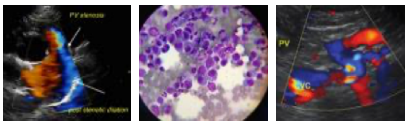
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

5/16/22

PATIENT

Matilda Gerst

SPECIES

Feline

BREED

Domestic shorthair

SEX

Female, spayed

AGE

2/26/2010

WEIGHT

8.5 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Paradise AH

REFERRING VET

Dr. Riehl

INVOICE

13364

PRESENTING CLINICAL SIGNS

Marked weight loss (2 lb since October 2021) with decreased appetite. . Grade 2/6 systolic murmur (historic) with normal proBNP. Gas distended abdomen, rodent ulcers. Sneezing serous nasal discharge. Pruritic ears

Current Medications: Started prednisolone empirically due to patient status/pruritus/rodent ulcers. Prednisolone 5 mg q 24 Hr, Convenia: 0.4 mL SQ.
Lab Results: Normal BW except elevated fPL 7.4 and BUN 42 with USG 1.020.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: gabapentin only, very sweet kitty.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS

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 with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1-2 cm, are normal.

The left kidney is small in size (3.43 cm in length) with an irregular shape. 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 or hydroureter.

The right kidney is normal in size (2.75 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. At least one small nephrolith is visualized. Mild pyelectasia is present (0.21 cm in the transverse plane). There is no evidence of hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.58 cm length; 0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.71 cm length; 0.35 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively prominent in size (1.00 cm in width at the level of the hilus) with a mildly undulating medial contour. Using the high frequency probe, the parenchyma appears mottled, bordering on “moth-eaten”. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance. A 1.14 cm ill-defined hypoechoic nodule is observed on the right side. In addition, a 1.18 cm ill-defined hypoechoic nodule is observed on the left. Intrahepatic biliary tracts contain mineralized sand. Hepatic vasculature is of normal volume with no evidence of congestion. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is normal in thickness. A small to moderate amount of gravity-dependent mineralized sand is observed within the gallbladder and cystic duct lumen. The cystic and common bile ducts are visible but not overtly dilated. Duodenal papilla is thickened (0.55 cm in width).

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 is diffusely thickened (up to 0.33 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments, with a 1:1 ratio in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The pancreas is diffusely visible/prominent with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. The pancreatic duct is diffusely dilated (up to 0.55 cm). Approximately 1 cm from the duodenal papilla, a small (0.51 cm) aggregation of mineralized sand is visualized. The mesentery effacing the serosal surface of the pancreas is mildly hyperechoic.

Free Abdomen

There is no evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 0.80 cm in length. In addition, a 0.48 cm lymph node is observed in the right cranial quadrant. The mesentery surrounding the nodes is mildly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The splenic parenchymal changes could be consistent with infiltrative neoplasia (i.e., lymphoma, antigenic stimulation, extramedullary hematopoiesis, lymphoid hyperplasia or splenitis).
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The pancreatic changes are consistent with chronic +/- active pancreatitis.
- The hypoechoic hepatic nodules could be consistent with inflammatory foci, granulomas or emerging neoplasia.

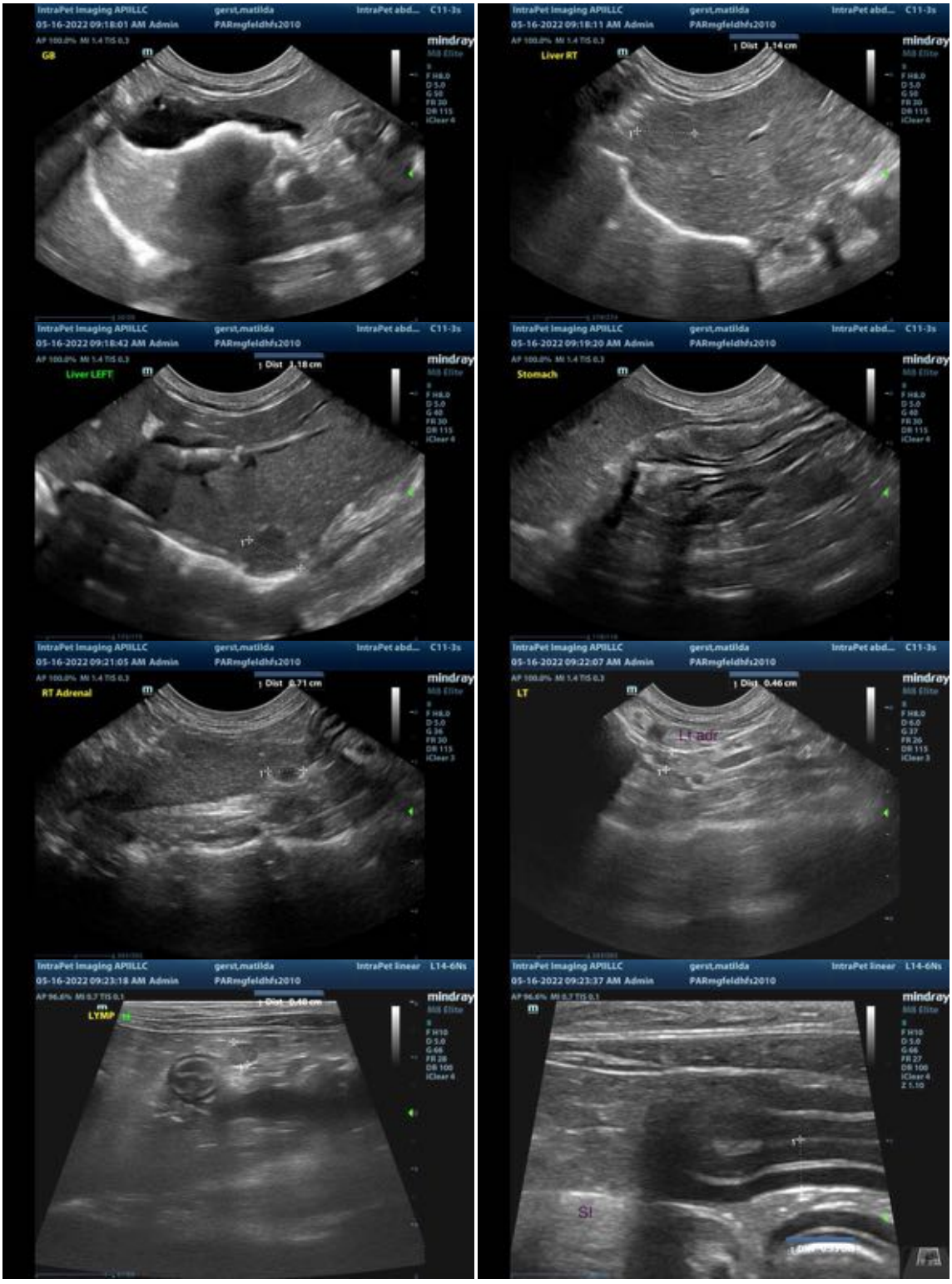
Secondary Findings:

