

**PATIENT**

Rocco Lake

**SPECIES**

Feline

**BREED**

DSH/Bengal

**SEX**

Neutered Male

**AGE**

9.5 years

**WEIGHT**

8.5 lbs

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Loetitia Saint-Jacques,  
RVT LVT

**HOSPITAL NAME**

Grass Valley VH

**REFERRING VET**

Dr Kristi Cortright

**INVOICE**

11858

**DATE**

10.20.22

**PRESENTING CLINICAL SIGNS**

History: Reason for Ultrasound: Weight loss - r/o hyperT4, renal, neoplasia, open Enucleated OD - hx of iris melanoma w/ follow-up chemo. History: weight loss. Had eye enucleation due to melanoma of the iris. Lower energy level than usual. Indoor/outdoor. Fluctuating appetite sometimes appears related to the weather. Started regurgitating food in the beginning of the summer which is abnormal for him.

Abnormal PE/Chem/CBC/UA Results: Physical exam findings: 2-3/9 generalized muscle wasting. OS: Lids, conjunctiva, and globe WNL. Mod calculus, mild gingivitis. Recession over 104. Cachectic - generalized muscle wasting. Abnormal CBC values: Platelet Count=952X1000/UL -- Neutrophils=12642 /UL - Lymphocytes=882 /UL Abnormal Chemistry Values: TOTAL PROTEIN= 5.1 / GLOBULIN=2.0 / A/G RATIO=1.6 / NA/K RATIO=30 Abnormal UA Values: Specific Gravity=1.069 / Protein=2+ / Bilirubin=1+ RADS: unremarkable

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The **urinary bladder** is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A scant amount of suspended, echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. The region of the trigone is normal.

The **left kidney** is normal size (4.05 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 relative to the spleen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The **right kidney** is normal size (4.39 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 relative to the spleen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

**Adrenal Glands**

The **left adrenal gland** is normal size (0.44 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (0.45 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

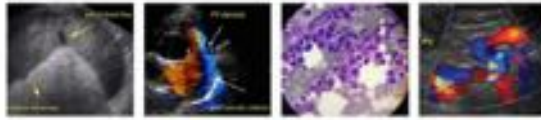
**Spleen**

The **spleen** is normal to slightly prominent in size (0.73 cm in width at the level of the hilus) with normal curvilinear peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The **liver** is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic 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 **gall bladder** lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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**Gastrointestinal**

The **gastric lumen** is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. A <4.00 cm segment of jejunum is severely thickened (up to 0.60 cm) with a mass effect. The wall in this region is hypoechoic with complete loss of the normal layering pattern. The mesentery effacing the serosal surface in this region is hyperechoic. Within this segment, the lumen contains a small amount of hyperechoic shadowing material. The remaining small intestinal segments are normal in thickness with a normal with a normal layering pattern and appropriate mural detail. The colonic wall is normal.

**Pancreas**

The right limb of the **pancreas** is 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 (0.18 cm in diameter). There is no evidence of peripancreatic inflammation or effusion.

**Free Abdomen**

Trace free fluid is observed. A few enlarged, rounded, hypoechoic to slightly heterogenous mesenteric **lymph nodes** are visualized, the largest measuring 2.85 cm in length.

**Other**

A **brief echocardiogram** reveals no evidence of pericardial effusion.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Jejunal mass effect with adjacent peritonitis. Neoplasia (i.e., lymphoma, adenocarcinoma, leiomyosarcoma) is suspected with a lower possibility of a severe focal inflammatory process (i.e., pyogranulomatous).
- The mesenteric lymphadenopathy is also concerning for infiltrative neoplasia with a lower possibility of reactive change.

**Secondary Findings**

- Minor age-related pancreatic remodeling
- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, other hepatopathy, or normal variant.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Fine-needle aspirates of the jejunal mass and mesenteric lymph nodes are recommended if clotting status is appropriate. Twenty-five gauge-needles should be used. If cytology results are inconclusive, more advanced testing (i.e., flow cytometry, PARR or surgical biopsies) may be necessary to get a definitive diagnosis.

Three-view thoracic radiographs are also recommended to assess cardiopulmonary status.

Also consider a malabsorption panel including serum cobalamin and folate, TLI and PLI to assess for concurrent maldigestion/malabsorption and pancreatitis.



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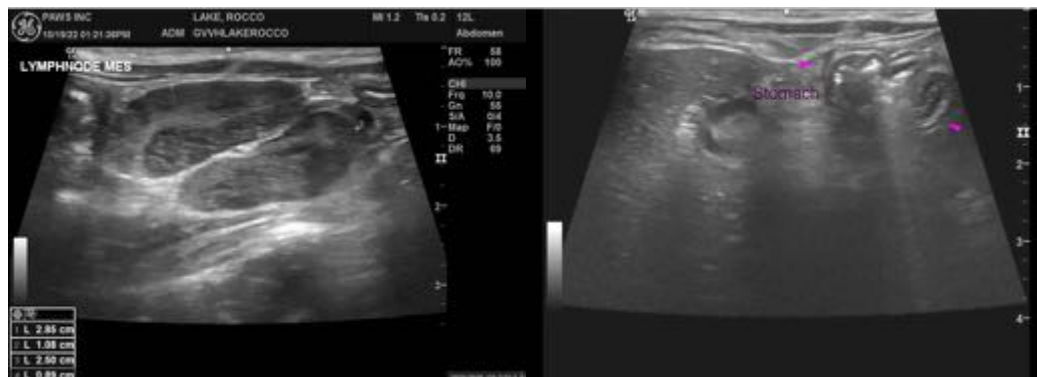
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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