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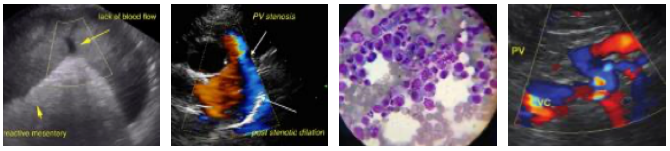


PATIENT
Benny Gerish

SPECIES
Feline

BREED
Domestic shorthair

SEX
Male, neutered

AGE
13 Yrs.

WEIGHT
12.8 lbs.

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

IMAGING PERFORMED BY
Dr. Sheldon

HOSPITAL NAME
Advanced PetCre of Oakland

REFERRING VET
Dr. Sheldon

INVOICE
12394

DATE
10/19/21

PRESENTING CLINICAL SIGNS

History: Stopped eating on his own about a week ago, owner has been force feeding. No vomiting or diarrhea. Losing weight 3-4 weeks. Fairly normal energy level per owner.
Abnormal PE/Chem/CBC/UA Results: cbc-LO lymph 0.51, HI mono 0.69, LO plt 59, PCT 0.11 diff slide-adequate platelets noted chems- HI sdma 22 (normal creat 0.9) LO bun 14, HI alkp 315, HI ggt 7 HI tbili 2.4 t4 3.9 normal Radiographs of the abdomen:Ill-defined soft tissue opacity superimposed between the stomach and colon on the lateral view is concerning for focal enlargement of the pancreas. Differentials include inflammatory (pancreatitis) and neoplastic etiologies. Hepatosplenomegaly. This is concerning for neoplasia however other causes of hepatomegaly including vacuolar hepatopathy secondary to hepatic lipidosis or underlying endocrine disease or hepatic inflammation are also considered possible. Additional differentials for splenomegaly including side effect of sedation (if given), lymphoid hyperplasia and extramedullary hematopoiesis are also considered possible. Lumbosacral degeneration.

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. A moderate amount of aggregated echogenic suspended 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 (3.67 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.72 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.53 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

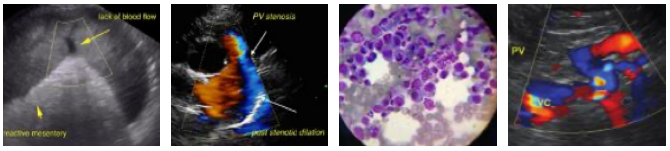
The region of the right adrenal gland is evaluated. No obvious pathology is observed.

Spleen

The spleen is subjectively enlarged with swollen peripheral margins and a folded contour. The parenchyma is mottled in appearance. No focal lesions are observed. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.



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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. 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 lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The pancreas is diffusely prominent in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

A small amount of free fluid is visualized. The mesentery in the cranial abdomen is hyperechoic. A few prominent hypoechoic mesenteric lymph nodes are visualized, the largest measuring 1.39 cm in length. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

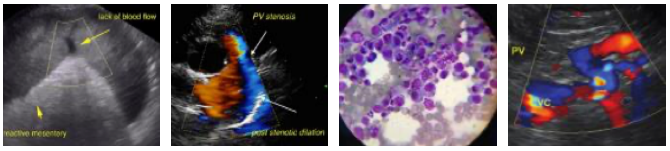
- The splenic changes are concerning for infiltrative neoplasia (i.e., round cell tumor) with a lower possibility of benign pathology (i.e., extramedullary hematopoiesis or lymphoid hyperplasia).
- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Cranial peritonitis, likely secondary to splenic and hepatic pathology.
- The abdominal lymphadenopathy may be secondary to reactive lymphadenitis, lymphoid hyperplasia, or infiltrative neoplasia.
- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The pancreatic changes are suggestive of pancreatitis.

Secondary Findings:

- Minor age-related renal pathology.
- Urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for neoplasia in the chest.
- Fine needle aspirates of the spleen and liver are recommended (if clotting status is appropriate). 25-gauge needles should be used. If cytologic evaluations are inconclusive, surgical biopsies