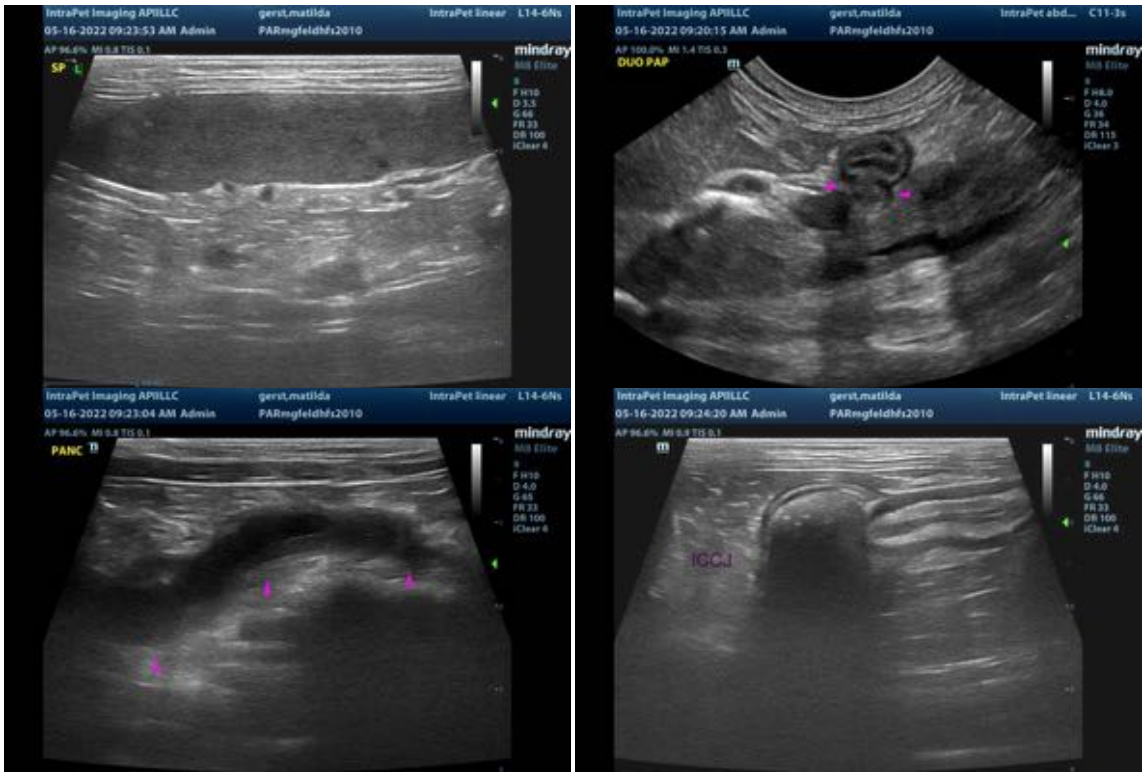
- Gallbladder/bile duct sand.
- Bilateral chronic age-related renal changes with right nephrolithiasis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fine needle aspirate of the spleen is recommended (if clotting status is appropriate) along with thoracic radiographs to assess for occult neoplasia in the chest.
- Depending on the results of the above diagnostics, an abdominal exploratory with gastrointestinal, abdominal lymph node and liver biopsies may be necessary to get a definitive diagnosis.

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





The information and recommendations provided are based on the images presented by the referring veterinarian. 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 ACVIM (*Small Animal Internal Medicine*)
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