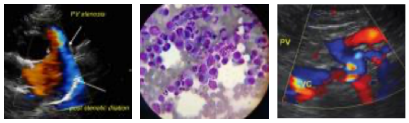
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

5-8-23

PATIENT

Miyuki Rice

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9/5/2018

WEIGHT

6.03 lbs

INTERPRETED BY

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

HOSPITAL NAME

Jacksonville VH

REFERRING VET

Dr. Burk

INVOICE

12962

PRESENTING CLINICAL SIGNS

Weight loss, icterus, decreased appetite, owner noted icterus and decreased appetite 5/3/23, owner says weight loss is recent. 3/18/22 wt= 10.3 pounds. 5/4/23 wt= 6.03 pounds. QAR BCS 3.5/9, icteric, decreased muscle mass, gingivitis, suspect tooth resorption lesions

Current Medications: 5/4/236 SQ fluids, b12 1/4cc SQ, convenia 0.28cc SQ, Cerenia 0.14cc SQ, Clavamox drops 3/4cc PO BID, Metronidazole 37.5mg SID, Denamarin for cats/small dogs 1 tab BID
Lab Results: FELV neg, FIV neg, FPL normal, HCT 30.5%, lymphocytes 22.75 k, monocytes 2.27 k bands suspected, ALT 288, ALP 151, GGT 8, T Bili 6.0
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone is normal.

The left kidney is normal in size (3.48 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. A few small foci of mineralization are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.48 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. A few small foci of mineralization are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is borderline enlarged (0.51 cm width) with a slightly rounded shape. There is normal glandular echogenicity and detail. Surrounding vasculature appears normal.

The right adrenal gland is enlarged (0.61 cm width) with a slightly rounded shape. There is normal glandular echogenicity and detail. Surrounding vasculature appears normal.

Spleen

The spleen is enlarged (1.09 cm in width at the level of the hilus) with swollen peripheral contours. The parenchyma is diffusely mottled, with a “moth-eaten” appearance. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hypoechoic 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 portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder is mildly to moderately distended. The wall is thickened (up to 0.24 cm) and hypoechoic with a “double-walled” effect. A small amount of echogenic debris is observed within the lumen. The cystic

and common bile ducts are tortuous and dilated (up to 0.53 cm). The walls are thickened. There is no obvious evidence of an intraluminal obstruction. The duodenal papilla is normal in size (0.20 cm in width).

Gastrointestinal
The gastric lumen is not distended. The gastric wall is normal to moderately thickened (up to 0.65 cm) with loss of the normal layering pattern in the thickened segments. The pyloric outflow tract appears patent. A few small intestinal segments are severely thickened (up to 0.79 cm) with loss of the normal layering pattern. The remaining small intestinal segments are normal in thickness with a normal layering pattern and appropriate mural detail. The small intestinal lumen is not dilated. The ileocecocolic junction is normal. There is no obvious evidence of an obstructive pattern.

Pancreas
The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen
The mesentery throughout the abdomen is mildly hyperechoic. Trace free fluid is observed. Several enlarged hypoechoic lymph nodes are observed throughout the abdomen (the largest measuring 1.92 cm in length).

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The splenic changes are more concerning for infiltrative neoplasia. Lymphoma is the top differential.
- The diffuse abdominal lymphadenopathy and bowel changes are also concerning for a neoplastic process (i.e., lymphoma) with a lower possibility of inflammatory change, other.
- The hepatic parenchymal changes could be consistent with infiltrative neoplasia, emerging hepatic lipidosis, inflammatory disease, other.
- The gallbladder and cystic/common bile duct wall changes are most consistent with inflammation (i.e., cholecystitis/cholangitis) with a lower possibility of infiltrative neoplasia.