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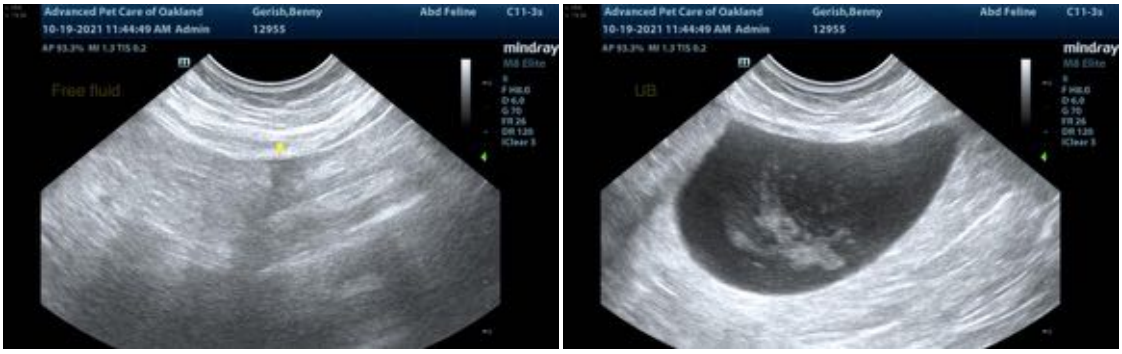
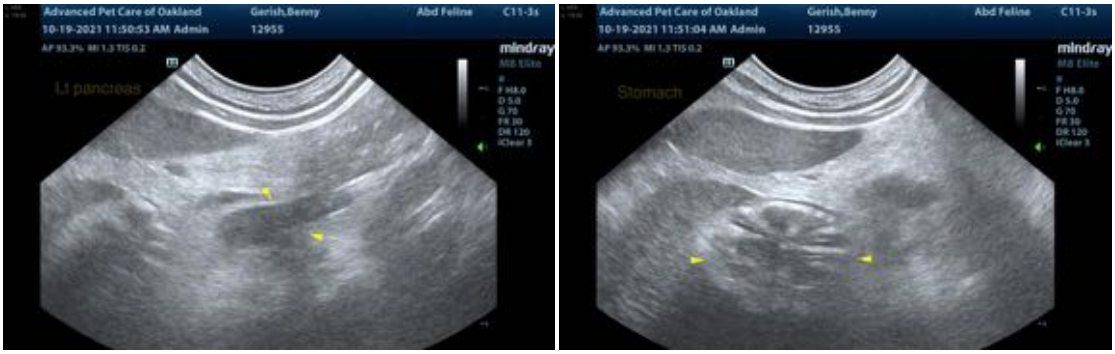
may be necessary to get a definitive diagnosis. If surgery is pursued, biopsies of the gastrointestinal tract and prominent abdominal lymph nodes should also be obtained.

- A malabsorption panel should also be considered.
- Given the hepatic changes and history of anorexia, nutritional support (i.e., via temporary feeding tube) is strongly recommended to provide adequate caloric intake.





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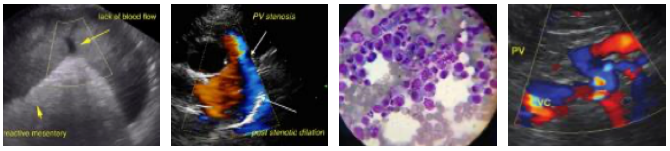

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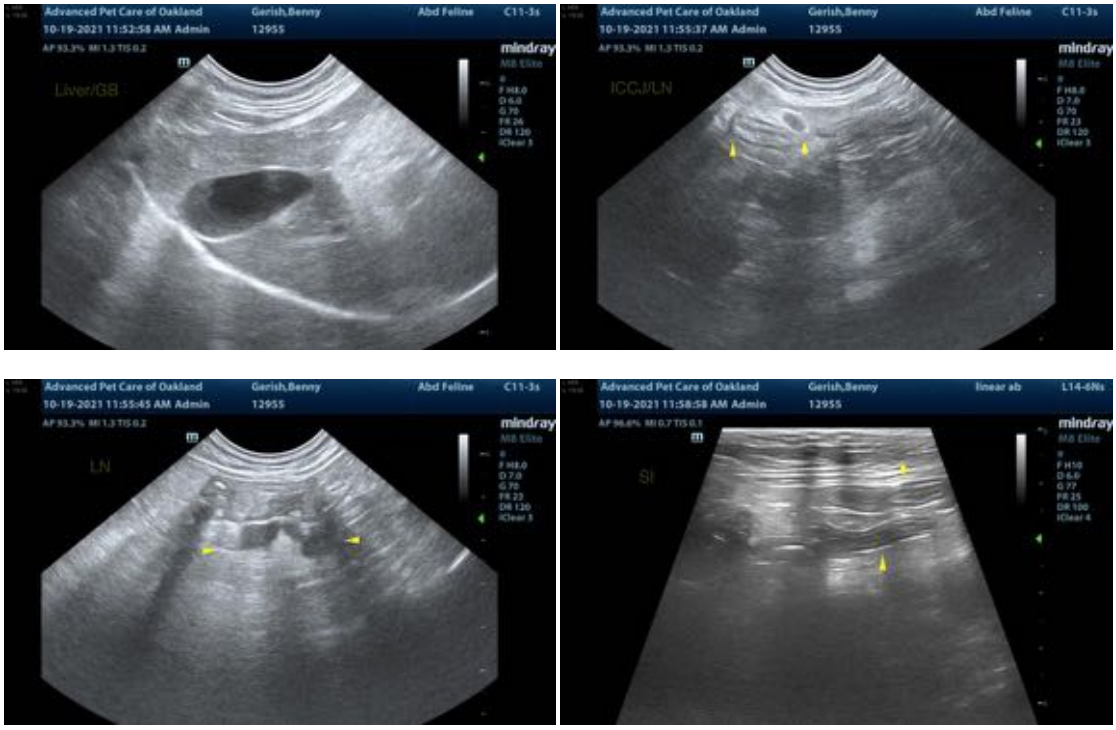

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

Andrea.nicastro@sonopath.com