IMAGING PERFORMED BY

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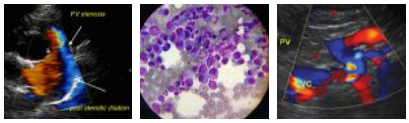

SonoPath
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DATE

10/28/21

PATIENT

Joseph Sheuerman

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

5/5/2007

WEIGHT

10.2 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Stock

INVOICE

14041

PRESENTING CLINICAL SIGNS

History: Patient has ongoing lifelong tearing on/off - suspected Feline Herpes Virus; however, it has been noted that with the last several visits, patient has been losing a significant amount of weight. Was 15.4# in 2017 and each year has decreased 1-3# since. No known V/D and still E/D normally.

Current Medications: No current medications.
Lab Results: Slight increased BUN, high normal Creat, RenalTech Profile (positive). Otherwise, NSF - normal T4 as well. Attached separately.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Gabapentin administered prior to scan.
Stat Report: not requested

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 scant 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 2.0 cm, are normal.

The left kidney is normal size (3.74 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.80 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with minimal to mild 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 size (0.46 cm width) with a normal shape and smooth peripheral contours. A few hyperechoic foci are observed within the parenchyma. The remaining parenchyma has normal glandular echogenicity and detail. Surrounding vasculature is normal.

The right adrenal gland is normal size (0.41 cm width) with a normal shape and smooth peripheral contours. A few hyperechoic foci are observed within the parenchyma. The remaining parenchyma has normal glandular echogenicity and detail. Surrounding vasculature is normal.

Spleen

The spleen is subjectively normal in size (0.77 cm in width at the level of the hilus) with undulating peripheral contours. 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. No pathological hepatic lymphadenopathy observed.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

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. A >2.0 cm segment of small intestine is severely thickened (up to 0.88 cm) with a mass effect. There is complete loss of the normal layering pattern in this region. Adjacent to this segment, shadowing foreign material (3.18 cm) is observed within the lumen but does not appear obstructive. In the remaining small intestinal segments, the wall is thickened (up to 0.57 cm) with a disruption in the normal 1:3 muscularis to mucosal ratio in most segments and occasional loss of layering. The colonic wall is normal.

Pancreas

The pancreas is severely enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and diffusely nodule and heterogeneous in appearance. The pancreatic duct is dilated (up to 0.35 cm in diameter). The mesentery effacing the serosal surface is mildly hyperechoic.

Free Abdomen

There is no evidence of free fluid. Several prominent to enlarged rounded hypoechoic lymph nodes are observed in the cranial to mid abdomen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The bowel changes are most consistent with infiltrative neoplasia (i.e., lymphoma) with a lower possibility of a severe inflammatory process. Intestinal foreign material is suspected but does not appear overtly obstructive and may be lodged in the lumen due to the thickened adjacent bowel wall.

- The abdominal lymphadenopathy could be consistent with infiltrative neoplasia, reactive lymphadenitis or lymphoid hyperplasia.

- The pancreatic changes could be consistent with chronic active pancreatitis with excessive nodular hyperplasia. However, neoplasia (i.e., adenocarcinoma) cannot be completely excluded. Regional peritonitis is present.

