



**PATIENT**

Mau Mau Savage

**SPECIES**

Feline

**BREED**

Siamese

**SEX**

Spayed Female

**AGE**

15 years

**WEIGHT**

12.3 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Loetitia Saint-Jacques,  
RVT LVT

**HOSPITAL NAME**

Options VC

**REFERRING VET**

Dr. Hewitt

**INVOICE**

10770

**DATE**

4/18/22

**PRESENTING CLINICAL SIGNS**

History: -P needed Butorphanol 10mg/mL 0.14mL IV to help facilitate with scan (painful with imaging of the cranial abdomen). Under therapy for suspected hepatic lipidosis Under therapy for suspected pancreatitis Emerging diabetes mellitus Constipation Jaundice Overweight Mild tartar- not eating on her own for a couple of weeks- tried a feeding tube and now owner has been force-feeding- icterus generalized-

Abnormal PE/Chem/CBC/UA Results: In-House Fructosamine Outcome: Fructosamine Results: 333 (191-349) ALT 893 U/L AST 297 U/L ALP 255 U/L GGT 7 U/L 6 TOTAL BILIRUBIN 9.0 mg/dL BILIRUBIN UNCONJUGATED 3.1 mg/dL BILIRUBIN CONJUGATED 5.9 mg/dL CHOLESTEROL 358 mg/dL HCT 23.2 RBC 5.55 repeated Labs ALT 653 U/L ALKP 426 U/L GGT 16 U/L 0 TBIL 23.8 mg/dL CHOL 401

**Urinary System**

The urinary bladder, trigone, and pelvic urethra are 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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (3.82 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 in size (3.87 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild 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 (0.47 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 enlarged (1.39 cm in width at the level of the hilus) with a slightly swollen peripheral margins and mild scalloping of the medial contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. One to two small, cystic lesions are present. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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The gall bladder is moderately distended. The wall is thickened (up to 0.26 cm), irregular and hyperechoic. A moderate amount of aggregated, echogenic-to-mineralized debris/sludge +/- a discreet cholelith, are observed within the lumen. The cystic and common bile ducts are dilated (up to 0.71 cm) and tortuous. Echogenic material is observed within the lumen.

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**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 is patent. At the level of the duodenal papilla, a pancreatic mass is adjacent to +/- invading into the duodenal wall. The small intestinal lumen is segmentally dilated with chyme. The remaining small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The ileoceocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

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**Pancreas**

A 2.05 x 1.82 cm hypoechoic-to-heterogenous mass is arising from the pancreatic parenchyma in the region of the duodenal papilla. The mass surrounds +/- invades the duodenum. The remainder of the pancreas is enlarged with irregular peripheral contours and hypoechoic parenchyma. The pancreatic duct is dilated (up to 0.31 cm in diameter). The mesentery surrounding the pancreas is hyperechoic.

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**Free Abdomen**

There is no obvious evidence of free fluid. A 3.12 x 1.31 cm irregular, hypoechoic, cavitated mesenteric lymph node is observed. Surrounding mesentery is hyperechoic.

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**Other**

A brief echocardiogram reveals no evidence of pericardial effusion.

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**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

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- Pancreatic mass at the level of the duodenal papilla, with suspected common bile duct obstruction. Neoplasia (i.e., adenocarcinoma) is the top differential. Concurrent pancreatitis with regional peritonitis is present.
- The gall bladder changes could be consistent with cholecystitis or benign age-related hyperplasia. There is mineralized gall bladder debris +/- a distinct cholelith. The echogenic material within the common bile duct lumen may represent debris/mucous or extension of the pancreatic mass.
- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. The cystic hepatic lesions are likely benign.
- The enlarged mesenteric lymph node may be secondary to infiltrative neoplasia, lymphadenitis or lymphoid hyperplasia.
- The splenomegaly may be secondary to lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or infiltrative neoplasia.



