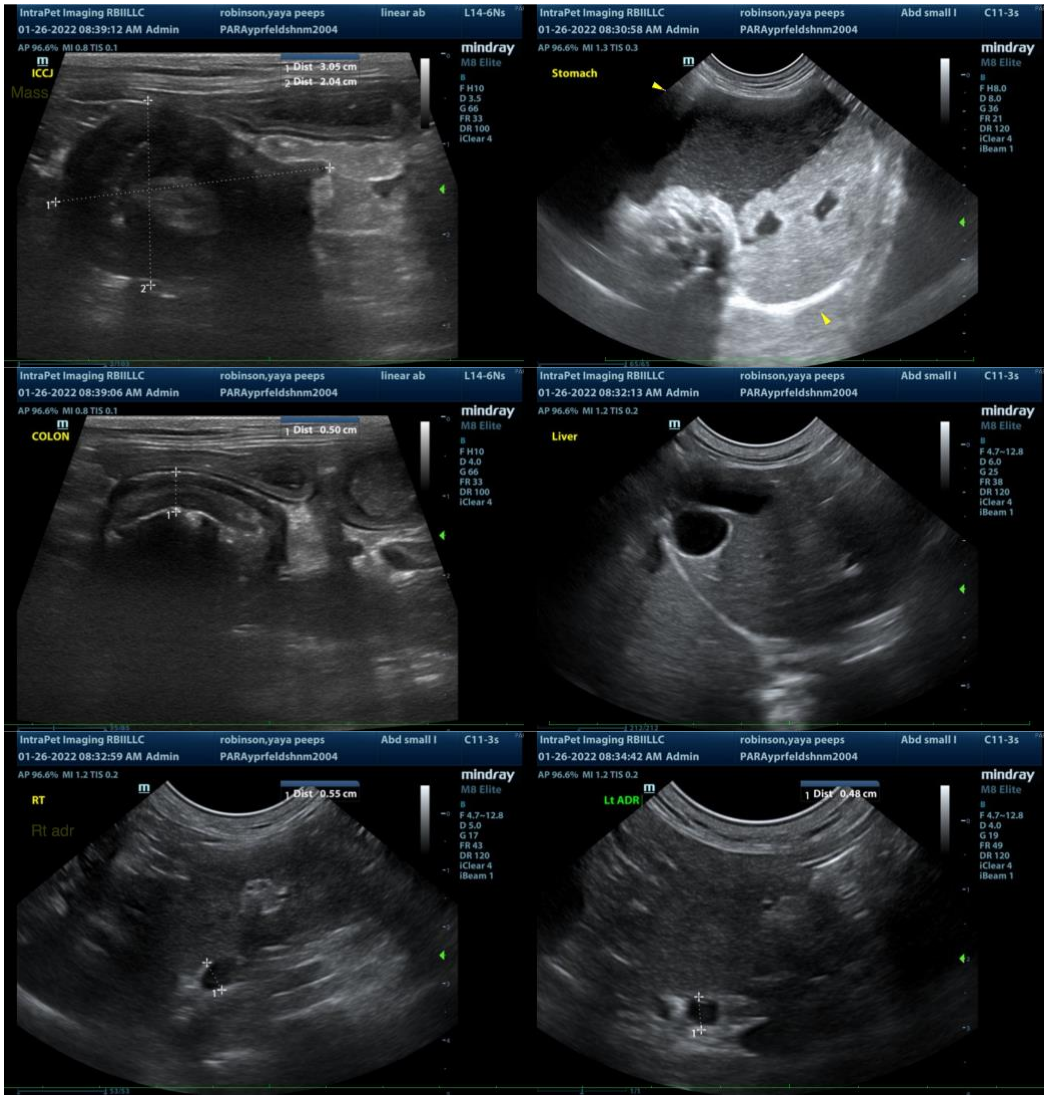
- Ileocecocolic junction mass effect with regional peritonitis. Neoplasia (i.e., lymphoma, adenocarcinoma, other) is suspected, with a low possibility of a severe inflammatory process (i.e., pyogranulomatous). Diffuse gastrointestinal ileus is present +/- partial outflow obstruction at the level of the ileocecocolic junction.
