



DATE

2-27-26

PATIENT

Barney Kinney

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

6/23/2010

WEIGHT

15lbs

INTERPRETED BY

Andrea Nicastro, DVM,
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Cat Sense Feline
Hosp & Boarding, Inc

REFERRING VET

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PRESENTING CLINICAL SIGNS

Patient History: Barney presented for weight loss, frequent vomiting, variable appetite, and soft, smelly stool. He is thin, BCS 2/5, has a palpable thyroid nodule, a new Grade 2/6 murmur with a HR of 180 when being on 100mg gabapentin and his intestines felt prominent. Bloodwork shows stage 2 ckd and a T4 in the lower end of the grey zone but the FT4 is not consistent with hyperthyroidism at this time. A free-catch urinalysis showed a lot of struvite crystals.

Current Medications: None currently.

Labwork Results: Labwork attached, reported as: BUN=39, creat=1.9, urine s.g.=1.016, wbcs=10-15/hpf, rbcs=20-30/hpf, 4+ struvite crystals

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Torbugesic.

Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. A 1.2 x 0.5 cm echogenic nodule is arising from the ventroapical aspect and protruding into the lumen. The remaining wall is normal in thickness with a smooth mucosal surface. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.90 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. Trace pyelectasia is present (0.16 cm in the longitudinal plane). Hyperechoic shadowing diverticular foci are visualized. There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (4.02 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild- to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

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

The right adrenal gland is normal size (0.28 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent-in-size (1.10 cm in width at the level of the hilus) with an undulating medial contour. 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 curvilinear 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 gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of suspended



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echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

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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 is normal to mildly-thickened (up to 0.31 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

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Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic 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.

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Lymph Nodes

(See "Other" category).

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Free Abdomen

There is no obvious evidence of free fluid.

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Other

In the left mid-abdomen, a 3.2 x 1.7 cm echogenic- to slightly-heterogenous mass with at least one, small, irregular, mostly avascular cavitated area is visualized. Surrounding fat is hyperechoic.

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ULTRASONOGRAPHIC FINDINGS

15lbs

Primary Findings

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- Mass in the left- mid-abdomen, the origin of which is unclear. It may be arising from lymph node, mesentery, other. Considerations include neoplasia, inflammatory focus/granuloma, other.

- The bladder wall nodule at the ventroapical aspect could be consistent with neoplasia (i.e., transitional cell carcinoma) or a polypoid-like/inflammatory lesion.

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Secondary Findings

- Bilateral nonspecific age-related renal changes with dystrophic mineralization and trace left pyelectasia
- The mild splenomegaly may be secondary to lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation, emerging neoplasia, normal variation in the larger feline patient, other.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Consider fine-needle aspiration of the mass in the left- mid-abdomen (assuming normal clotting status). A 25-gauge needle should be used. Alternatively, can consider an abdominal exploratory with excisional

