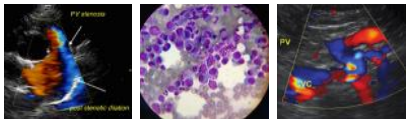
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

1/5/22

PATIENT

Theodore Sproles

SPECIES

Feline

BREED

British Shorthair

SEX

Neutered Male

AGE

8/1/12

WEIGHT

14.5 Lbs.

INTERPRETED BY

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

HOSPITAL NAME

Stevenson Village VH

REFERRING VET

Dr. Rathburn

INVOICE

13126

PRESENTING CLINICAL SIGNS

History: Presented for exam on 12/23/21. The owner had been noting weight loss over the past several months and the patient had been sneezing with slight discharge from his eyes for a few weeks preceding the examination. Mild generalized muscle atrophy noted on PE; small left-sided thyroid nodule. No overt GI signs have been noted at home.

Lab Results: Mild hypocalcemia: 7.8 mg/dL (8.2-10.8), mild neutrophilia: 14.1K/uL (2.5-8.5); 3+ proteinuria (collected via cystocentesis), mild pyuria: 4-10 WBC/HPF (0-3); TT4 and fT4 were WNL. Attached separately.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Stephanie Pearce RDCS, RVT

**Due to the amount of ingesta throughout the GI tract, it is possible that some pathology may be missed/obscured.*

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 is moderately distended. A small amount of suspended echogenic debris is observed within the lumen. 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 (5.57 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. The cortex is hyperechoic. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (5.65 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. The cortex is hyperechoic. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.53 cm width). with a normal shape and smooth peripheral contours. A few hyperechoic areas are observed within the parenchyma. Surrounding vasculature appears normal.

The right adrenal gland is normal size (0.52 cm width). with a normal shape and smooth peripheral contours. A few hyperechoic areas are observed within the parenchyma. Surrounding vasculature appears normal.

Spleen

The spleen is subjectively prominent in size (1.06 cm in width at the level of the hilus) with slightly swollen

peripheral contours. Using the high frequency probe, the parenchyma appears slightly mottled. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with swollen peripheral contours. The parenchyma is isoechoic to hyperechoic relative to the spleen and homogeneous in appearance. No focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is mildly distended. The wall is diffusely thickened (up to 0.27 cm) and hyperechoic. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is 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 segmentally dilated with chyme. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely prominent to enlarged with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. The pancreatic duct is visible but not overtly dilated (0.19 cm in diameter).

Free Abdomen

A moderate amount of free fluid is present. The mesentery throughout the abdomen is hyperechoic. Several prominent to enlarged lymph nodes are observed adjacent to the ileocecocolic junction, the largest measuring 2.43 cm in length.

Other

A brief echocardiogram (echocardiogram) reveals no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

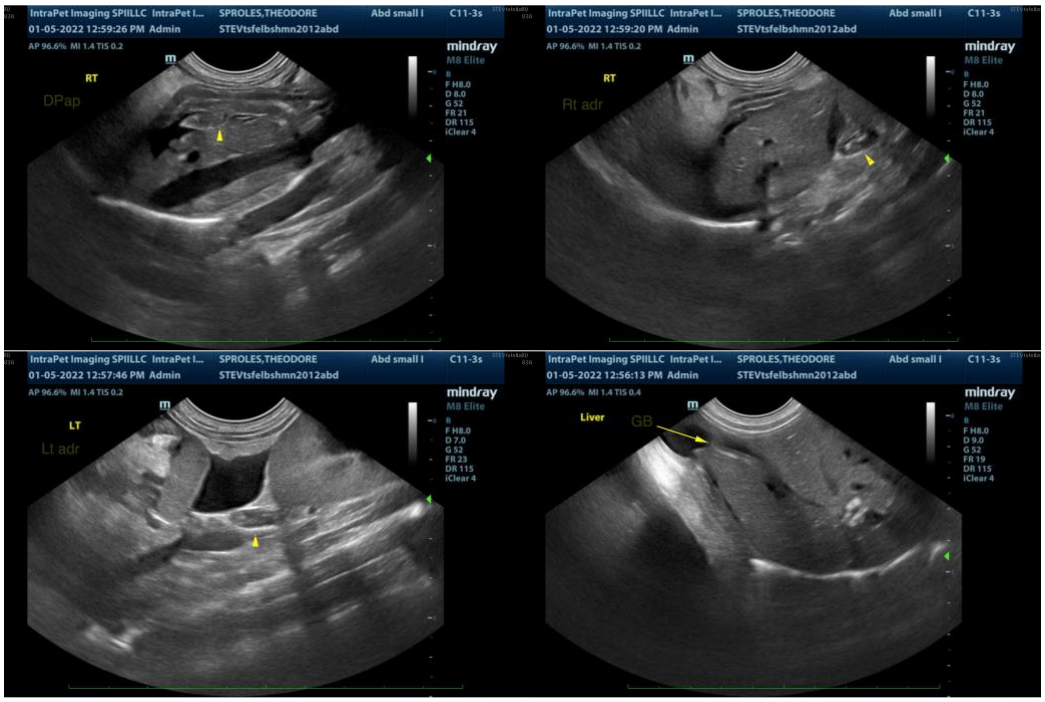
- The abdominal lymphadenopathy could be consistent with infiltrative neoplasia (i.e., lymphoma), reactive lymphadenitis or lymphoid hyperplasia.
- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- The gallbladder all changes could be consistent with cholecystitis, benign age-related hyperplasia or artifactual due to lack of full repletion. Correlation with clinical findings is recommended.
- The pancreatic changes are consistent with pancreatitis, which may be acute or chronic and active.
- The ascites may be secondary to increased vascular permeability, low oncotic pressure or increased hydrostatic pressure.

