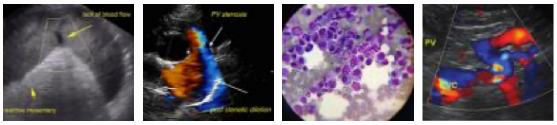


PATIENT
Jude Kurtz

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
13 years

WEIGHT
8.44 lbs

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

IMAGING PERFORMED BY
Sara Hansen

HOSPITAL NAME
Banfield So. Eugene

REFERRING VET
Dr Jackson

INVOICE
12427

DATE
3.15.23

PRESENTING CLINICAL SIGNS

History: Pet presented for routine comprehensive exam. O notes weight loss. Systems: e/d/u/def normally. no c/s/v/d HWP: revolution plus FTP: revolution plus Diet: hills C/D science diet wet and dry food Allergies: none reported Chronic conditions: idiopathic cystitis Current meds/supplements: none Lifestyle: indoor/outdoor, lives with other cats WT: 3.87 kgs BCS: 4/9 BAR, T: NE P: 150 R: 50 CRT < 2 sec/pink, moist MM. COAT/INTEG: no lesions nor ectoparasites appreciated. EYES/EARS: OU WNL. AU clear. N/T: No nasal discharge, no sneezing, no cough on tracheal palpation. ORAL: healthy dentition. mild tartar HEART/LUNGS: no murmurs nor arrhythmias, synchronous pulses, Lungs clear previously noted murmur not appreciated today LN: peripheral LNs are normal in size, shape, consistency. GI/UG: soft nonpainful abdomen on palpation. external genitalia normal ~6cm firm irregular mobile abdominal mass appreciated on palpation M/S: no lameness nor abnormalities appreciated. NEURO: appropriate mentation, no deficits appreciated, nor spinal pain.

Abnormal PE/Chem/CBC/UA Results: CBC-Low HCT-28.97%, MCV/MCHC are WNL - anemia (r/o chronic disease/neoplasia v. others), high NEU 16.36 k/uL, otherwise WNL Chem - Low ALB 2.2 g/dL (TP wnl at 6.1 g/dL, GLOB wnl at 3.9 g/dL), low CREA 0.6mg/dL, otherwise WNL. UA (cysto) - pending, see labs Current Medications pet will be sedated prior to AUS with butorphanol Radiographic Findings: no x-rays have been performed.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small to moderate 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 cm, are normal.

The left kidney is borderline enlarged (4.23 cm in length) with a slightly irregular shape. The cortex is mildly thickened with mild to moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is borderline enlarged (4.26 cm in length) with a slightly irregular shape. The cortex is mildly thickened with mild to moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.47 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

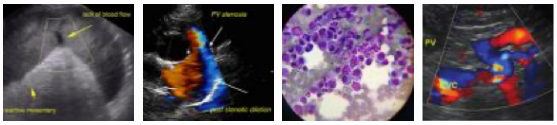
The region of the left adrenal gland is evaluated. No obvious pathology is observed.

Spleen

The spleen is normal in size (0.88 cm in width at the level of the hilus) with a normal capsular 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 contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or



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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 scant amount of 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 appears patent. The small intestinal lumen is not overtly dilated. A >4.50 cm irregular mass, suspected to be of small intestinal origin, is observed in the midabdominal region. The wall in the region of the mass is severely thickened (up to 1.90 cm), irregular, and hypoechoic, with a complete loss of the normal layering pattern. The lumen in this segment is slightly dilated with fluid and gas. The mesentery effacing the serosal surface of the mass is hyperechoic. In the remaining small intestinal segments, the wall is normal in thickness with a normal layering pattern the lumen is empty and appropriate mural detail. The colonic wall is normal. There is no obvious evidence of an obstructive pattern.

