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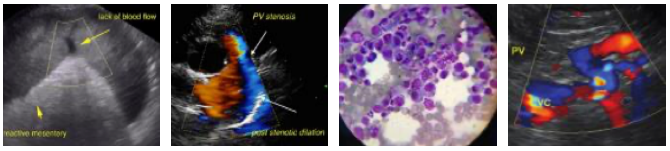

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Austin Brian

SPECIES

Feline

BREED

Domestic mediumhair

SEX

Male, neutered

AGE

12 Yrs.

WEIGHT

2.54 kg.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY

Dr. Patti Mayfield

HOSPITAL NAME

Bend Animal Emergency and Specialtiy Center

REFERRING VET

Dr. Poet

INVOICE

12839

DATE

PRESENTING CLINICAL SIGNS

History: Patient presents to BAESC for referral US services due to chronic weight loss and loose stools (years). Appetite remains adequate, but weight loss persists. Most recent blood work was performed February 2021 (~ 1 year ago) in which CBC was unremarkable and CHEM revealed hyperglobulinemia. T4, FeLV/FIV/HW and Fecal were all WNL/Negative No UA was submitted at the time. No treatments with prednisolone have been pursued to the clients knowledge, however it was discussed with Dr. Poet.
Abnormal PE/Chem/CBC/UA Results: PE: Lenticular sclerosis OU, moderate dental disease. Generalized thin/lean muscle atrophy. Stiff on mobility. Thickened intestines palpated. No obvious abdominal masses. Purring loudly, no murmur appreciated. No recent blood work; Last evaluated 2/2021 Hyperglobulinemia, 6.3 g/dL (3-5.9) Remainder senior screen and fecal analysis unremarkable Upon completion of the AUS, performed US-guided splenic and LN FNA. Telecytology pending at Sonopath

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. Overall, the wall is normal in thickness with a smooth mucosal surface. Luminal contents are mostly anechoic. A 0.24 x 0.14 cm proliferative lesion is observed in the region of the trigone. The visible portion of the proximal urethra is normal.

The left kidney is normal in size (4.05 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.16 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.23 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.19 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is mildly enlarged (1.22 cm in width at the level of the hilus) with slightly swollen peripheral margins and scalloping of the medial contour. The parenchyma is subtly mottled in appearance. No distinct focal lesions are observed. Splenic vasculature is normal with no evidence of thrombosis.

Liver

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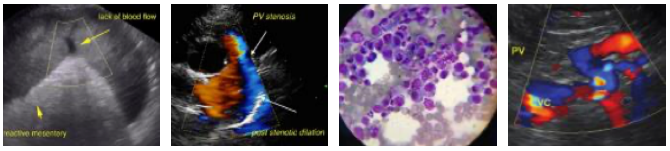

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The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen. A 2.17 x 1.93 cm multi-septated cystic mass is observed mid liver. The remaining parenchyma is homogeneous in appearance. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of aggregated echogenic partially dependent sludge is observed within the lumen. 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 small intestinal lumen is not dilated. An approximately 2 cm segment of jejunum is corrugated and thickened with a suspected loss of the normal layering pattern. In the remaining small intestinal segments, the wall is normal to mildly thickened (up to 0.27 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The left limb/body is prominent to enlarged with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and slightly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.15 cm in diameter).

Free Abdomen

Trace free fluid is observed. Several prominent mesenteric lymph nodes are visualized, the largest measuring 1.81 cm in length. In addition, a few prominent colic nodes are seen as well as a 1 cm gastric node.

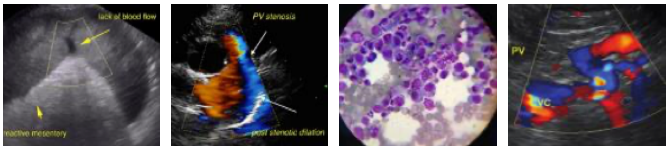
***Ultrasound guided fine needle aspirates of the spleen and mesenteric lymph nodes were obtained during the study without incident.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The splenic changes could be consistent with infiltrative neoplasia (i.e., lymphoma). Alternatively, a benign process (i.e., lymphoid hyperplasia or extramedullary hematopoiesis) may be present.
- The focal jejunal thickening may also represent a neoplastic process. Alternatively, an inflammatory focus may be present.
- The abdominal lymphadenopathy could be consistent with infiltrative neoplasia, lymphoid hyperplasia or reactive lymphadenitis.
- Trace ascites.

Secondary Findings:



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- The cystic hepatic mass is most consistent with biliary cystadenoma or cyst adenocarcinoma.
- The pancreatic changes are suggestive of chronic pancreatitis.
- Bilateral, age-related renal changes with dystrophic mineralization.
- The proliferative lesion in the region of the trigone may represent an inflammatory focus or an emerging neoplastic process.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult disease in the chest.
- If splenic and abdominal lymph node cytology results are inconclusive, an abdominal exploratory with gastrointestinal, abdominal lymph node and splenic biopsies may be necessary to get a definitive diagnosis.
- A GI panel (sent to Texas A&M) is also recommended.

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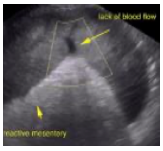
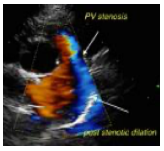
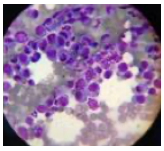
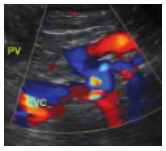

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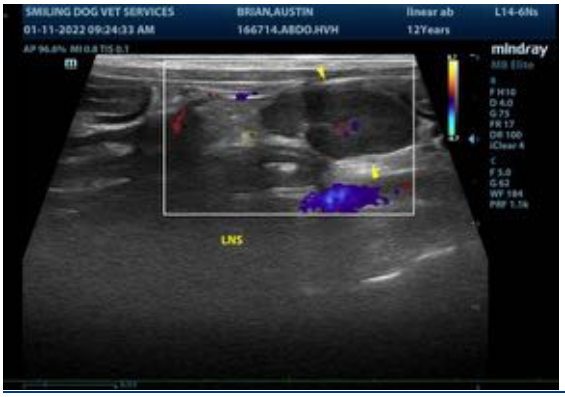

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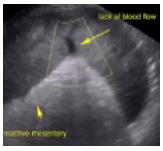
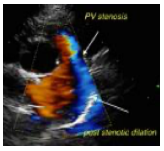
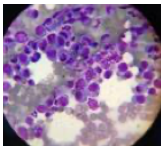
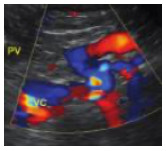

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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