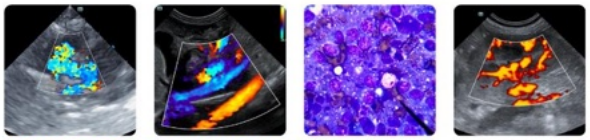


PATIENT
Elsa Merlo

SPECIES
Feline

BREED
Domestic shorthair

SEX
Female, spayed

AGE
10.5 Yrs.

WEIGHT
2.8 kg.

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

IMAGING PERFORMED BY
Lindsay Powell

HOSPITAL NAME
Hershey Animal Emergency Center

REFERRING VET
Dr. Lang

INVOICE
13406

DATE
1/20/26

PRESENTING CLINICAL SIGNS

History:

- Recently diagnosed diabetic - Vetsulin 2U BID
- O gave insulin tonight despite not eating well
- Presented obtunded - BG 34 mg/dL
- Was neurologic and ataxic at home causing O to bring PT in
- Recently diagnosed with pancreatitis and was put on miritaz but had been gaining her appetites back so O stopped Miritaz
- Recent pancreatitis
- Hx pancreatic mass diagnosed here on AUS
- Recurring abscess like massess; responsive to clavamox
- PE:Oral Cavity: Mucous membranes pink/moist; full oral exam not performed
- Abd: Soft and compliant with possible mass affect in cranial to mid abdomen; gaseous intestines
- Musculoskeletal: Ambulation not assessed; patient laterally recumbent with neck hyperextended
- Nervous system: Obtunded
- BG Triage: 32,BG following initial dextrose bolus: 71, BP: 108
- CBC: RBC 4.35 (L) HCT 17.9 (L) Hemo 5.4 (L) WBC 27.00 (H) Neutrophils 24.12 (H) Monocytes 0.88 (H)
- EPOC: BE,ECF -9.7 (L) Na 146 (L) BUN 11 (L) Glu 169 (H) HCT 17 (L)
- Chem15: Creat 0.4 (L) BUN 10 (L) ALT <10 (L)
- Pancreatic Lipase: 19.2 (H)
- BG at 2am: 277,BG at 4am: 277,BG at 6am: 211

Abnormal PE/Chem/CBC/UA Results: Abd/chest reads: Decreased abd serosal detail is concerning of mild abdominal effusion–mesenteric reaction. Underlying carcinomatosis cannot be excluded. Poss mass in the cranioventral abdomen: DDx. Mass originating from the pancreas [neoplasia including adenocarcinoma, abscess, granuloma], spleen [neoplasia, nodular hyperplasia, extramedullary hematopoiesis], lymph node or mesentery. Entero–gastroenteropathy: DDx. Gastroenteritis–enterocolitis, inflammatory bowel disease or infiltrative neoplasia including lymphoma. Small mineral opaque bodies in the dorsal abdomen is concerning of uroliths in the ureters. DDx. Material within the gastrointestinal tract. Mod distended urinary bladder compatible with urine retention–correlate with the clinical exam

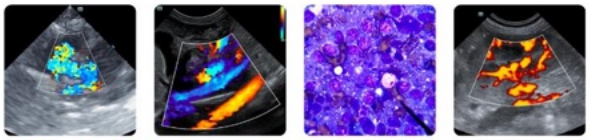
ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.60 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Mild pyelectasia is present (0.21 cm in the longitudinal plane). There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (3.69 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several



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hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present (0.17 cm in the transverse plane). There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.88 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. 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. A scant amount of echogenic to mineralized debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

A 4.7 x 2.7 cm irregular, echogenic mass with fluid pockets is arising from the region of the pancreas. Surrounding mesentery is hyperechoic.

Lymph nodes

A few prominent mesenteric lymph nodes are visualized, one of the nodes measuring 1.05 x 0.59 cm. Surrounding mesentery is hyperechoic.

Free Abdomen

The mesentery in the cranial to mid-abdomen is hyperechoic. Trace free fluid is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Cranial to mid-abdominal mass suspected to be of pancreatic origin. Neoplasia (i.e., adenocarcinoma, round cell tumor) is suspected with a lower possibility of a benign process (i.e.,

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inflammatory). Fluid pockets are observed within the mass. There is mild adjacent peritonitis. The mass appears slightly larger compared to the previous sonogram.

