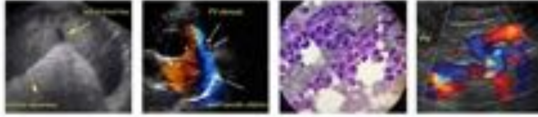

PATIENT

Gia Daniel

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Female, spayed

AGE

3 Years

WEIGHT

7 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Donner Truckee VH

REFERRING VET

Dr. VAnnini

INVOICE

12377

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PRESENTING CLINICAL SIGNS

History: weight loss- CBC with reticulocyte count: HCT well WNL with elevated reticulocyte count and mild neutrophilia, rest WNL. LM detailing lab results. Detailed no anemia and rec consider AUS and fecal exam +/- Fenbendazole empirical deworm, especially if patient continuing to vomit, lose weight, or have a poor appetite. Reason for Visit: Vomiting Recheck GI signs. Patient was having vomiting ~2 wks ago and had a work up here on 10/5/2021. Anemia and stress vs inflammatory leukogram were noted. Rads were unremarkable. Patient was treated with Convenia, Cerenia, and SQF. Vomiting appeared to resolve, ut patient had another episode of vomiting this morning. She also spit out her hard food after the episode of vomit. Good energy, appetite is fair, but is not interested in her usual canned food. No C/S/D. No historical problems/current medications reported. Indoor only, except for brief outdoor time under supervision.
Abnormal PE/Chem/CBC/UA Results: 1) Recent mild anemia - r/o: loss, destruction, decreased productions, spurious. 2) Intermittent vomiting with weight loss - r/o: parasite, IBD, FB, open

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. Luminal contents are mostly anechoic. 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 (3.17 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.44 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.25 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

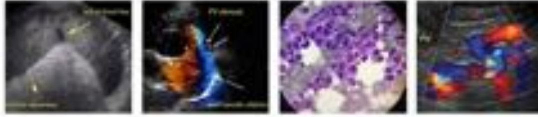
The right adrenal gland is normal in size (0.24 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is enlarged with irregular peripheral contours. A 2.36 x 1.79 cm irregular hypoechoic vascular mass appears to be arising from the medial aspect. The mesentery effacing the serosal surface is hyperechoic. Cavitated areas are observed within the parenchyma of the mass. The remaining splenic parenchyma is homogeneous in appearance. Splenic vasculature appears normal with no evidence of thrombosis.

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. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately



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distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly fluid distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. A 2.32 cm hypoechoic proximal duodenal mass is visualized. The wall in this region is thickened (up to 0.80 cm) with complete loss of the normal layering pattern. In the remaining small intestinal segments the wall thickness is normal with a normal layering pattern and appropriate mural detail. The ileocecal colic junction and colonic wall are normal. No obvious obstructive disease is noted.

Pancreas

The left and right limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

Trace free fluid is observed. A 0.86 cm lymph node is observed in the cranial abdomen adjacent to the pylorus. See also *Other.*

Other

A 1.21 x 1.15 cm irregular echogenic mass is observed superficially near the ileocecal colic junction. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

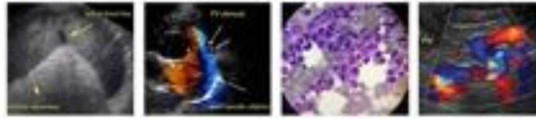
Primary Findings:

- Splenic mass. Neoplasia (i.e., round cell tumor, sarcoma) is considered likely with a low possibility of benign pathology.
- Proximal duodenal mass. Again, neoplasia (i.e., round cell tumor, carcinoma) is considered likely with a lower possibility of a focal inflammatory process.
- The echogenic mass effect adjacent to the ileocecal colic junction is thought to represent enlarged lymph nodes which may be due to infiltrative neoplasia, reactive lymphadenitis or lymphoid hyperplasia.
- The trace ascites is likely secondary to splenic and bowel pathology.

