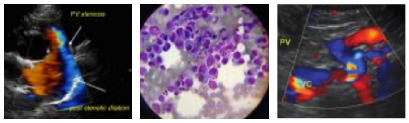
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

3.16.2023

PATIENT

Harley Edwards

SPECIES

Feline

BREED

Siamese Mix

SEX

Neutered Male

AGE

5/1/2008

WEIGHT

12.2 lbs

INTERPRETED BY

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

HOSPITAL NAME

Honeygo AH

REFERRING VET

Dr. Wright-Weighert

INVOICE

12428

PRESENTING CLINICAL SIGNS

Complaint- not eating, lethargic. History- bladder stones, V/D in Feb. PE- weight loss, muscle atrophy, mild dehydration.

Current Medications: Depo-Medrol injection 1mL on 3/13/23.
Lab Results: Mildly elevated ALT 118 (10-100).
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Declined at this time.
Imaging Performed By: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended. The wall is normal in thickness with a smooth mucosal surface. A moderate 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 borderline enlarged (4.30 cm in length) with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. At least one cortical infarct is suspected at the craniomedial aspect. Nonobstructive nephroliths are visualized. Trace pyelectasia is present. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is borderline enlarged (4.54 cm in length) with a slightly irregular shape. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is a questionable infarct at the lateral aspect. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and 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 (0.77 cm in width at the level of the hilus) with slightly irregular peripheral contours. 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 hypoechoic relative to the spleen. A 0.97 cm hyperechoic nodule is observed deep on the left side, adjacent to the gall bladder. The remaining parenchyma is homogenous. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is mildly distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with fluid. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. A >7.00 cm irregular, hypoechoic small

intestinal mass is observed in the midabdominal region. The wall of the mass is severely thickened (up to 1.10 cm), irregular, and hypoechoic, with loss of the normal layering pattern. Within the abnormal tissue, a 0.82 cm irregular fluid pocket is observed. It is not clear whether this fluid pocket is continuous with the intestinal lumen. In addition, a few foci of mineralization are seen. The mesentery effacing the serosal surface in this region is hyperechoic. In the remaining small intestinal segments, the lumen is empty, and the small intestinal wall is normal in thickness. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. The ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely prominent in size with slightly irregular peripheral contours. The parenchyma is hypoechoic to isoechoic relative to surrounding omental fat and diffusely mottled in appearance. The pancreatic duct is visible but not overtly dilated (0.20 cm in diameter). Surrounding mesentery is hyperechoic.

Free Abdomen

The mesentery throughout the abdomen is hyperechoic and irregular in appearance. Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

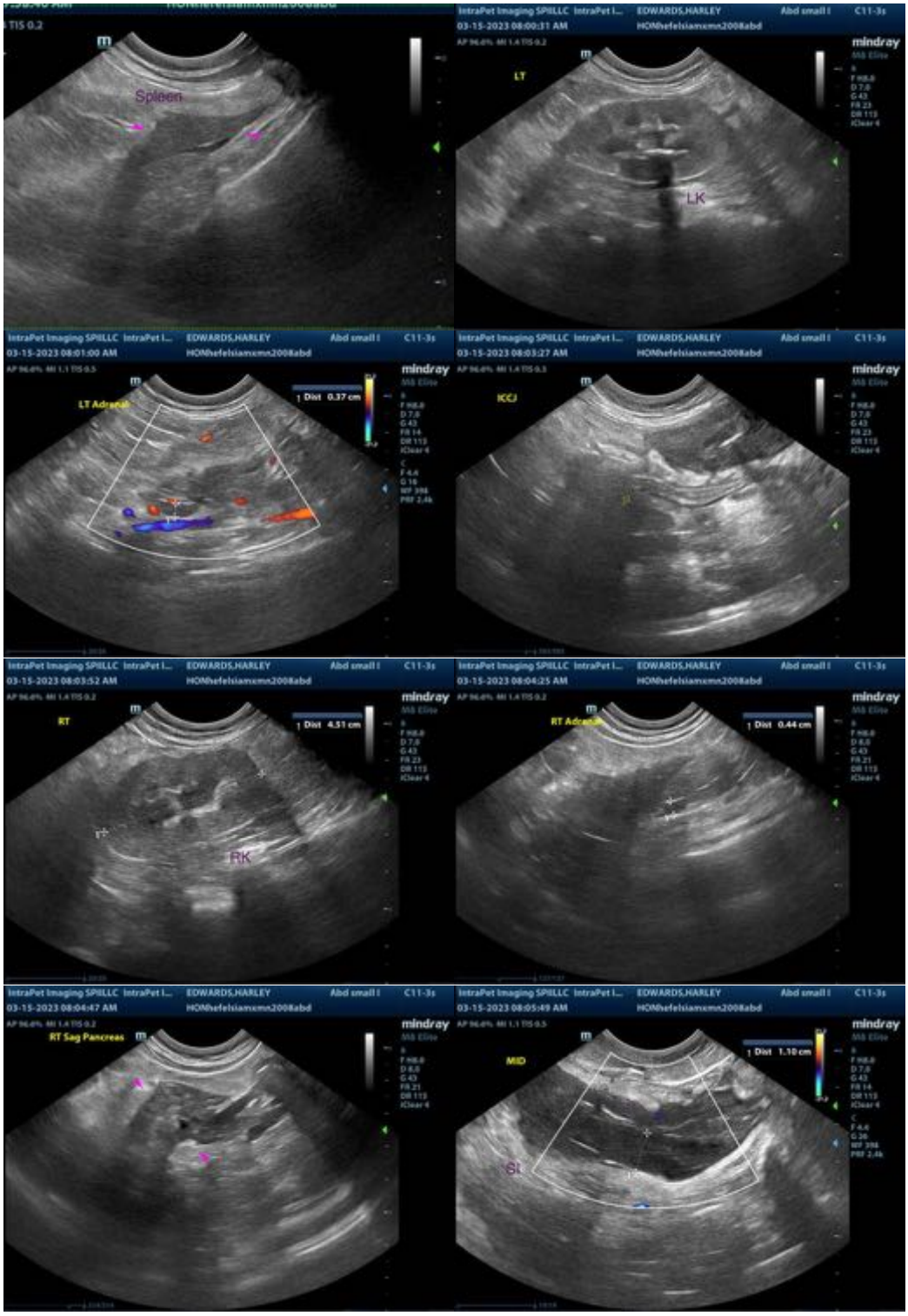
- Small intestinal mass. Neoplasia (i.e., lymphoma, adenocarcinoma, leiomyosarcoma) is suspected, with a lower possibility of a severe inflammatory process (i.e., pyogranulomatous). Adjacent peritonitis is present.
- The pancreatic changes are suggestive of chronic active pancreatitis with age-related remodeling +/- fibrosis.