- The pancreatic changes are consistent with moderate, acute or acute-on-chronic pancreatitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

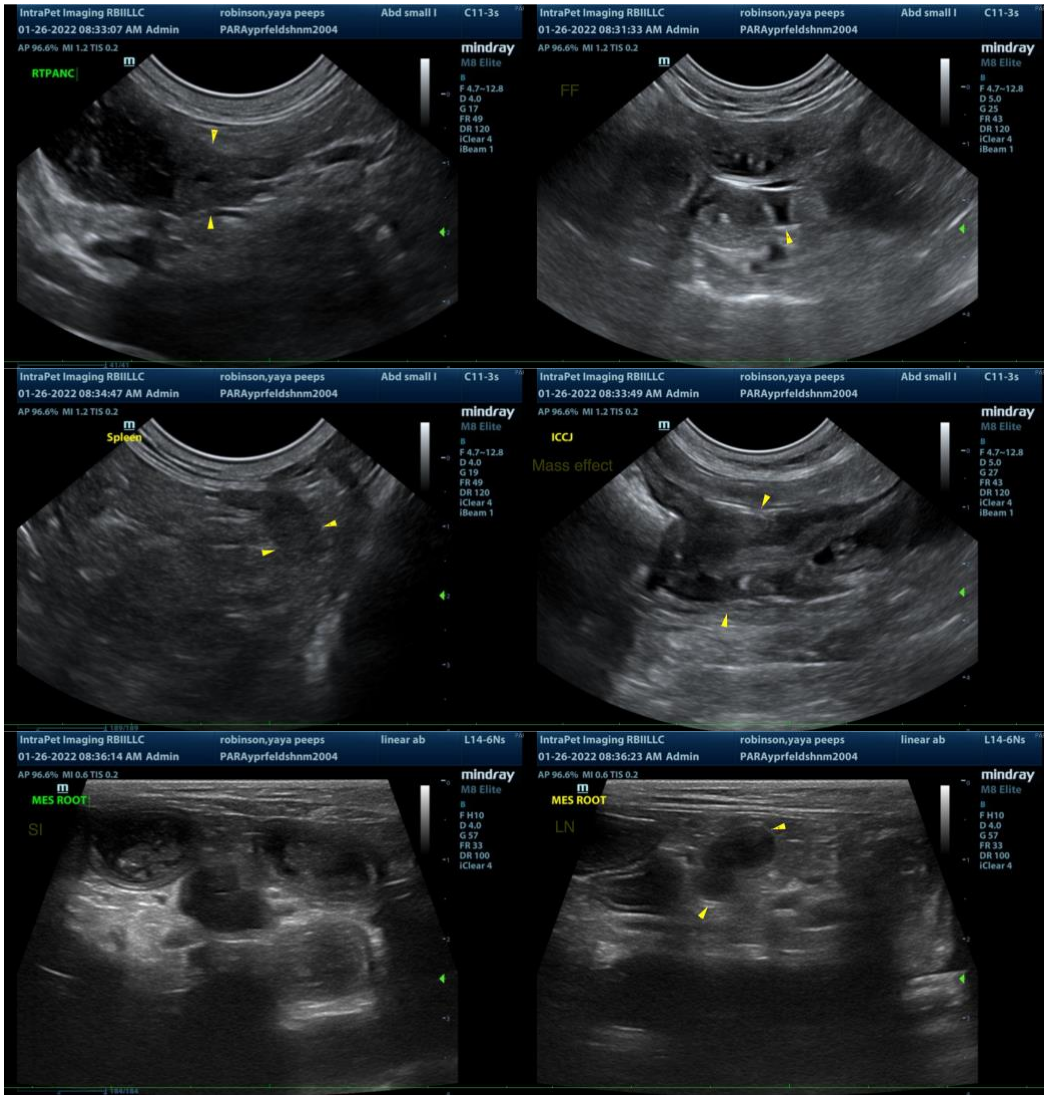
Secondary Findings

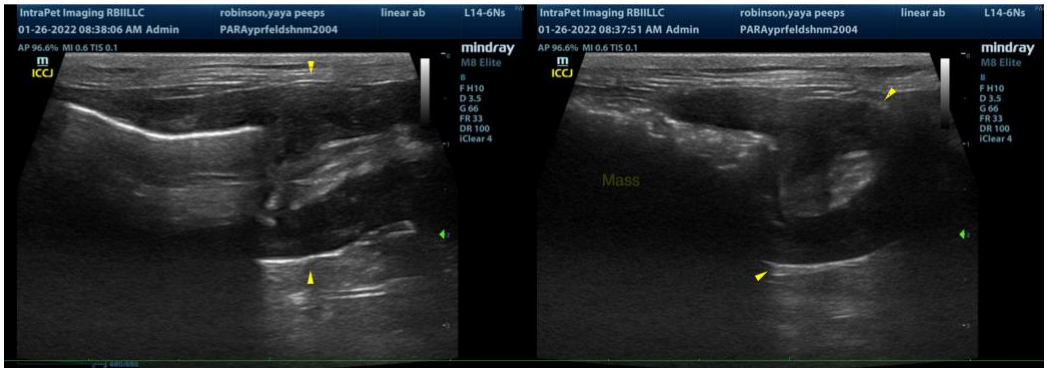
- Bi-lobed gall bladder – incidental
- The hepatic parenchymal changes are most consistent with and inflammatory process (i.e., cholangiohepatitis, lymphoplasmacytic hepatitis), with a lower possibility of infiltrative neoplasia or other hepatopathy.
- Bilateral degenerative renal changes with left pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- A fine-needle aspirate of the mass at the ileocecocolic junction is recommended if clotting status is appropriate. If cytology results are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis.
- A malabsorption panel, including serum cobalamin, folate PLI, and TLI is also recommended.




IntraPet Imaging RBIILLC
robinson,yaya peeps
Abd small I
C11-3s
01-26-2022 08:33:07 AM Admin