Secondary Findings:

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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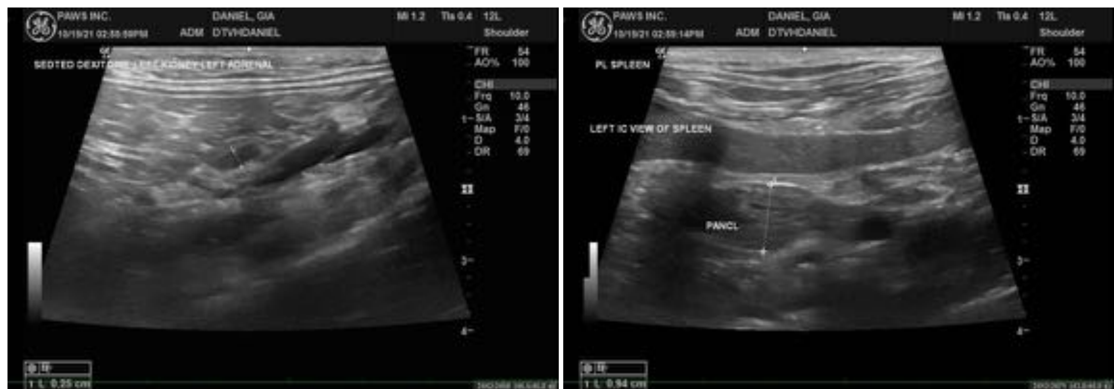
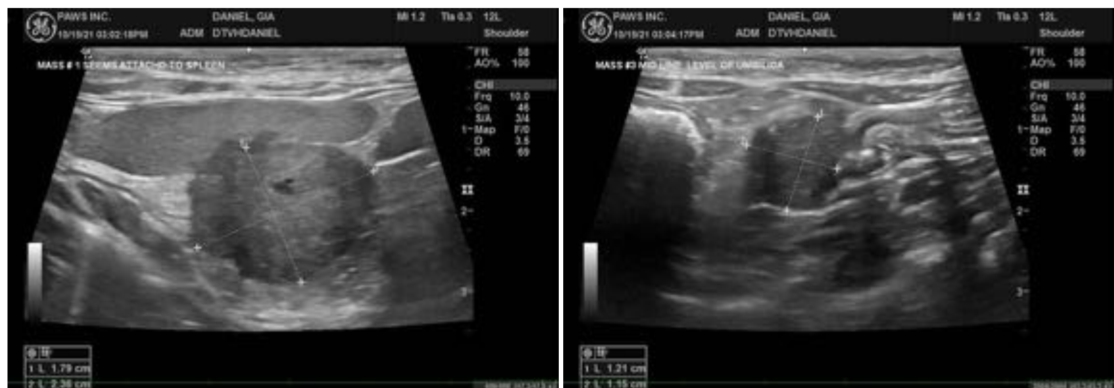
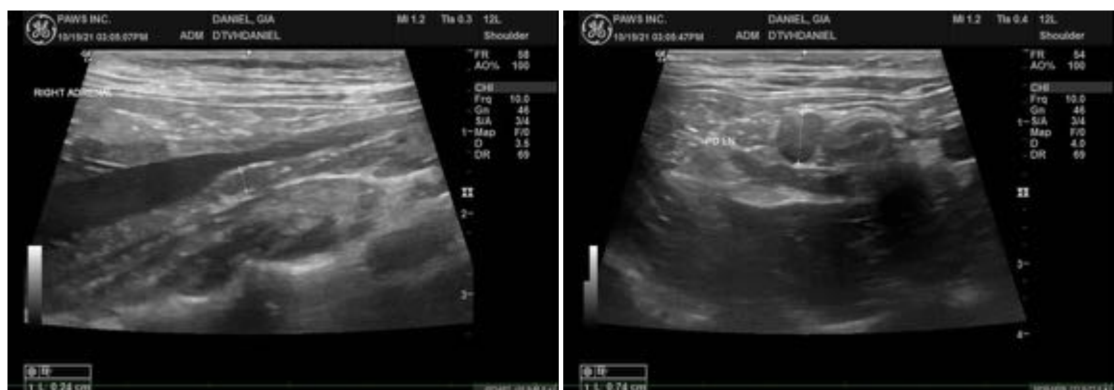
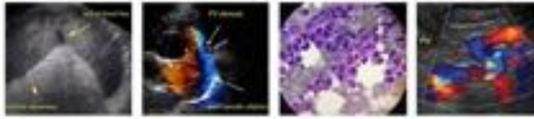
- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If accessible, fine needle aspirates of the splenic and duodenal masses are recommended using 25-gauge needles. Clotting status should be assessed prior to aspiration. If cytologic evaluations are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis.
- Other diagnostic considerations include feline leukemia and FIV testing as well as a GI panel (i.e., serum cobalamin, folate, TLI and PLI).