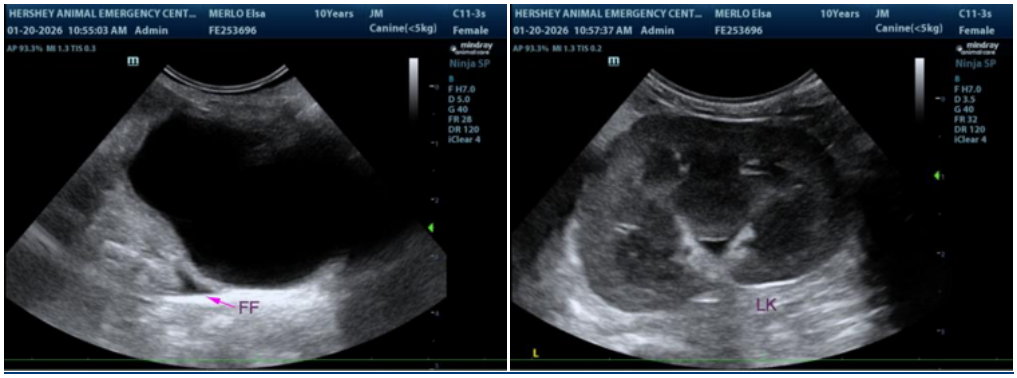
- Cranial peritonitis, likely secondary to pancreatic pathology. Changes are similar to the previous sonogram.

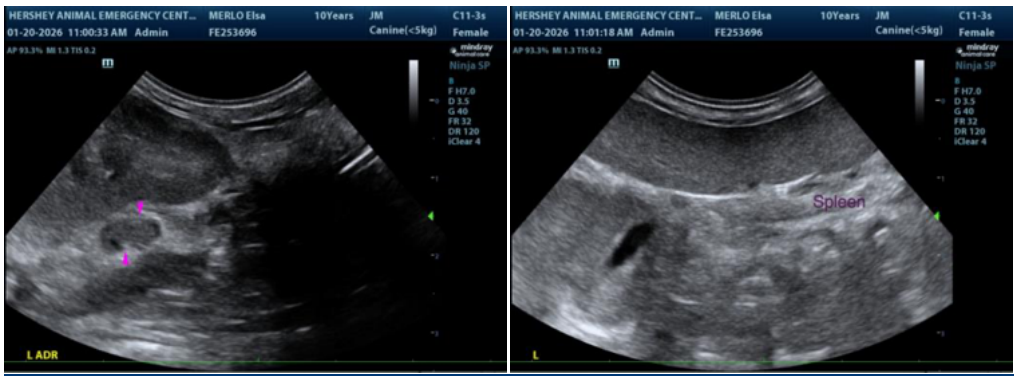
Secondary Findings:

- Minor bilateral, age-related renal changes with dystrophic mineralization. The bilateral pyelectasia may be secondary to parenchymal remodeling, pyelonephritis, PU/PD (if applicable) or some combination thereof.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
2. Consider fine needle aspiration of the pancreatic mass (assuming normal clotting status). A 25-gauge needle should be used. Depending on cytology results, consultation with a board-certified oncologist may be indicated. If tissue sampling is not pursued, palliative care is recommended.





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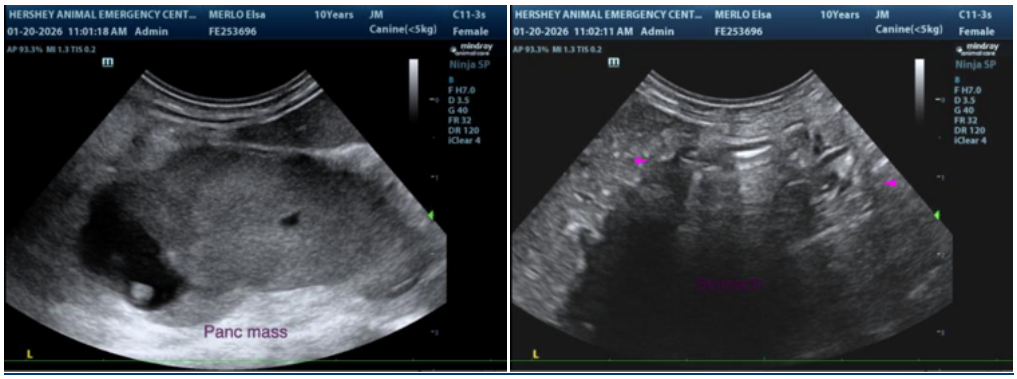

