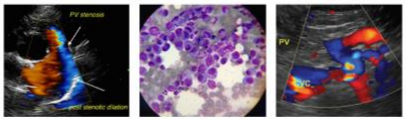

PATIENT

Tigger Johnson

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

6 years

WEIGHT

11.1 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew LVT

HOSPITAL NAME

SVS Imaging Michigan

REFERRING VET

Cat Care of Rochester Hills

INVOICE

11905

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12.22.22

PRESENTING CLINICAL SIGNS

History: Presented 12-2-22 for inappropriate urination, specifically urine spraying on horizontal surfaces. Urine smells malodorous like tomcat urine. PU/PD. Issues with FIE-UA and smelly urine started about a year ago. Was neutered at shelter at age 2. Last year he had work up for weight loss and vomiting (abd u/s 11-29-21 done by local IM specialist attached - normal sized adrenals). Vomiting and weight loss controlled - on GI Biome dry, Cerenia

Abnormal PE/Chem/CBC/UA Results: Patient had strong general smell of tomcat urine since he urinated in his carrier. Confirmed penile spines. UA - USG 1.017, otherwise ua wnl. CBC/Chem/T4 - nsf. Testosterone Baseline (CLIA) MSU 3.7 H [<=0.7]

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 scant amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (3.62 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of nephroliths or infarcts. Moderate to severe pyelectasia/hydronephrosis is present (0.91 cm in the transverse plane). The proximal urethra is dilated (0.87 cm in diameter) for 2-3 cm, after which it appears to taper and is no longer visible.

The right kidney is normal size (4.26 cm in length) with a normal shape and smooth peripheral contours. The cortex is thickened. There is moderate loss of corticomedullary distinction. Moderate pyelectasia is present (0.49 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is enlarged (0.73 cm width) with a rounded shape and slightly heterogenous parenchyma. Ill-defined anechoic areas are observed within the gland. There is loss of glandular detail. Surrounding vasculature are normal.

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

Spleen

The spleen is subjectively normal in size (0.70 cm in width at the level of the hilus) with a folded contour and normal curvilinear peripheral margins. The parenchyma is of appropriate echogenicity and echotexture. Numerous, small, irregular hyperechoic nodules are observed throughout the organ. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. Several intrahepatic biliary stones are visualized. Hepatic vasculature and intrahepatic 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 gravity dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

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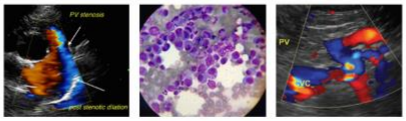

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Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract 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 left limb and base 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
There is no evidence of free fluid.

Lymph node
(See "Other" category).

Other
A 3.55 x 2.50 cm irregular, multiseptated cystic structure is observed in the right cranial to midabdomen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The left adrenomegaly, in conjunction with the patient's clinical history of penile spines and elevated testosterone could represent a functional testosterone-secreting tumor. However, a more benign process (i.e., hyperplasia, stress) cannot be completely excluded.

Secondary Findings

- Bilateral chronic nephropathy. The left hydronephrosis/hydroureter may be secondary to a urethral stricture, a small stone, or less likely, a tumor.
- The hyperechoic splenic lesions trend toward the benign (i.e., myelolipomas) with a lower possibility of a neoplastic process.
- Intrahepatic biliary stones – incidental
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The bowel pattern is consistent with inflammatory bowel disease with some potential for emerging lymphoma.
- The origin of the cystic structure in the right cranial to midabdomen is unclear. It may represent a cystic lymph node, or may be arising from liver, pancreas, mesentery, other. Its significance is unclear.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A urine culture and sensitivity is recommended, if not already performed, to assess for occult infection.