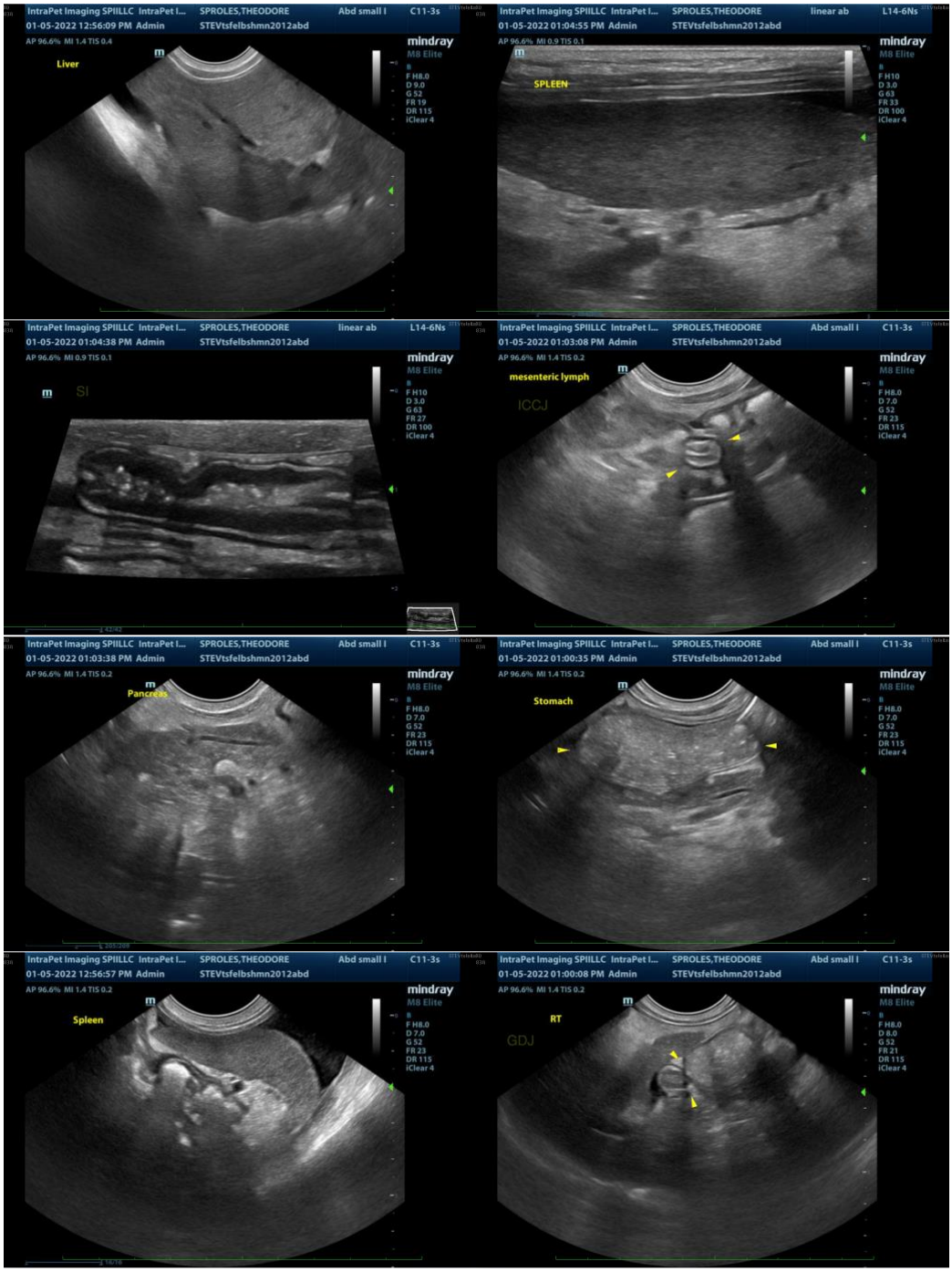
Secondary Findings

- The splenic parenchymal changes could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis or infiltrative neoplasia (i.e., lymphoma).
- Bilateral age-related renal changes
- The hyperechoic foci in both adrenal glands are likely a benign, age-related incidental finding

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for neoplasia in the chest.
- If clotting status is appropriate, fine needle aspirates of the liver and enlarged abdominal lymph nodes are recommended. 25-gauge needles should be used. Also consider submission of the abdominal fluid for analysis and cytology. If cytologic evaluations are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis.
- Also consider a malabsorption panel, including serum cobalamin, folate, TLI and PLI.





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.

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