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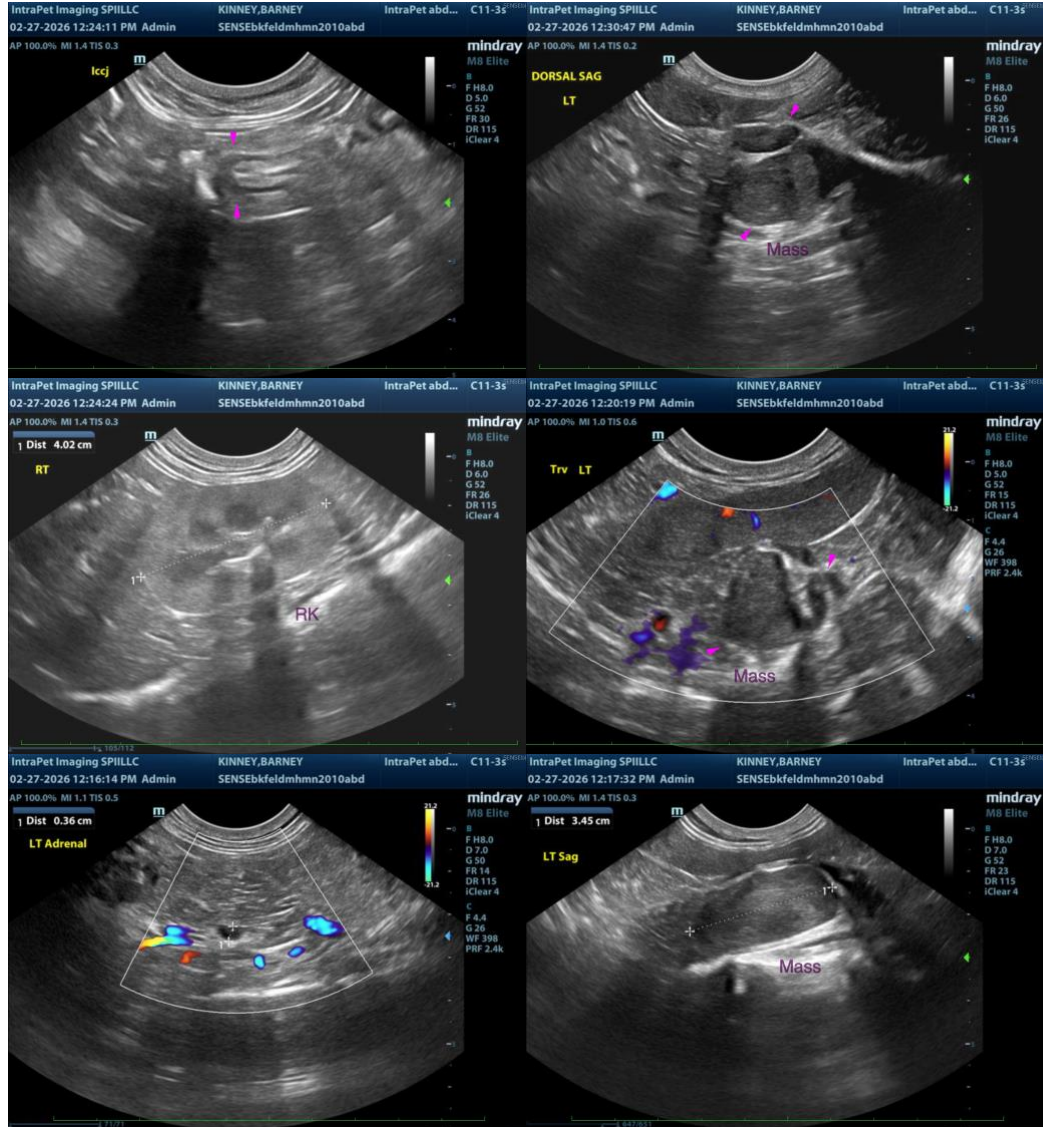
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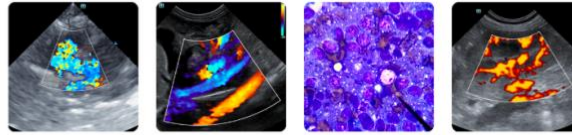
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biopsy of the mass and submission for histopathology, along with excisional biopsy of the bladder wall mass (with submission for histopathology).

- Given the weight loss, also consider a GI panel including serum cobalamin and folate, TLI and PLI, along with a fecal evaluation for ova and Giardia and thoracic radiographs (as stated above).