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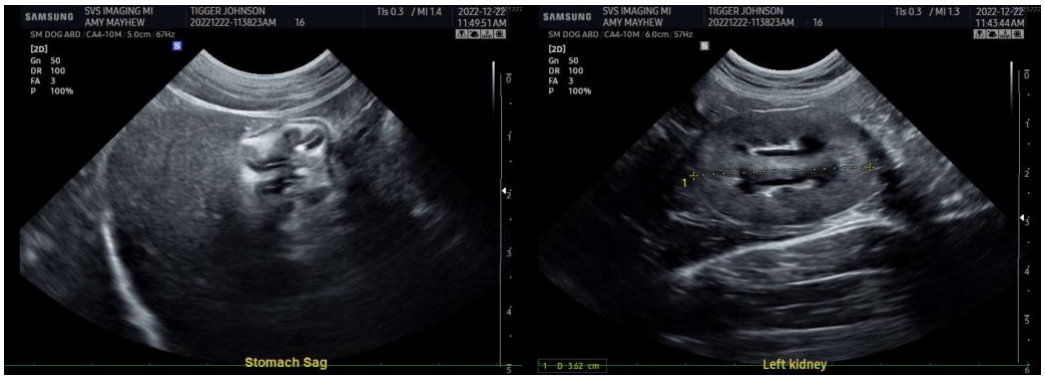
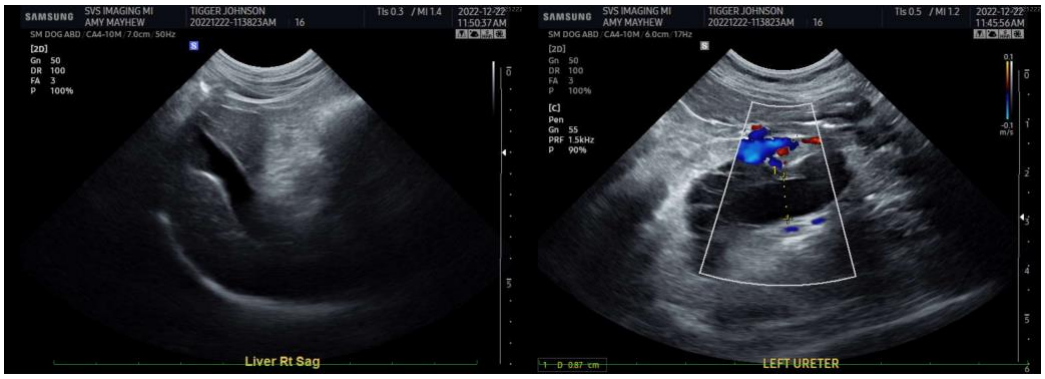
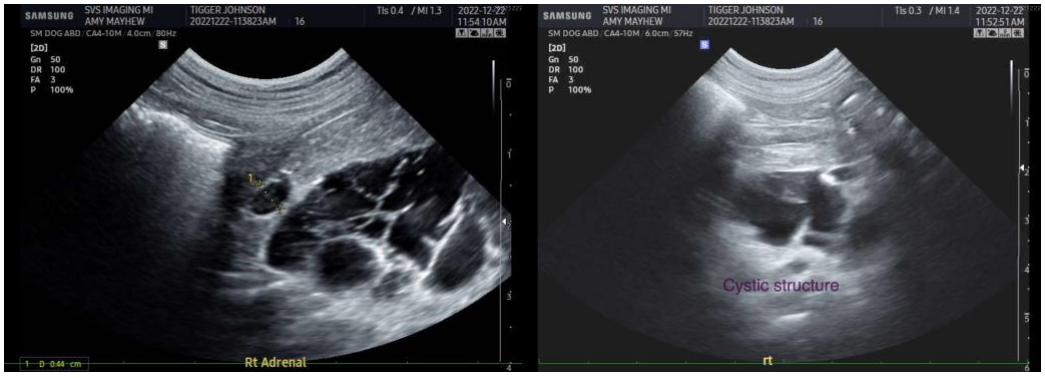
- If an aggressive approach is desired, a left adrenalectomy with submission of the gland for histopathology can be considered. An abdominal CT scan may be useful in better characterizing the cystic lesion on the right side and evaluating for a possible cryptorchid testicle, if that is a possibility. Thoracic radiographs should be performed prior to anesthesia to assess for pulmonary metastatic disease.

- If a more conservative approach is desired, consider consultation with a board-certified theriogenologist.







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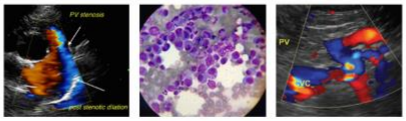