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**Secondary Findings**

- Bilateral age-related renal changes with right dystrophic mineralization

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Three-view thoracic radiographs are recommended to assess for pulmonary metastases. Consider a fine-needle aspirate of the pancreatic mass (if clotting status is appropriate). A 25-gauge needle should be used. If cytology results are inconclusive, or an aggressive approach is desired, an abdominal exploratory with pancreatic mass removal or debulking with possible bile duct rerouting can be considered. An abdominal CT scan would be useful in presurgical planning. If surgery is pursued, referral to a board-certified surgeon is recommended. Unfortunately, given the high likelihood of aggressive neoplasia, surgery may not be a reasonable option. Therefore, palliative care should be considered.

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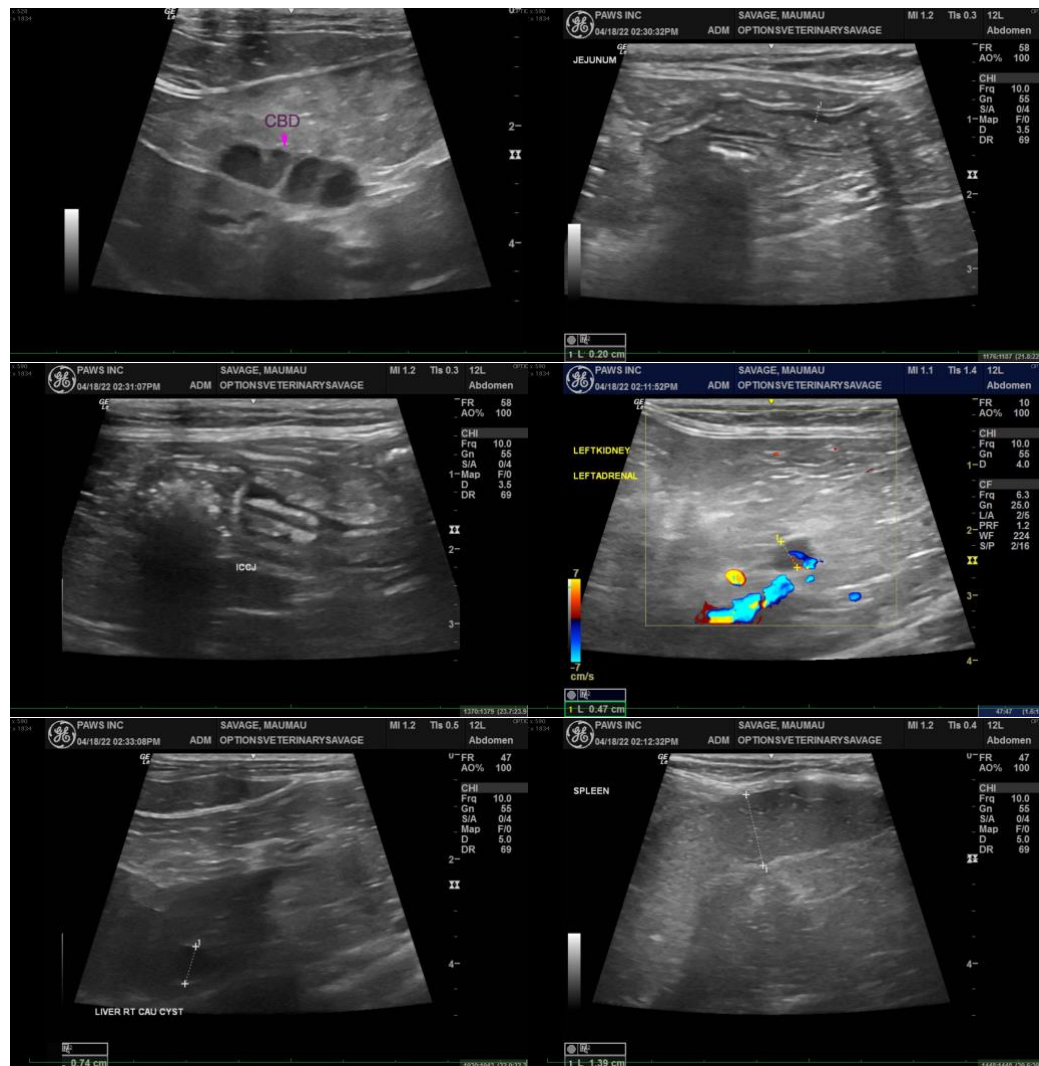
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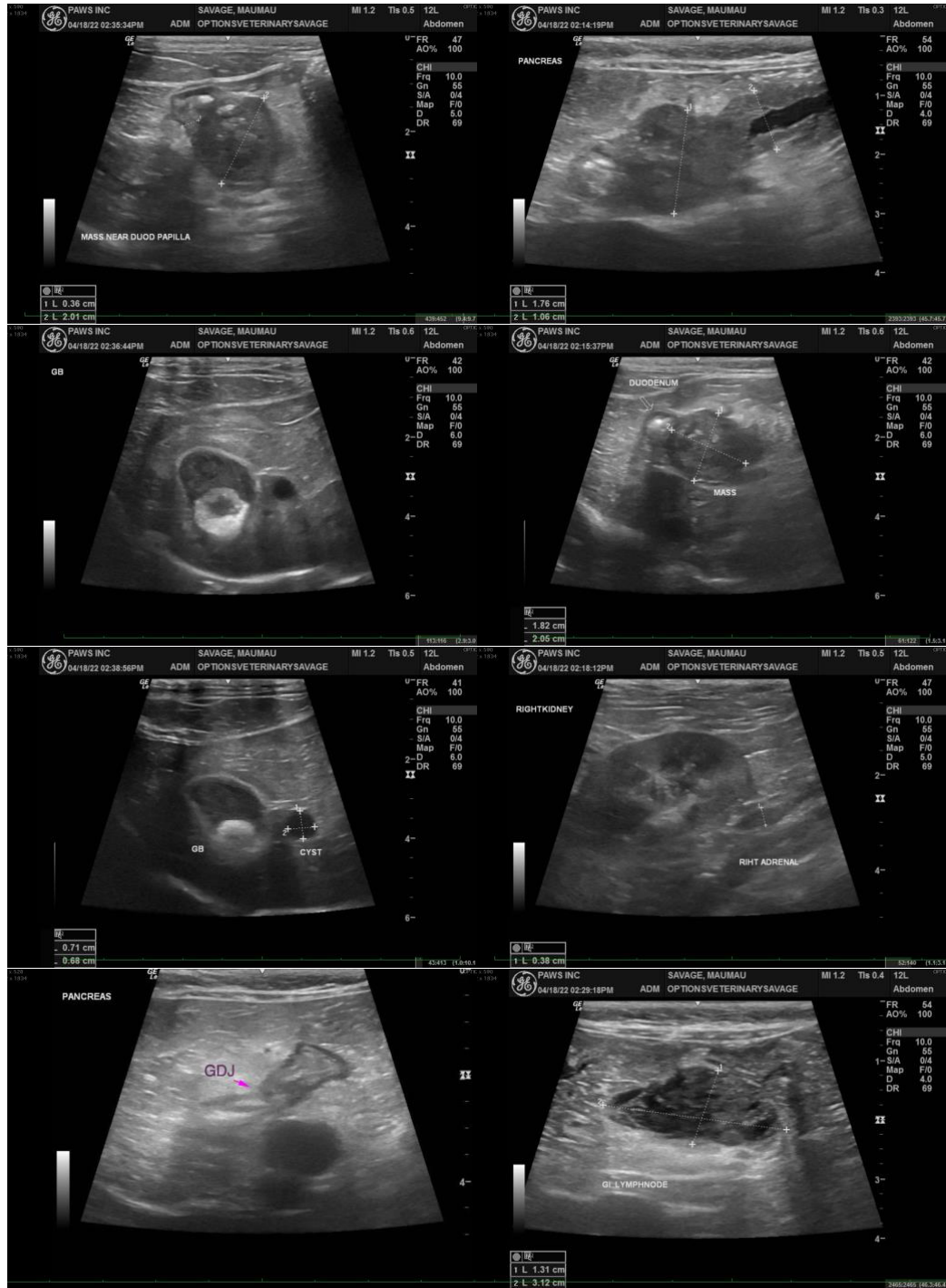
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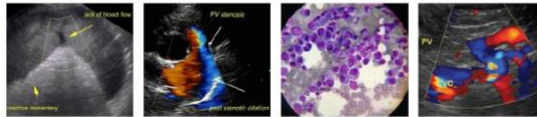
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer.

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No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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)**  
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