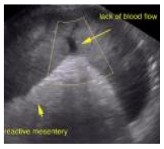
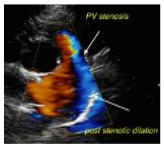
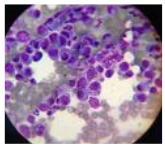
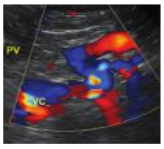
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Cooper Irwin

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 years

WEIGHT

6.82 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Saum Hadi

HOSPITAL NAME

Bethany Family PC

REFERRING VET

Dr. Saum Hadi

INVOICE

10686

DATE

4/5/22

PRESENTING CLINICAL SIGNS

History: P presented with a 1x1x1 cm slightly raised, white, freely moveable, slow growing mass on the R ventrolateral thorax. FNA revealed a mast cell tumor. P has significant weight loss in the last year (8.74 -> 6.82). Ultrasound and lab work performed today to investigate weight loss and to r/o metastasis. USG: 1.032

Abnormal PE/Chem/CBC/UA Results: CBC/Chem 27/Full UA/T4 pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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. A small 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 normal size (3.83 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic. 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 hydroureter.

The right kidney is normal size (4.54 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Mild pyelectasia is present (0.37 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

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

Spleen

What is thought to be spleen is normal in size (0.60 cm in width at the level of the hilus) with a normal curvilinear peripheral contours and homogenous parenchyma. Splenic vasculature appears normal with no evidence of thrombosis.

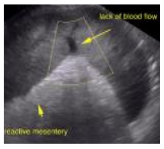
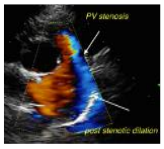
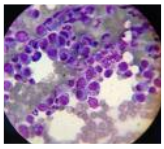
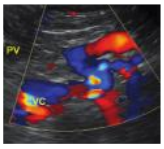
Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. 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.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. 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. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. In addition, the submucosal layer appears thickened. Discreet masses are not identified. The ileocecal colic junction appears

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normal. The proximal colonic wall is focally thickened (up to 0.76 cm) with a suspected loss of the normal layering pattern. The colonic wall tapers to a normal thickness until it reaches the descending colon, where it becomes mildly thickened (up to 0.39 cm), with retention of the normal layering pattern. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

Pancreas

What is thought to be the left limb and body of the pancreas is enlarged, with irregular, peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

Trace free fluid is observed. At least one prominent mesenteric lymph node is visualized, measuring 1.08 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

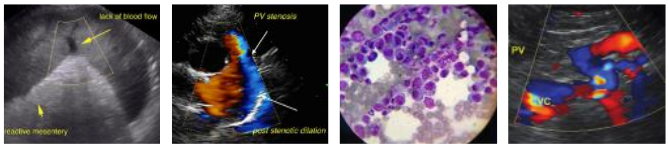
- The proximal colonic wall changes are concerning for infiltrative neoplasia (i.e., lymphoma, adenocarcinoma). However, a severe inflammatory process is also possible. The diffuse small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma.
- The pancreatic changes could be consistent with chronic pancreatitis or neoplastic process (i.e., adenocarcinoma).
- Trace ascites

Secondary Findings

- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Bilateral, minor age-related renal changes
- The prominent mesenteric lymph node is likely reactive with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Consider a fine-needle aspirate of the thickened proximal colonic wall, if accessible and if clotting status is appropriate. A 25-gauge needle should be used, and care should be taken to avoid penetration of the colonic lumen with the needle. Also consider a fine-needle aspirate of the pancreas. If cytology results are inconclusive or if the thickened colonic region is inaccessible, consider and abdominal exploratory with gastrointestinal, pancreatic and hepatic biopsies.