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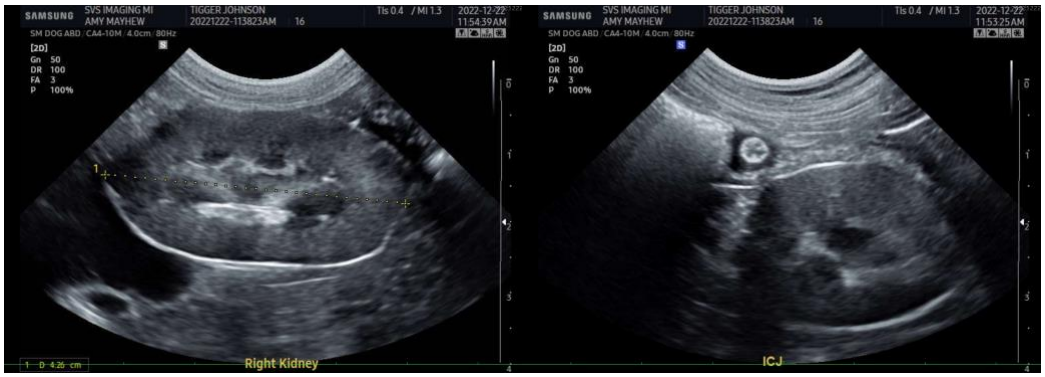

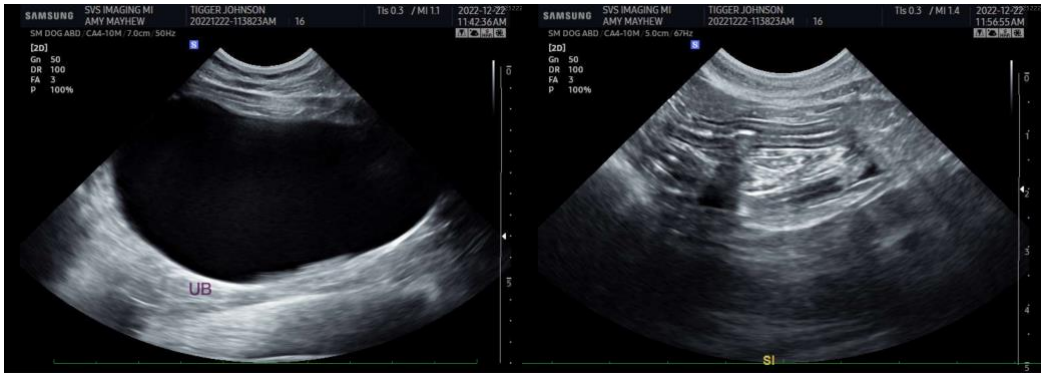

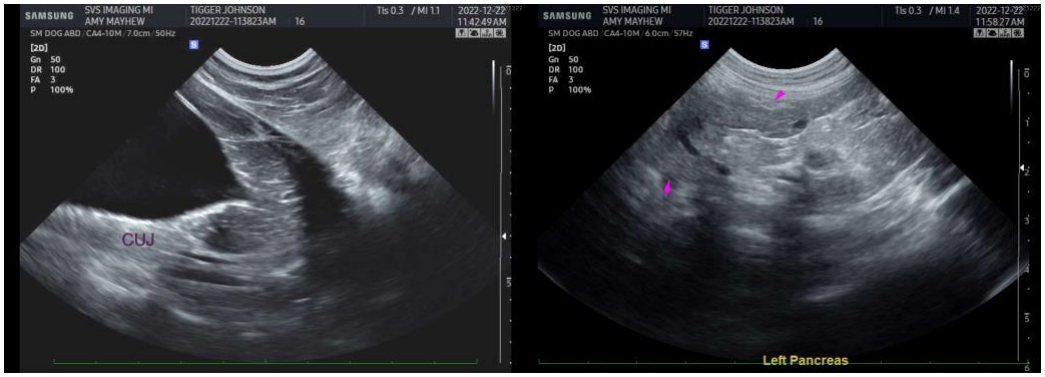

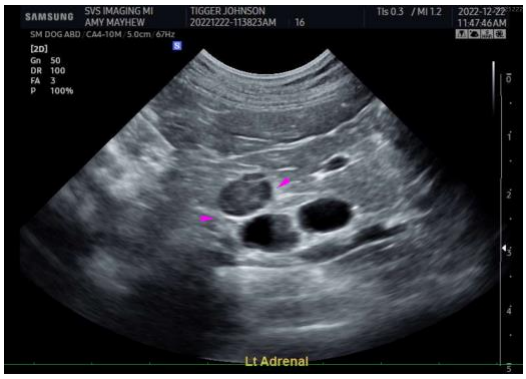

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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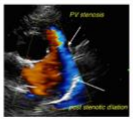
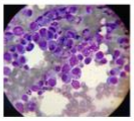
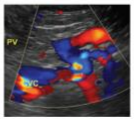

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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info@SonoPath.com