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Clinical Sonography & Telecytology
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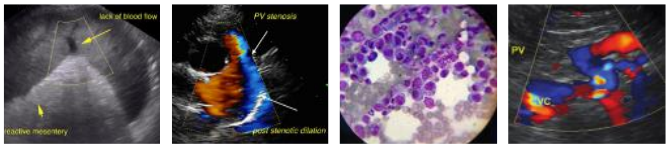

PATIENT

Carlos Palmer

SPECIES

Feline

BREED

Maine Coon

SEX

Neutered Male

AGE

10 years

WEIGHT

18.4 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

All Creatures Great&Small VC

REFERRING VET

Dr. Jessica Bailes

INVOICE

11013

DATE

6/2/22

PRESENTING CLINICAL SIGNS

History: History: Hx of liver lobectomy 8/21 - hepatic carcinoma excised w/ clean margins. Since then improved but persistent elevated ALT. Had a follow up AUS 10/21 to further evaluate abdominal pain, lethargy - small hepatic nodule noted @ that time. Examined again 5/22 for evaluation of possible abdominal pain again.

Abnormal PE/Chem/CBC/UA Results: Weight loss w/ moderate MCS atrophy noted on exam, severe dental disease, otherwise NSF on PE Bloodwork: CHEM: increased ALB (4.1), increased ALT (412), increased TBILI (1.5), otherwise WNL CBC: thrombocytopenia (91K) w/ adequate estimate TT4: WNL @ 3.2

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. The region of the trigone is normal.

The left kidney is normal size (5.25 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.49 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. 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 (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.49 cm cranial; 0.35 cm caudal; 1.32 cm length). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively normal in size. At the cranial pole, a 1.41 x 1.34 cm slightly hypoechoic swelling is observed. The swelling causes expansion of the lateral capsule. The remainder of the parenchyma is homogenous. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively prominent in size with swollen, slightly irregular peripheral contours. A 1.86 x 1.52 cm cavitated mass is arising from the left, lateral lobe. The lesion causes capsular expansion. The remaining parenchyma is hyperechoic relative to the spleen and homogenous in appearance. Hepatic vasculature and intrahepatic 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 moderately distended. The wall is normal in thickness. A few, gravity dependent cholelithes are observed within the lumen. The cystic and common bile ducts are normal/not seen.

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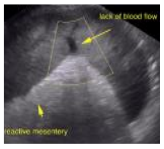
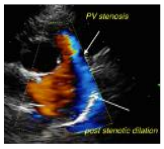
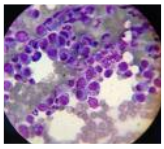
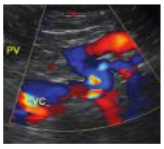

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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is minimally fluid 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 some segments. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely visible/prominent with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

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

- Cavitated hepatic nodule/mass in the left, lateral lobe. The lesion is slightly larger compared to the previous sonogram. The diffuse hepatic parenchymal changes are nonspecific and could be secondary to inflammatory disease (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis), hepatic lipidosis, or less likely, infiltrative neoplasia.
- The splenic swelling could be consistent with an emerging tumor/metastatic lesion. Alternatively, a benign process (i.e., focus of lymphoid hyperplasia, extramedullary hematopoiesis, or similar) may be present.

Secondary Findings

- Nonobstructive choleliths – incidental
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral, chronic, age-related renal changes
- Bowel pattern suggestive of inflammatory bowel disease. There is some potential for emerging lymphoma. However, neoplasia is considered unlikely at this time.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Thoracic radiographs are recommended to assess for pulmonary metastatic disease.
- Consider a fine-needle aspirate of the splenic swelling to further assess for neoplasia.
- Consultation with a board-certified surgeon can also be considered to discuss removal of the hepatic mass +/- splenectomy, if indicated.

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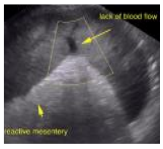
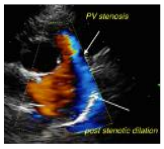
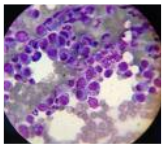
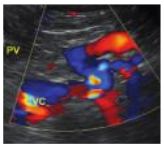