Pancreas
The left limb is prominent with minimal deviation from the normal peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen
There is no obvious evidence of free fluid. There is a questionably prominent mesenteric lymph node (1.31 cm in length) adjacent to the bowel mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

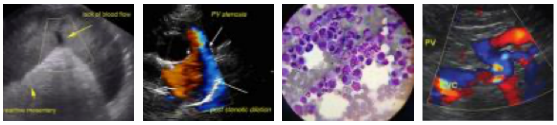
- Large mid-abdominal bowel mass, suspected to be of small intestinal origin. Neoplasia (i.e., adenocarcinoma, lymphoma, other) is suspected. Adjacent peritonitis is present.
- The mild bilateral renomegaly could be consistent with inflammatory disease or emerging neoplasia (i.e., lymphoma). Subtle dystrophic mineralization is present in both kidneys.

Secondary Findings

- Urinary bladder debris
- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Fine-needle aspirates of the bowel mass are recommended (if clotting status is normal). Twenty-five gauge-needles should be used. If the cytology results are inconclusive, additional testing (i.e., PARR or biopsies) may be necessary to get a definitive diagnosis.
- Regarding the renal changes, consider a urine culture and sensitivity +/- renal aspirate.



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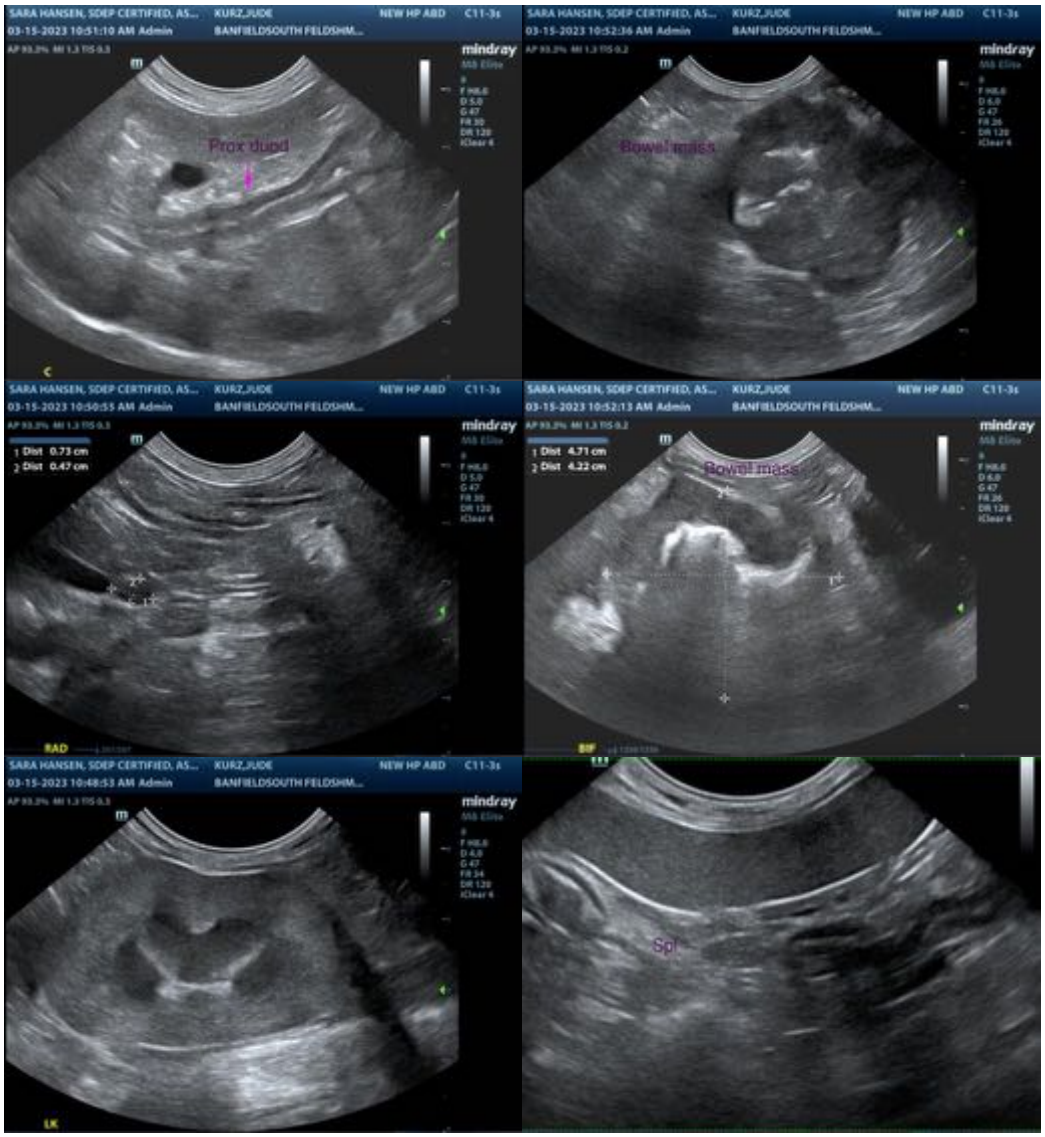
- Also consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI to assess for maldigestion/malabsorption and underlying pancreatic disease.



