

**DATE PRESENTING CLINICAL SIGNS**

6/20/2022 Fluid in abdomen, loss of appetite. History of liver cysts and heart disease.

PATIENT

Charlie Cochrane

Current Medications: Mirataz 5mg SID, Lasix, Benazapril, Plavix, Herbals.
 Date of Previous IntraPet Ultrasound: 1/18/21. See attached.
 Sedation: Not required to complete full diagnostic ultrasound.
 Stat Report: Declined.
 Imaging Performed By: Stephanie Pearce RDCS, RVT.

SPECIES

Feline

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**BREED****Urinary System**

DMH

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 and the visible portion of the proximal urethra are normal.

SEX

Neutered Male

The left kidney is normal size (3.40 cm in length); with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A few, nonobstructive nephroliths are visualized. There is a questionable cortical infarct. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

AGE

6/20/2005

The right kidney is small in size (2.84 cm in length) with an irregular shape. The cortex is variably thickened with moderate loss of corticomedullary distinction. A few, small, nonobstructive nephroliths are visualized. Trace pyelectasia is present. A cortical infarct is present at the caudal pole. There is no evidence of hydroureter. Renal vasculature is normal.

WEIGHT

10.4 lbs

INTERPRETED BY**Adrenal Glands**

The region of the left adrenal gland is evaluated. No obvious pathology is seen.

The right adrenal gland is normal size (0.44 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is contracted (0.57 in width at the level of the hilus) with normal curvilinear peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

HOSPITAL NAME

Animal Med Clinic
 Dulaney Valley

Liver

The liver is subjectively prominent to enlarged with irregular peripheral contours. Throughout the liver, varying-sized, irregular, hyperechoic to heterogenous cavitated masses are observed, the largest measuring approximately 5.00 cm in diameter. Several of the lesions are causing capsular expansion. A 2.15 cm irregular, multi-septated cyst is observed on the right side. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

REFERRING VET

Dr. Chrest

INVOICE

11134

The gall bladder lumen is moderately distended. The wall is normal in thickness. A small amount of mostly gravity dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts are visible/tortuous but not overtly dilated. The common bile duct measures 0.23 cm in diameter at the level of the duodenal papilla. There is no obvious evidence of an intraluminal obstruction.

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. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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

A large amount of echogenic free fluid is present. The mesentery throughout the abdomen is hyperechoic. A few, prominent mesentery lymph nodes are visualized, the largest measuring 1.69 cm in length.

Thorax

A 1.94 x 1.28 cm irregular, vascular, echogenic tissue structure is observed in the cranial mediastinum. There is questionable trace pleural effusion. The mesentery is hyperechoic and slightly irregular. There is no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The diffuse cystic masses could be consistent with biliary cystadenoma or cystadenocarcinomas. The lesions are similar to increased in number compared to the previous sonogram.
- The diffuse ascites and reactive mesentery may be secondary to the hepatic lesions. However, other causes (i.e., carcinomatosis, congestive heart failure, other) are considerations.

Secondary Findings

- Bilateral, chronic, age-related renal changes with nonobstructive nephrocalcinosis and suspected cortical infarcts.
- The splenic contraction is likely secondary to dehydration.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bowel pattern consistent with inflammatory bowel disease with some potential for emerging lymphoma. Changes are similar to the previous sonogram.

ULTRASONOGRAPHIC EXAMINATION OF THE THORAX

Findings

- Cranial mediastinal nodule. Differentials include lymph node, tumor, granuloma.
- Questionable trace pleural effusion.