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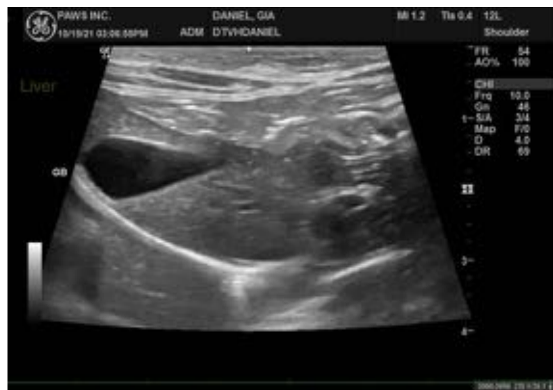

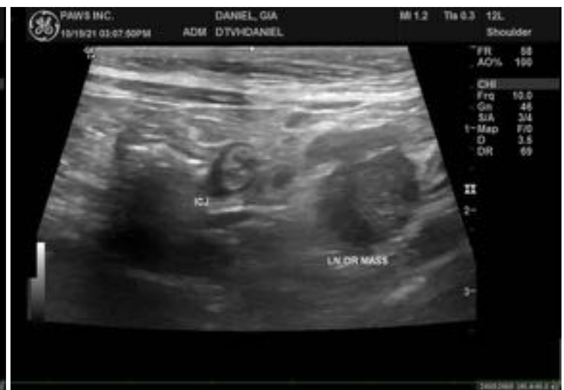

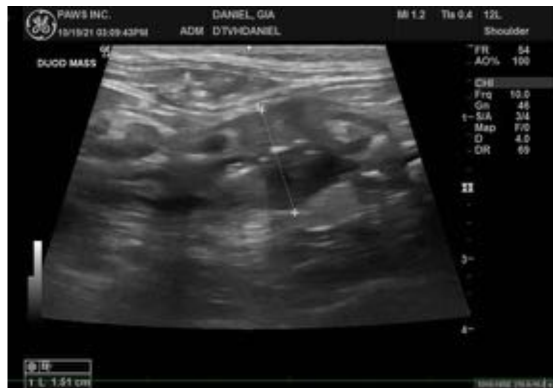

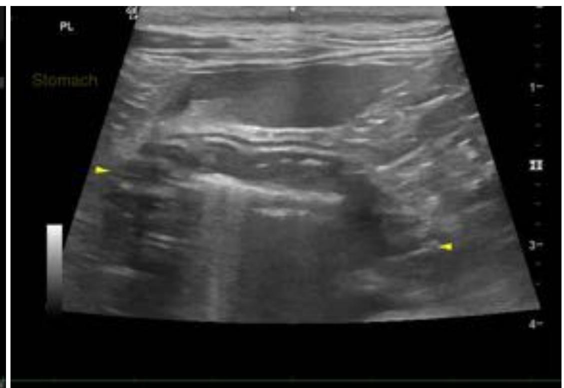

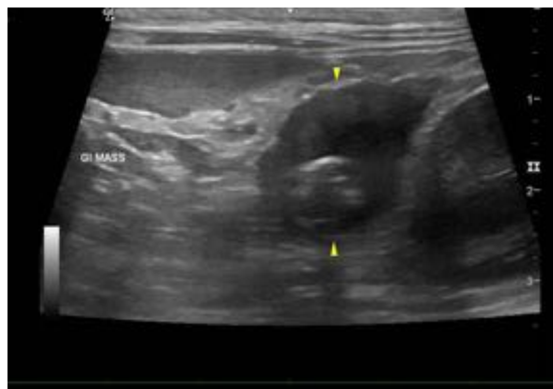

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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*)

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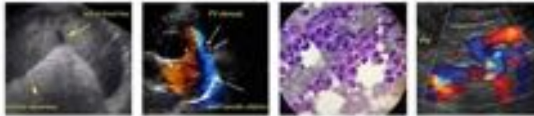

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pawsonography@gmail.com 530-786-8340

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