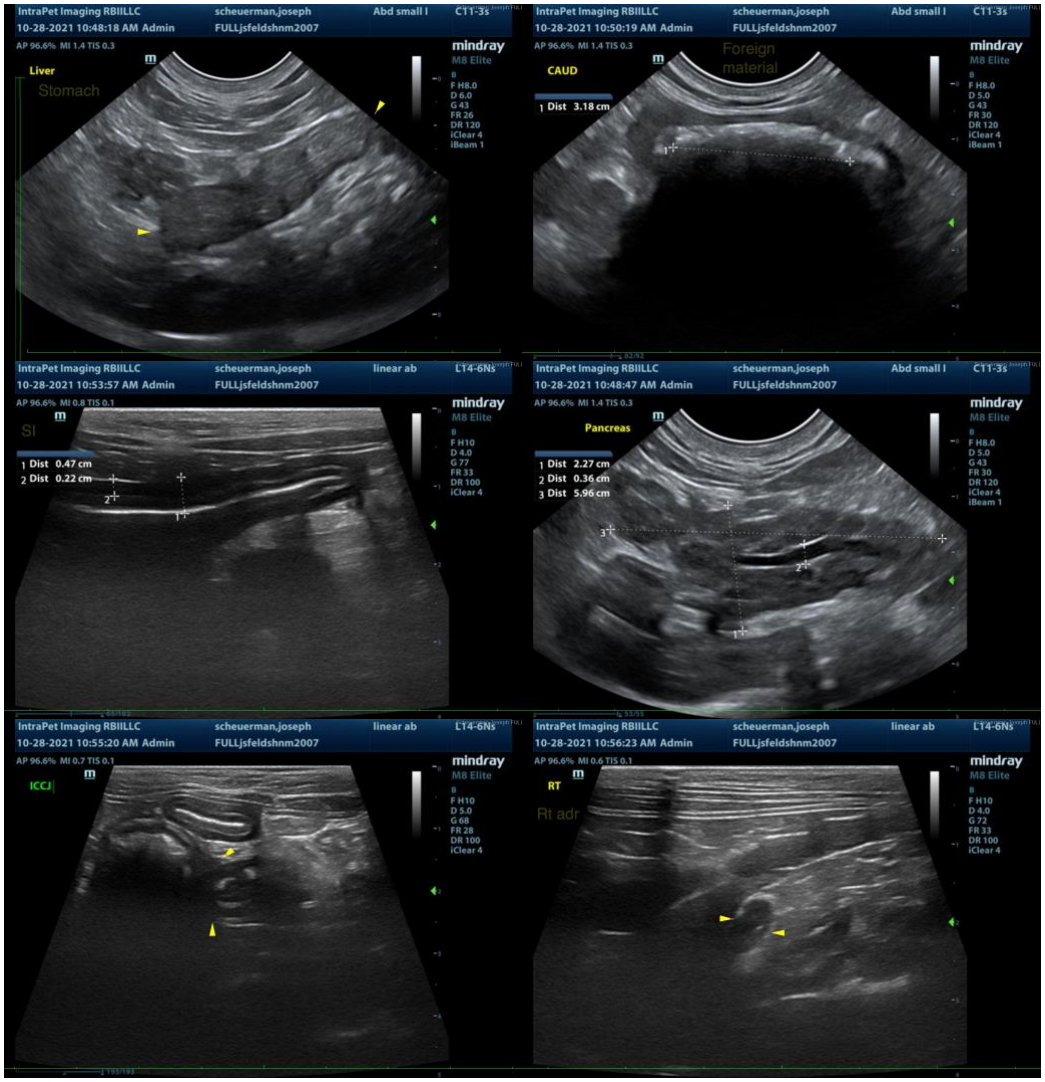
Secondary Findings

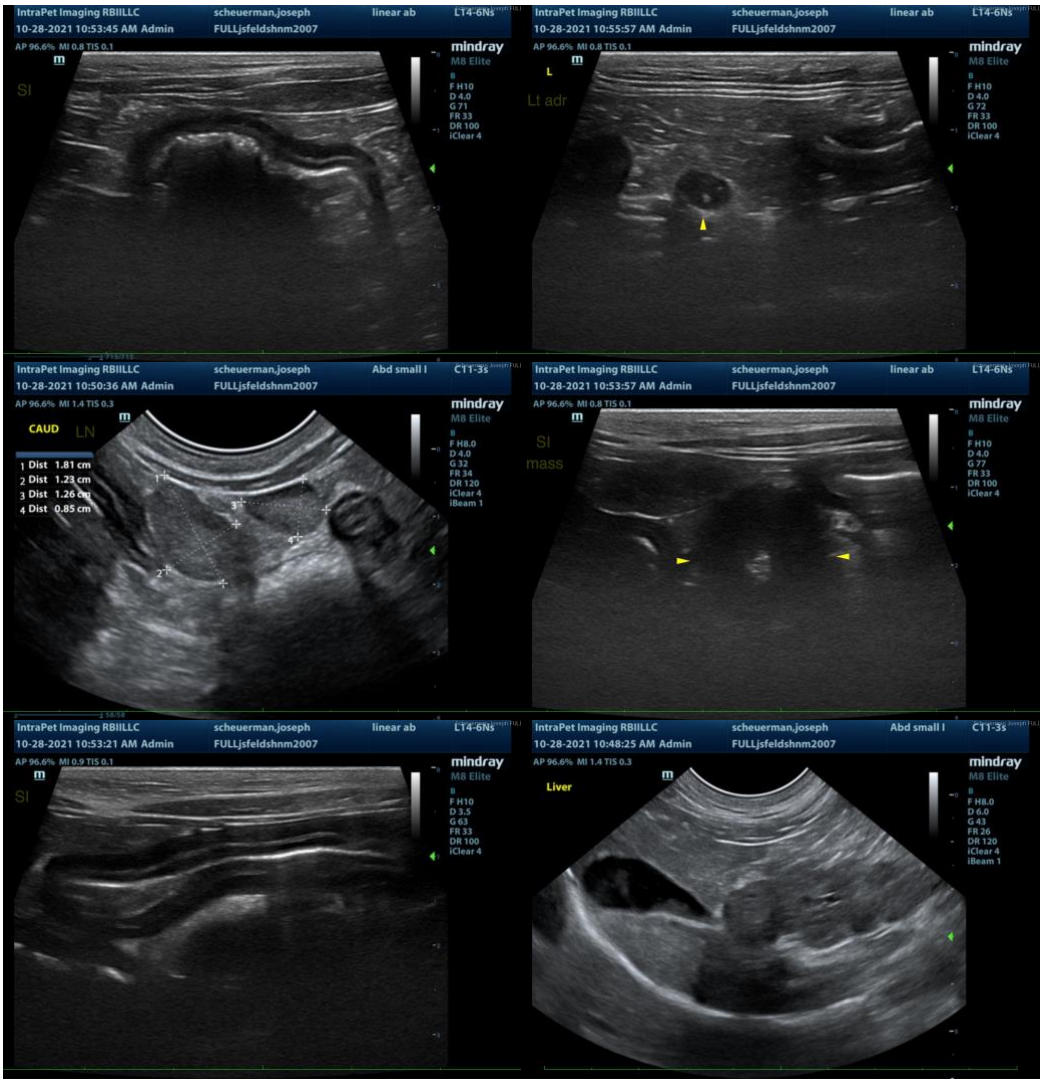
- Bilateral age-related nephropathy

- The hyperechoic foci in both adrenal glands is likely a benign age-related incidental finding.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Fine needle aspirates of the bowel mass and pancreas should be considered (if clotting status is appropriate). A 25-gauge needle should be used. If cytology results are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis. If tissue sampling is not to be pursued, palliative care should be considered.
- A malabsorption panel is also recommended.





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.

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