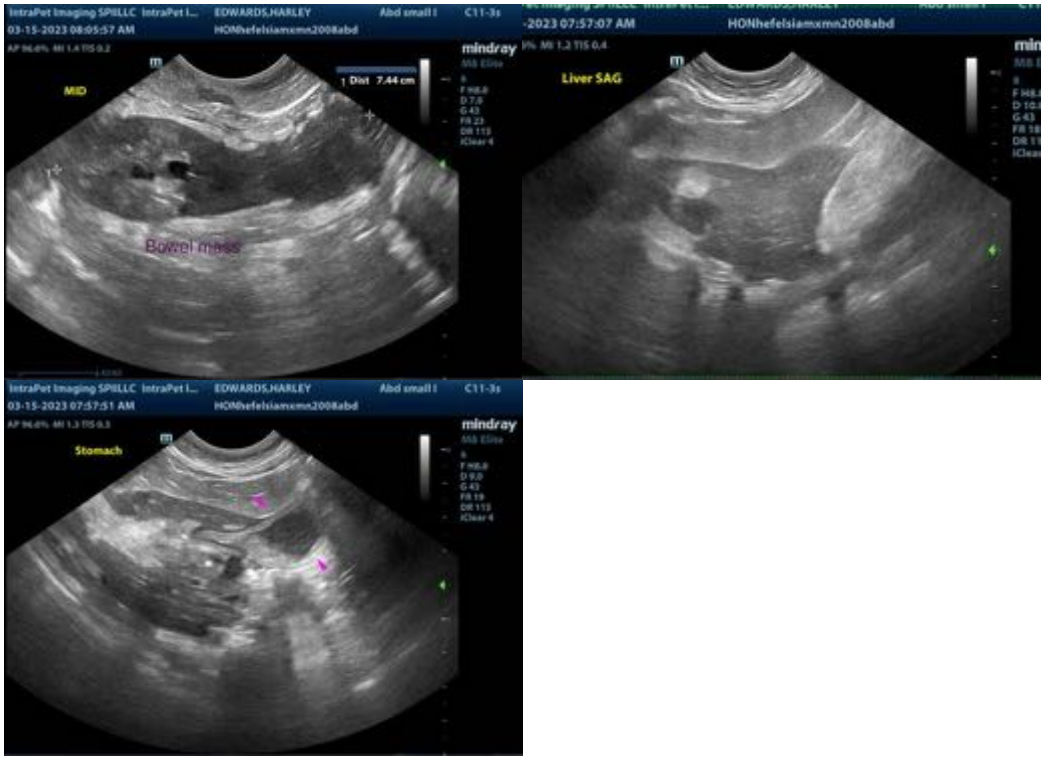
Secondary Findings

- Bilateral chronic renal changes with nonobstructive nephrocalcinosis and suspected cortical infarcts
- Urinary bladder debris
- The hyperechoic hepatic nodule trends toward the benign (i.e., focus of lymphoid hyperplasia, myelolipomas, or similar) with a lower possibility of an emerging tumor.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Consider a fine-needle aspirate of the bladder wall mass (if clotting status is normal). A 25-gauge needle should be used. If the cytology results are inconclusive, surgical biopsies +/- excision/resection and anastomosis may be necessary to get a definitive diagnosis.
- Also consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI to assess for concurrent maldigestion/malabsorption and underlying pancreatic disease.


Spleen
LT
LK
LT Adrenal
Dist 0.37 cm
ICCJ
RT
Dist 4.51 cm
RK
RT Adrenal
Dist 0.44 cm
RT Sag Pancreas
MID
Dist 1.10 cm
GL



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)
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