IMAGING PERFORMED BY

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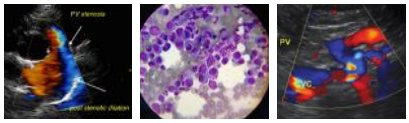

SonoPath
Clinical Sonography & Telecytology
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DATE

10/30/21

PATIENT

Isabel Hynson

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

16 Years

WEIGHT

5 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Timonium AH

REFERRING VET

Dr. Stephens

INVOICE

14108

PRESENTING CLINICAL SIGNS

History: Inappetence, weakness, soft stools; Jaundiced; Leukocytosis (neutrophilia with bands, monocytosis); Tbili 4.8.

Current Medications: Cerenia and Convenia on 10/29.
Lab Results: Leukocytosis (neutrophilia with bands, monocytosis); Tbili 4.8.
Radiographs: Poor abdominal detail on radiographs
Suspected peritonitis and lymphadenomegaly on in-house U/S.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not needed.
Stat Report: Not requested/declined.

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 with mostly anechoic urine. 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 (3.12 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.57 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. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.35 cm width). with a normal shape and smooth peripheral contours. A few pinpoint hyperechoic foci are observed within the parenchyma. Glandular detail is otherwise normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.36 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively prominent in size (0.87 cm in width at the level of the hilus) with slightly swollen peripheral margins and a scalloped medial contour. The parenchyma is homogeneous. No focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively enlarged with 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 gall bladder mildly distended. The wall is thickened and hyperechoic, but appropriate for the level of repletion. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal.

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 is normal to mildly thickened (up to 0.30 cm. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction is normal. The colonic wall is diffusely thickened (up to 1.48 cm) and irregular with ill-defined small hypoechoic nodules/areas within the wall. The colonic lumen contains echogenic fecal material. There is no obvious evidence of obstruction.

Pancreas

The left and right limbs of the pancreas are visible/prominent with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. The pancreatic duct is visible but not overtly dilated (0.21 cm in diameter). There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The Mesentery throughout the abdomen is mildly hyperechoic. Trace free fluid is observed. Several enlarged cranial and mid abdominal lymph nodes are visualized. The nodes are hypoechoic and rounded.

Other

A brief echocardiogram (no charge) reveals no evidence of pericardial effusion. The caudal vena cava appears slightly dilated relative to the abdominal aorta.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

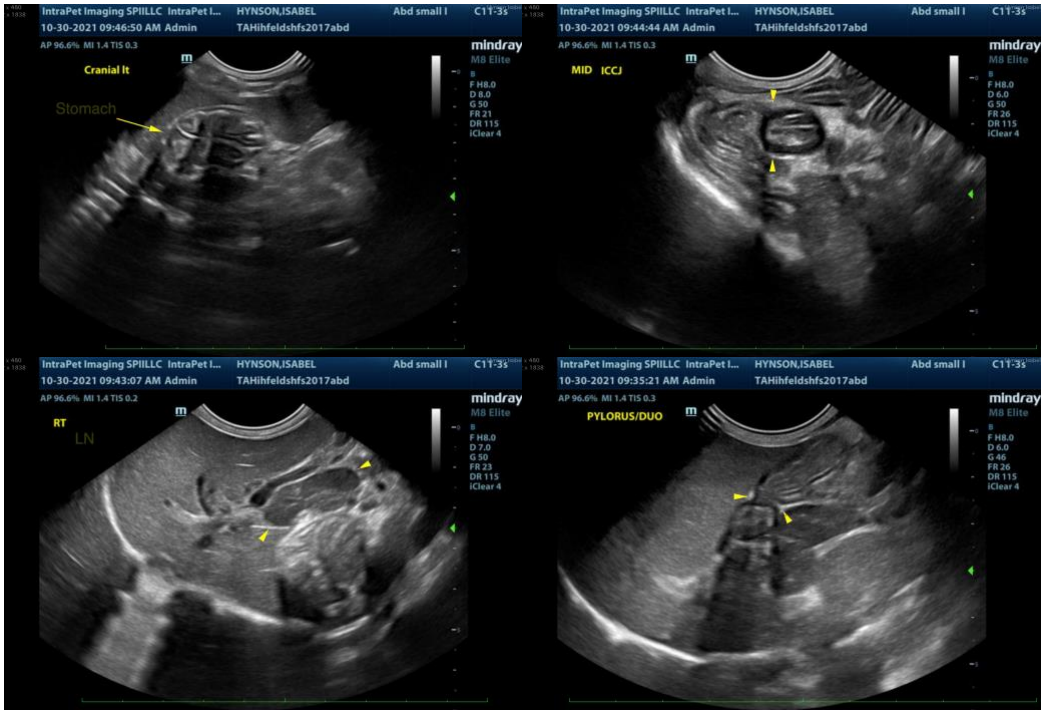
- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- The abdominal lymphadenopathy is concerning for infiltrative neoplasia (i.e., lymphoma). However, reactive lymphadenitis or lymphoid hyperplasia cannot be completely excluded.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The colonic wall changes are concerning for infiltrative neoplasia. However, a severe inflammatory process cannot be excluded. The small intestinal wall changes could be consistent with emerging lymphoma or inflammatory bowel disease.
- Diffuse peritonitis, likely secondary to bowel and/or hepatic pathology.

Secondary Findings

- Bilateral age-related renal changes.
- The hyperechoic foci in the left adrenal gland are most likely benign, age-related and incidental.
- 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.
- The mildly dilated caudal vena cava could be consistent with increased hydrostatic pressure or may be a normal variant for this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three view thoracic radiographs are recommended to assess for occult disease in the chest.
- Fine needle aspirates of the liver, abdominal lymph nodes +/- spleen should be considered if clotting status is appropriate. A 25-gauge needle should be used. If cytologic evaluations are inconclusive, an abdominal exploratory with gastrointestinal (including colon), abdominal lymph node and hepatic biopsies may be necessary to get a definitive diagnosis.
- A malabsorption panel including serum cobalamin, folate, TLI and PLI should also be considered.

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SI
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Pancreas
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mindray
M8 Elite


IntraPet Imaging SPIILLC IntraPet I... HYNSON,ISABEL Abd small I C11-3s
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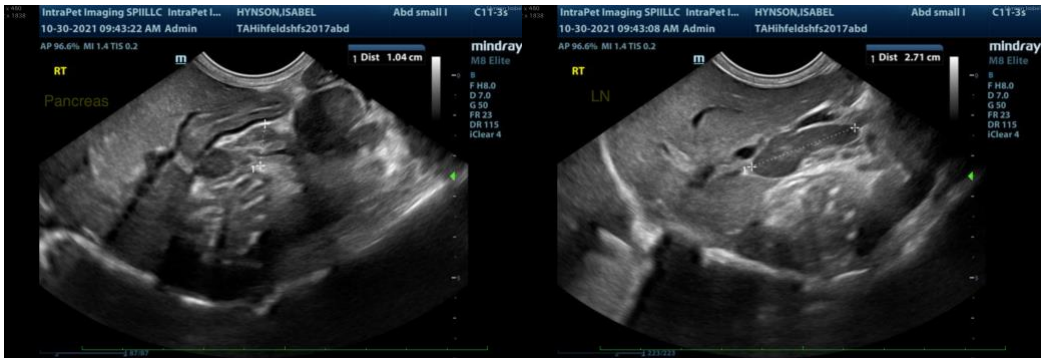

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 DACVIM (Small Animal Internal Medicine)
info@SonoPath.com