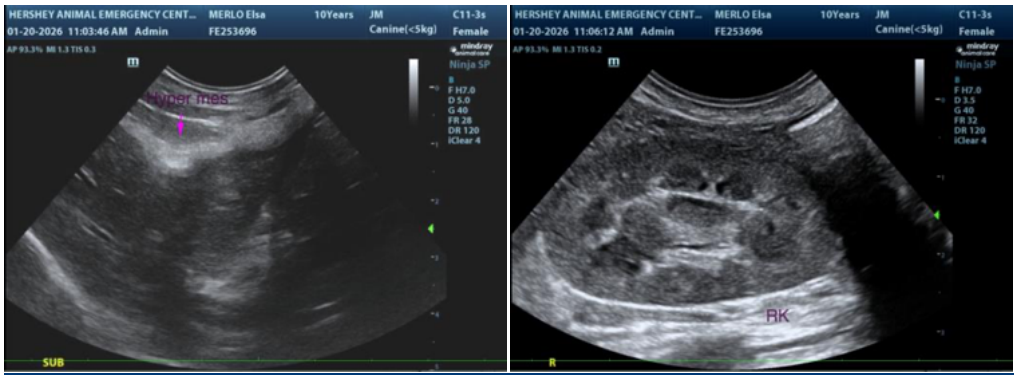

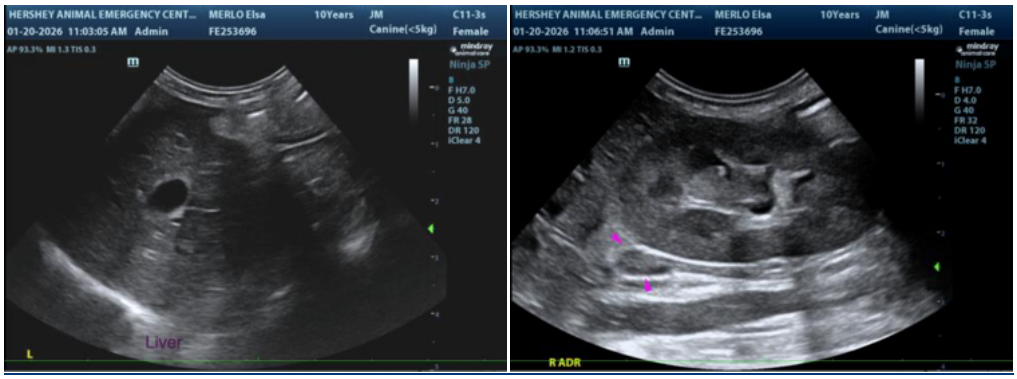

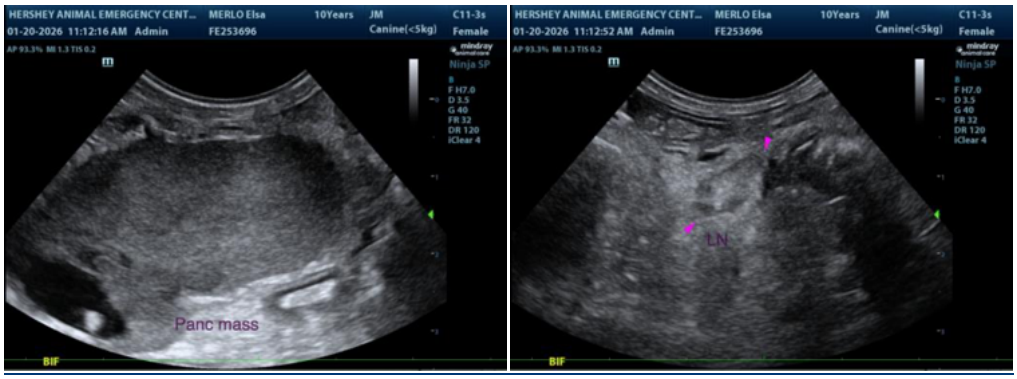

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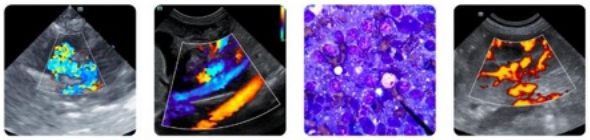

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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