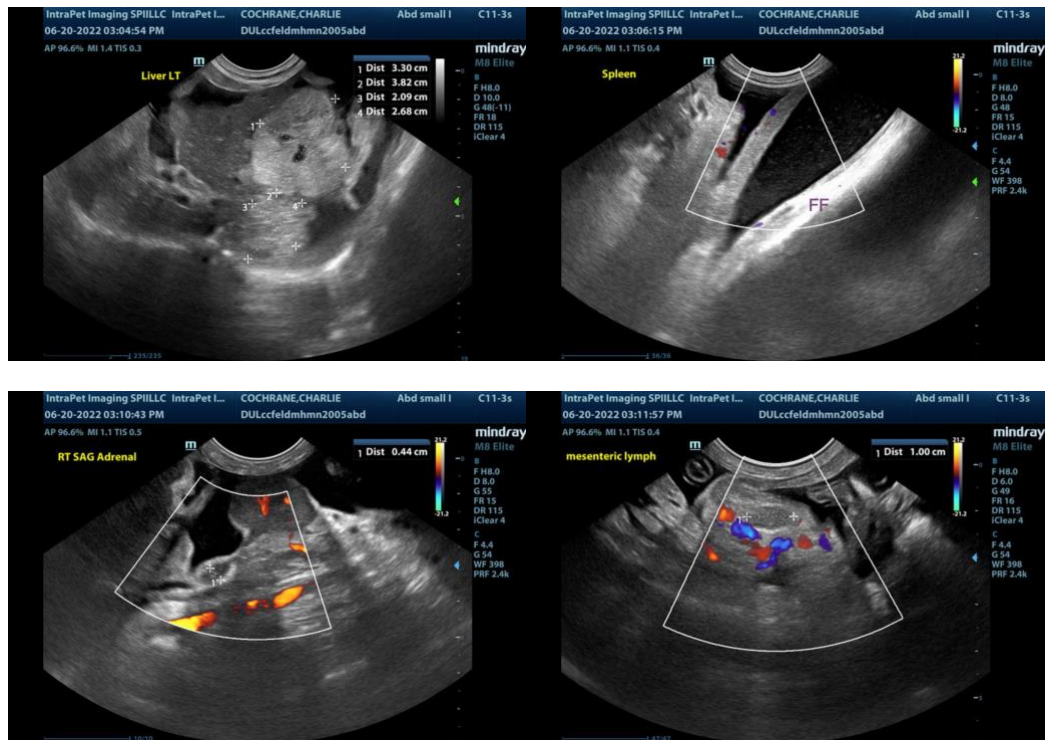
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

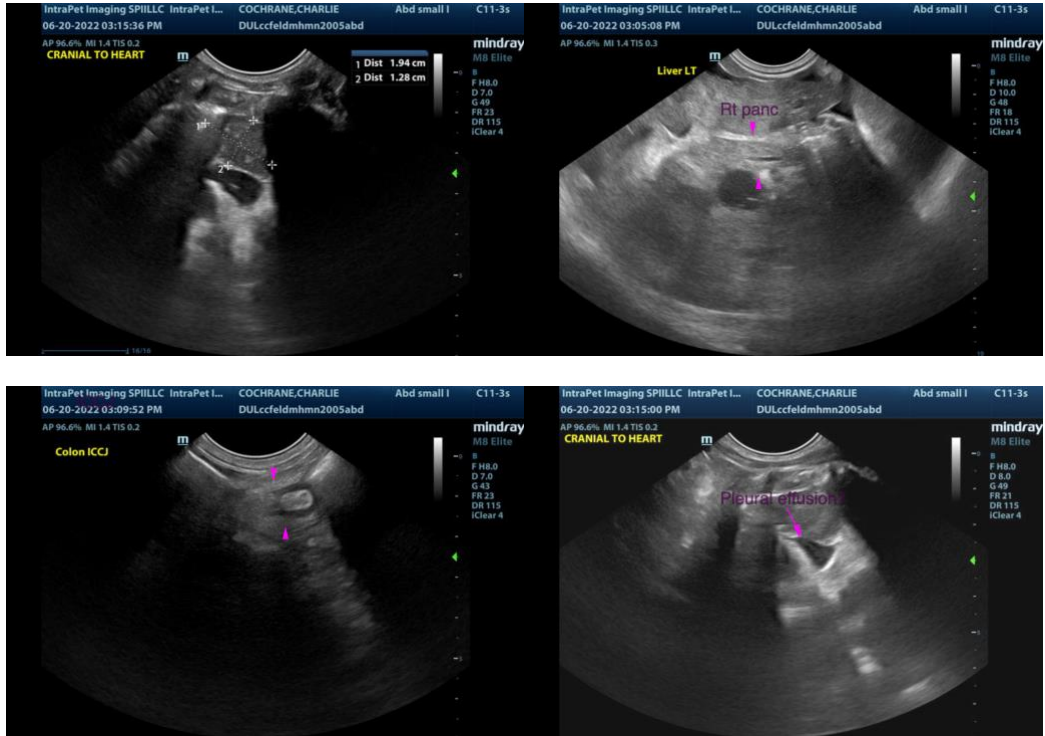
Submission of the abdominal fluid for analysis and cytology is recommended.

Thoracic radiographs are also recommended, if not already performed.

If accessible, fine-needle aspiration of the cranial mediastinal nodule can be considered. Alternatively, a thoracic CT scan may be useful in further defining the lesion.

Consider a complete echocardiogram to further evaluate for underlying cardiac disease as a cause for ascites.





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.

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