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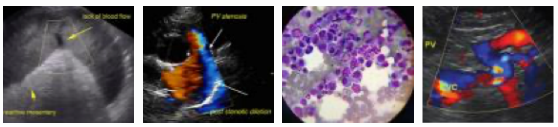

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IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

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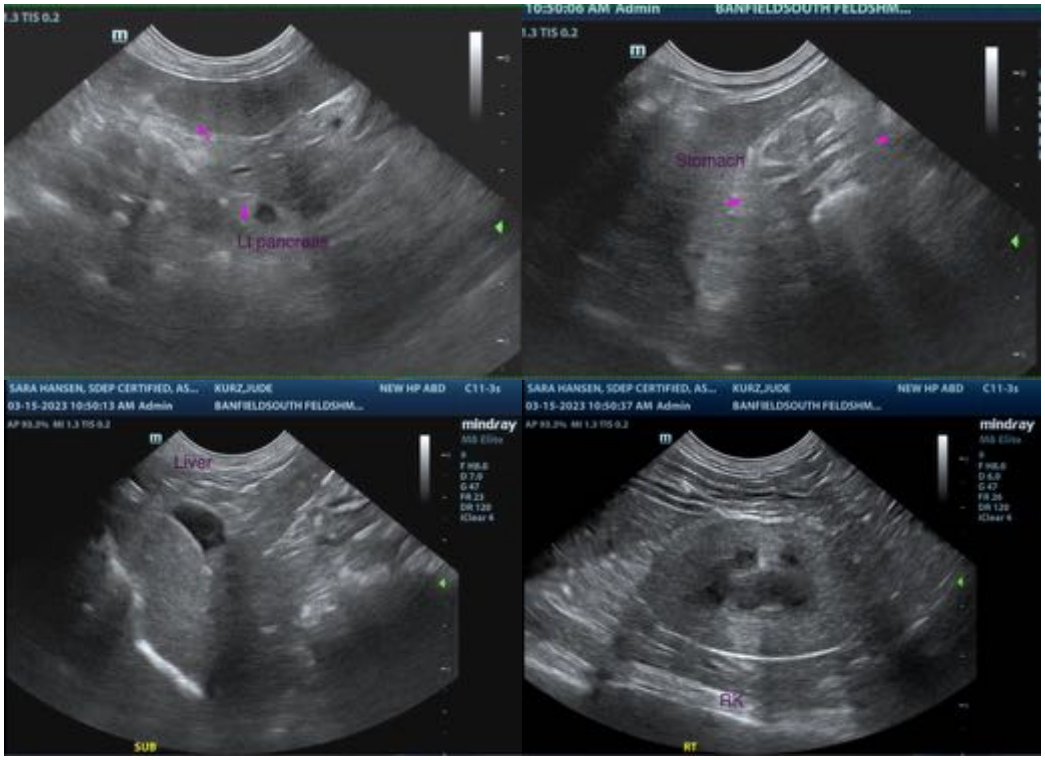

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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