



## PATIENT

Mic Dundee Thompson

## SPECIES

Feline

## BREED

DLH

## SEX

Neutered Male

## AGE

7 years

## WEIGHT

12.5 lbs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Sara Hansen

## HOSPITAL NAME

Reid VH

## REFERRING VET

Dr. Heider

## DATE

3/17/22

## INVOICE

10583

## PRESENTING CLINICAL SIGNS

History: Painful and splinting mid-cranial abdomen. No masses or FB readily palpable. No obstructive pattern or masses noted on radiographs. Small amount of stool in colon. NSF in CBC or Chem bloodwork. Pending response to empiric tx (BUP SR, Mirtazapine, SQ fluids).

Abnormal PE/Chem/CBC/UA Results:

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is mildly distended with mostly anechoic urine. A few polypoid-like lesions, the largest measuring 0.82 x 0.79 cm, are observed at the apical aspect and along the ventral wall. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (4.38 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.49 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

### Adrenal Glands

The left adrenal gland is normal size (0.82 cm length; 0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (1.07 cm length; 0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

### Spleen

The spleen is normal in size (0.81 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 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 is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.



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### **Gastrointestinal**

The gastric lumen is not distended. The wall in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pyloric antrum, a 0.93 x 0.93 cm irregular, echogenic structure appears to be arising from the wall in the region of the greater curvature. The pyloric outflow tract appears patent. 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. The colonic wall is normal. No obstructive disease is noted.

### **Pancreas**

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

### **Free Abdomen**

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- The lesion in the pyloric antrum could be consistent with a polyp, tumor, rugal fold, other.
- The urinary bladder wall changes are most consistent with polypoid cystitis. However, neoplasia (i.e., transitional cell carcinoma), cannot be excluded. Correlation with the patient's clinical history is recommended. If the patient has a history of chronic urinary tract infections, polypoid cystitis would be considered more likely.

### Secondary Findings

- Bilateral age-related chronic renal changes.

\*\*It is unclear whether the pyloric and/or bladder wall lesions are responsible for the patient's clinical signs or if another, concurrent issue (i.e., orthopedic or neurologic pain, occult pyelonephritis) is causing the signs.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a urine culture and sensitivity to assess for occult pyelonephritis. A cystocentesis should be avoided due to the uncertainty of whether or not a urinary bladder mass is present.



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- To further assess the pyloric region, consider a repeat ultrasound in 2-3 weeks or an upper GI endoscopy with biopsies. Thoracic radiographs (i.e., three-view), should be performed prior to any aesthetic event to assess cardiopulmonary status.

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- Also consider thorough orthopedic and neurologic evaluations to assess non-abdominal causes of pain.