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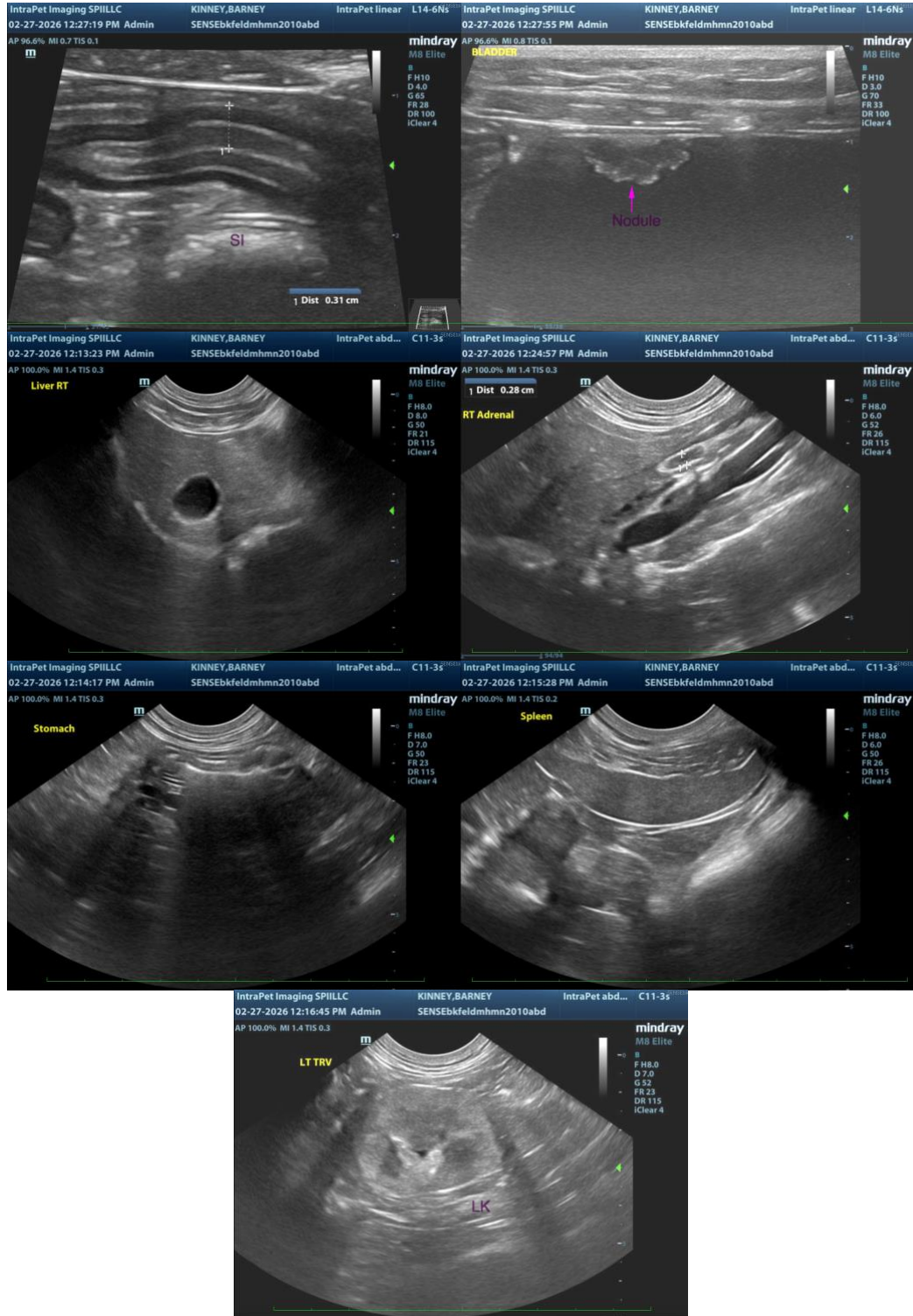
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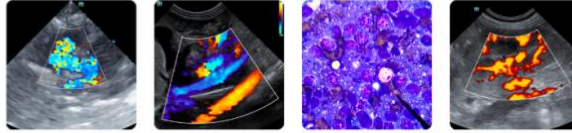
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in

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the image/video clips provided.

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Barney Kinney

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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