Secondary Findings

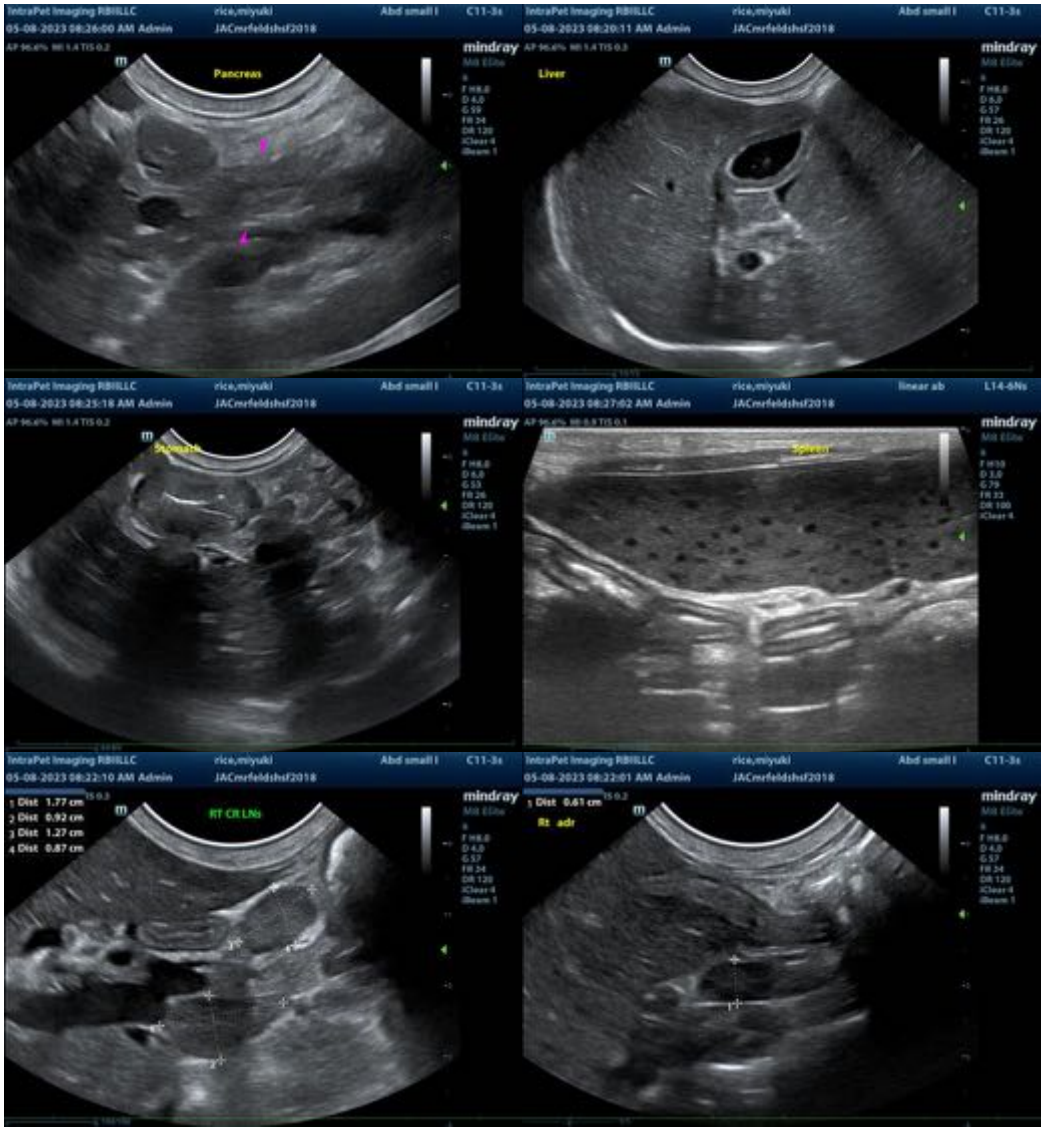
- Minor bilateral nonobstructive nephrocalcinosis
- The bilateral adrenomegaly may be a normal variant for this patient or may be secondary to stress or hyperplastic change.
- The pancreatic changes could be consistent with could be consistent with mild to moderate pancreatitis, edema, infiltrative neoplasia, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for lymphadenopathy in the chest.
- Fine-needle aspirates of the spleen, abdominal lymph nodes, +/- liver should be considered (if clotting status is appropriate). Twenty-five gauge-needles should be used. If the cytology results

are inconclusive, advanced testing (i.e., PARR, flow cytometry or biopsies) may be necessary to get a definitive diagnosis.

- Also consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI.
- Regarding the CBC changes, a clinical pathology review is 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.

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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