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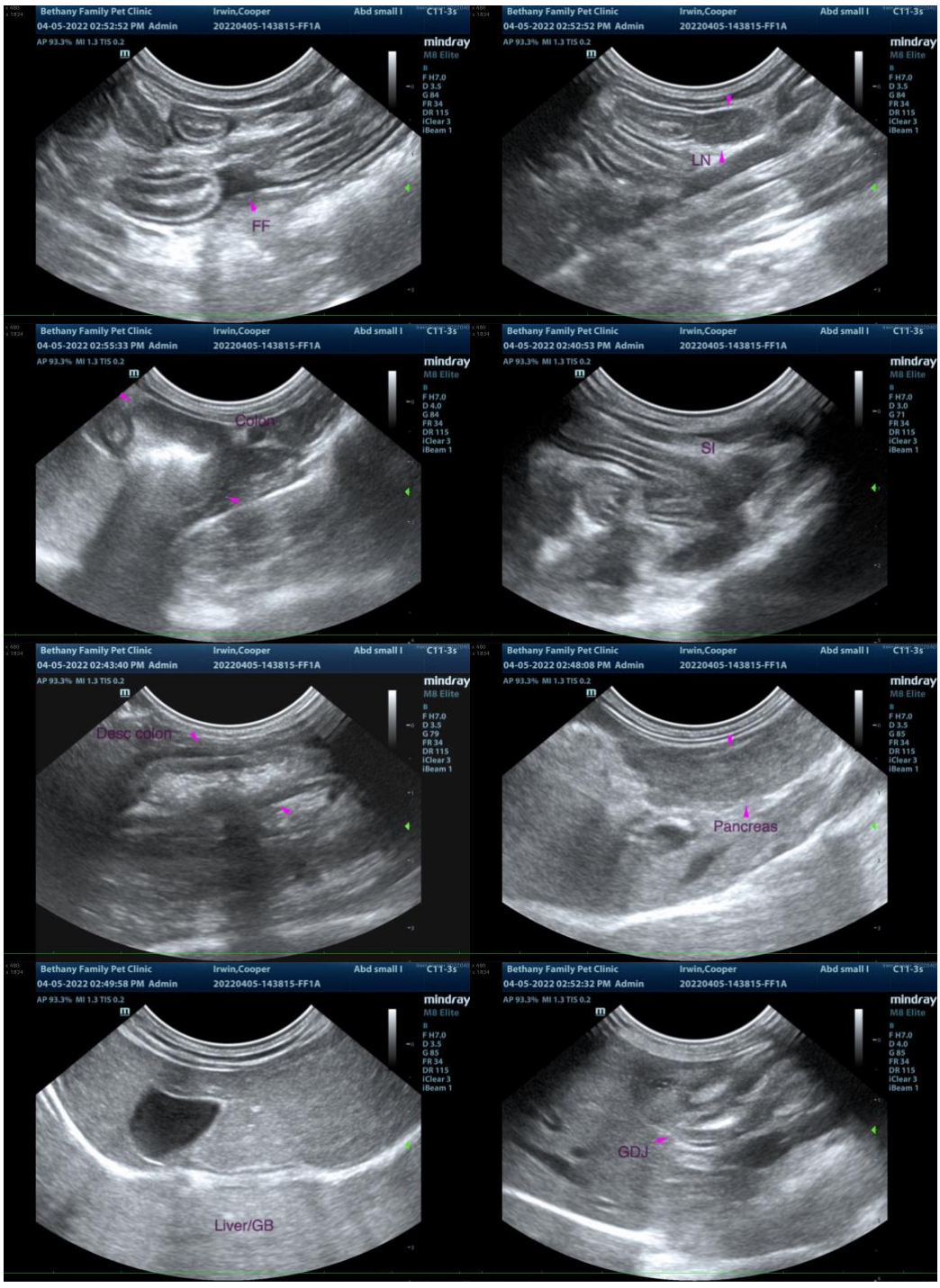
- A malabsorption panel, including serum cobalamin and folate, TLI and PLI, is also recommended.



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.

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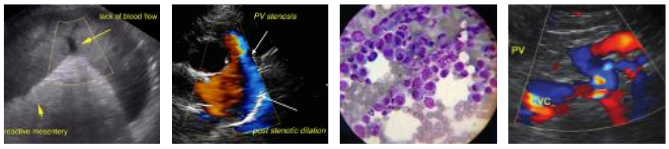

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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