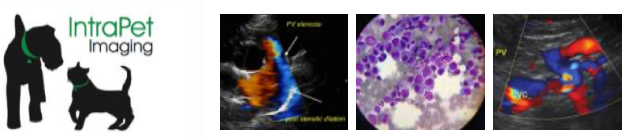
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

2/28/23

PATIENT

Cuddles Lantz

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

2/23/2009

WEIGHT

6 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Perry Hall AH

REFERRING VET

Dr. Miller

INVOICE

14668

PRESENTING CLINICAL SIGNS

Patient presents for evaluation for chronic weight loss at home. Owner also has noticed PU/PD at home when questioned about this specifically, (did not come up in initial history.) On PE was dehydrated, (chronically,) and under conditioned. Lab work results show DM, no evidence of DKA. Radiographs show concern for potential obstruction in the distal duodenum. Patient is experiencing no GI signs at home so potential concern for ST mass over obstruction. Discussed with owner that it would be a good idea for us to investigate this lesion prior to starting management for DM as this is an expensive disease to manage and if ST mass is present, we may decide to consider QOL.

Current Medications: None current - owner elects to hold on insulin therapy until workup for ST mass/obstruction, etc.
Lab Results: ALP 110, USG 1.052, 3+ glucosuria, 1+ proteinuria, normal T4
Radiographs: The possibility of a distal duodenal obstruction leading to pyloric outflow obstruction should be highly considered. Additional imaging would be necessary for further assessment. Concurrent enteritis due to nonspecific etiologies. Systemic disease such as pancreatitis, nondescript discomfort or inflammatory bowel disease can cause bowel atony resulting in a similar radiographic change. Constipation. Hypovolemia causing microcardia an otherwise unremarkable thorax.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is 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. The region of the trigone is normal.

The left kidney is normal size (3.98 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. Mild to moderate pyelectasia is present (0.29 cm in the transverse plane). There is no evidence of 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 mildly thickened and there is moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.49 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The region of the right adrenal gland is evaluated. No obvious pathology is observed.

Spleen

The spleen is contracted (0.51 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 normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen and slightly attenuating. A 1.04 cm irregular multi-septated cystic nodule is observed at the caudal aspect, on the right side. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is mildly distended. The wall is normal in thickness. A small amount of gravity-dependent echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears patent. The proximal duodenum is moderately distended with chyme. A 2.5 cm irregular hypoechoic mass is observed in a segment of small intestine, suspected to be duodenum. The lesion appears obstructive. In the remaining small intestinal segments, wall thickness is normal with a normal layering pattern. Several additional small intestinal segments are mildly distended with chyme. The colonic wall is normal.

Pancreas

The pancreas is diffusely visible/prominent with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. A few small cystic areas are seen. The pancreatic duct is dilated (up to 0.37 cm in diameter). Surrounding mesentery is slightly hyperechoic.

Free Abdomen

There is no obvious evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Small intestinal mass, suspected to be of duodenal origin. Neoplasia (i.e., adenocarcinoma, leiomyosarcoma, round cell tumor) is suspected with a lower possibility of a benign process (i.e., adenoma, inflammatory focus). The lesion appears obstructive.

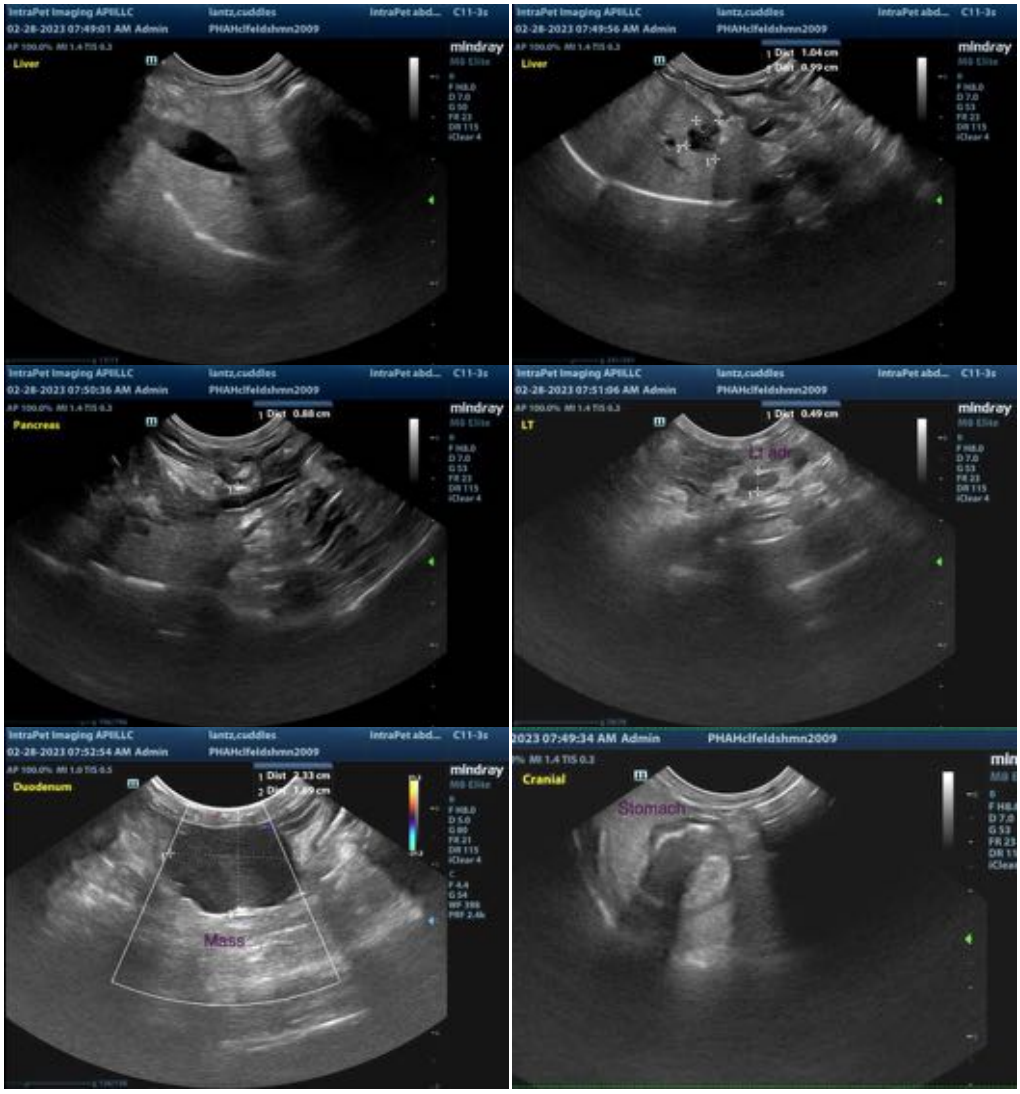
Secondary Findings:

- Bilateral, chronic renal changes with left pyelectasia and right dystrophic mineralization.
- The splenic contraction is likely secondary to dehydration.
- The hepatic parenchymal changes could be consistent with a diabetic hepatopathy, inflammatory disease, infiltrative neoplasia (i.e., lymphoma), other hepatopathy.
- The pancreatic changes are consistent with chronic +/- active pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

- Consider a fine needle aspirate of the small intestinal mass if clotting status is appropriate. A 25-gauge needle should be used. Ultimately, however, excisional biopsy of the mass would be recommended due to its obstructive nature.
- A malabsorption panel including serum cobalamin, folate, TLI and PLI should also be considered.



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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com