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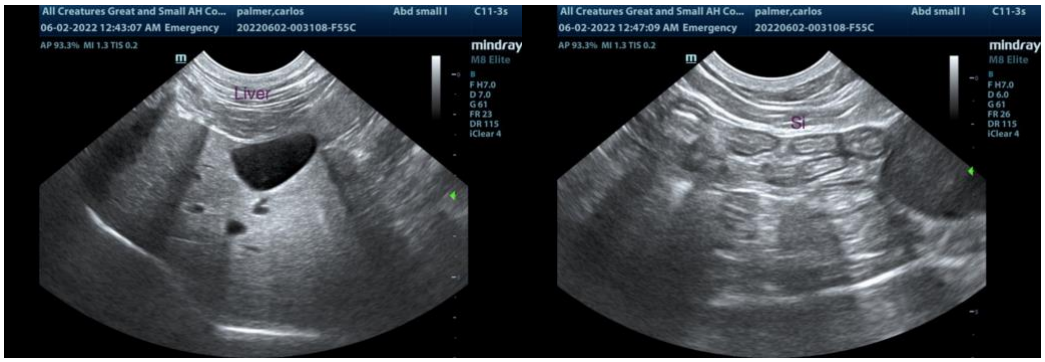

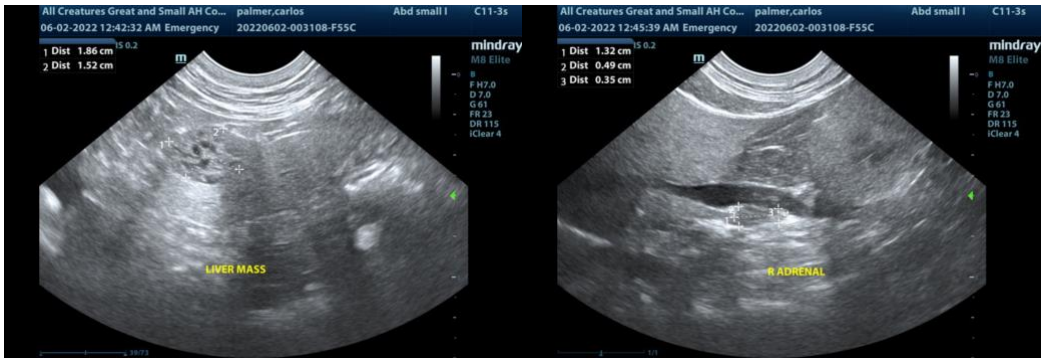

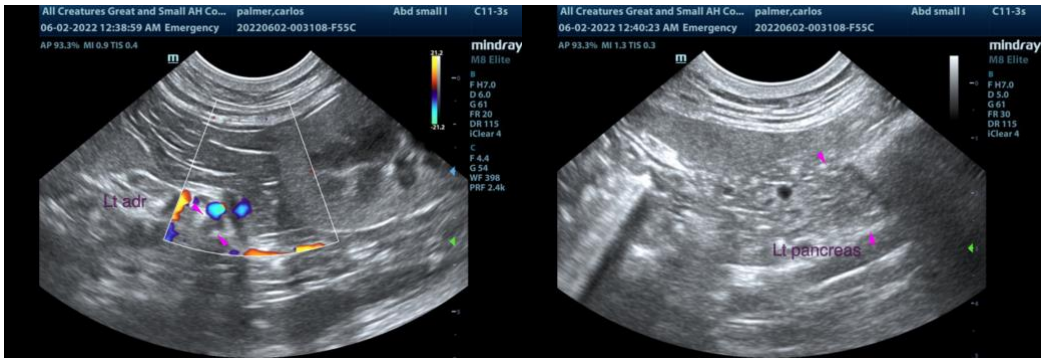

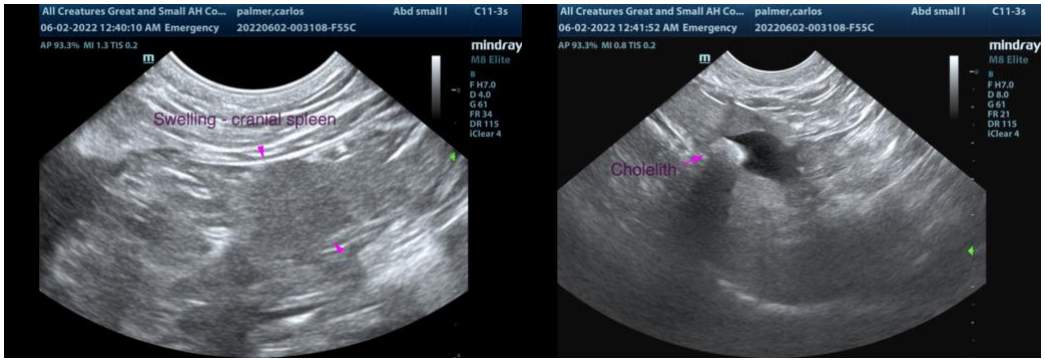

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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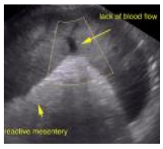
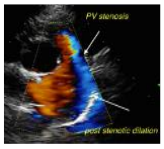
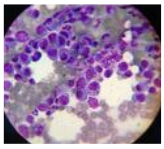
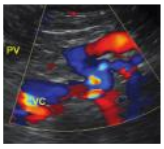

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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info@SonoPath.com