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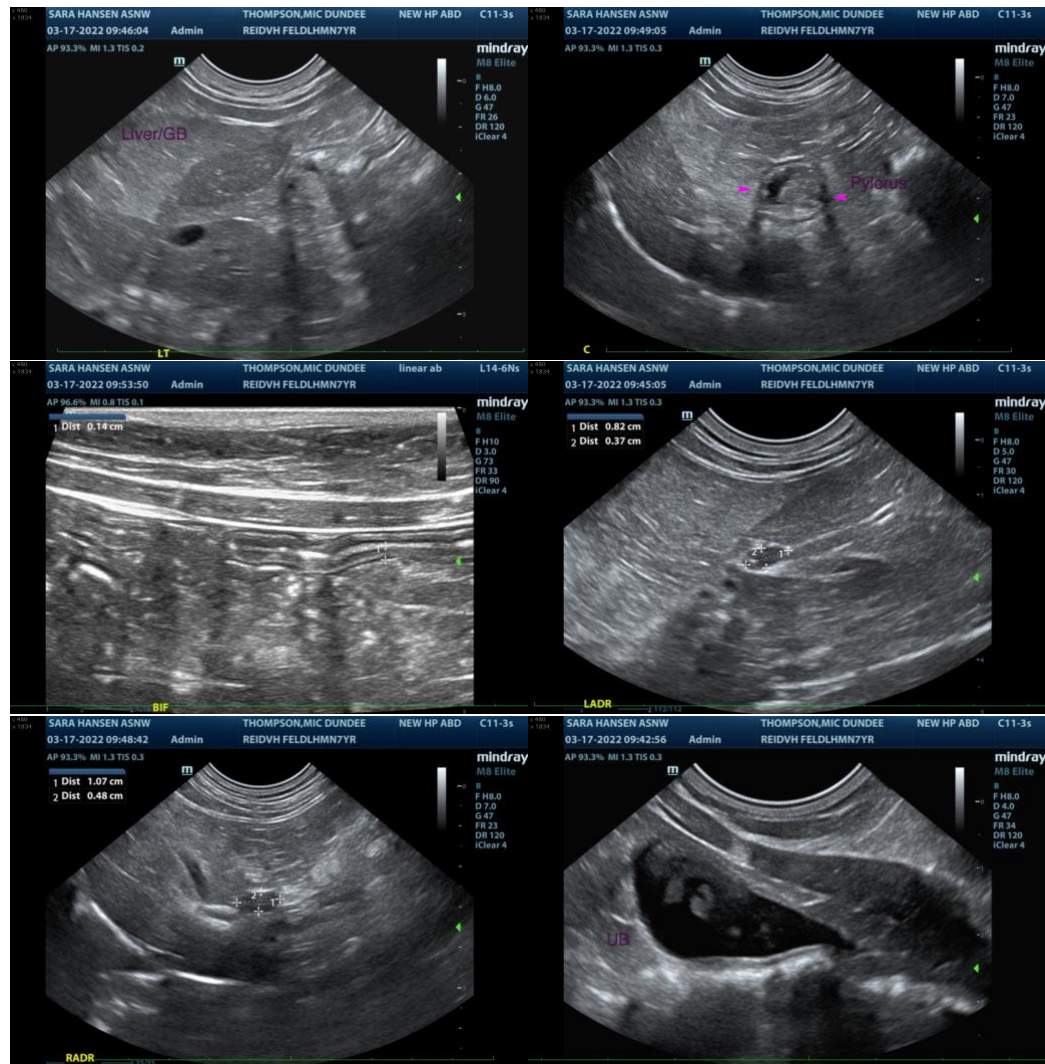
Dr. Heider

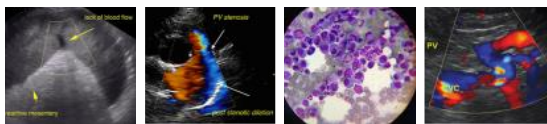
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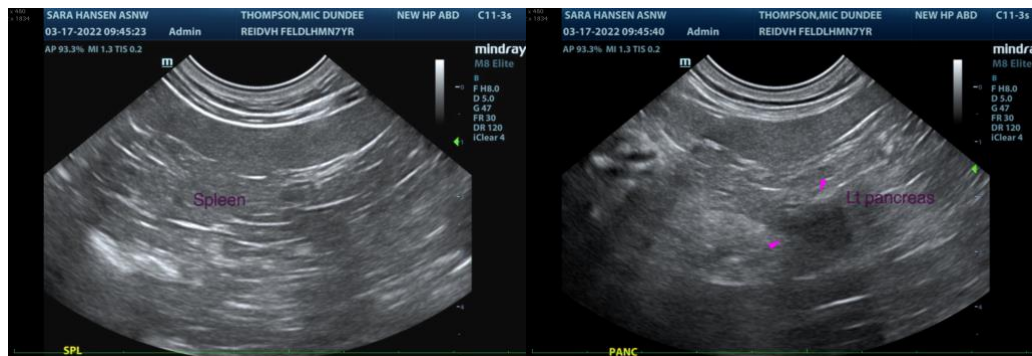
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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