PARAyprfeldshnm2004
AP 96.6% MI 1.2 TIS 0.2
RTPANC
mindray
M8 Elite
IntraPet Imaging RBIILLC
robinson,yaya peeps
Abd small I
C11-3s
01-26-2022 08:31:33 AM Admin
PARAyprfeldshnm2004
AP 96.6% MI 1.2 TIS 0.2
FF
mindray
M8 Elite
IntraPet Imaging RBIILLC
robinson,yaya peeps
Abd small I
C11-3s
01-26-2022 08:34:47 AM Admin
PARAyprfeldshnm2004
AP 96.6% MI 1.2 TIS 0.2
Spleen
mindray
M8 Elite
IntraPet Imaging RBIILLC
robinson,yaya peeps
Abd small I
C11-3s
01-26-2022 08:33:49 AM Admin
PARAyprfeldshnm2004
AP 96.6% MI 1.2 TIS 0.2
ICCJ
Mass effect
mindray
M8 Elite
IntraPet Imaging RBIILLC
robinson,yaya peeps
linear ab
L14-6Ns
01-26-2022 08:36:14 AM Admin
PARAyprfeldshnm2004
AP 96.6% MI 0.6 TIS 0.2
MES ROOT
SI
mindray
M8 Elite
IntraPet Imaging RBIILLC
robinson,yaya peeps
linear ab
L14-6Ns
01-26-2022 08:36:23 AM Admin
PARAyprfeldshnm2004
AP 96.6% MI 0.6 TIS 0.2
MES ROOT
LN
mindray
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.

Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com