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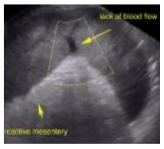
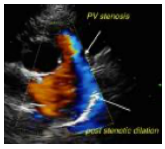
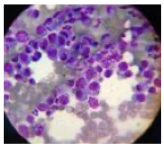
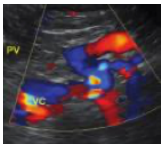

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1-800-838-4268 info@sonopath.com

PATIENT
Coco Dingley

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
12 years

WEIGHT
Not Provided

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

IMAGING PERFORMED BY
Jessica Miller

HOSPITAL NAME
Summit Dog&Cat

REFERRING VET
Dr. Vogler

INVOICE
11189

DATE
6.29.22

PRESENTING CLINICAL SIGNS

History: Possible abdominal mass, mass effect on x-ray.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A moderate amount of suspended, echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The **left kidney** is normal size (4.45 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. The cortex is mildly hyperechoic. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (4.36 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. The cortex is mildly hyperechoic. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.45 width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is enlarged with irregular peripheral contours. A 2.21 x 1.58 cm isoechoic swelling/mass is observed at the medial aspect. In the remainder of the spleen, the peripheral margins are curvilinear. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The **liver** is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The portal vein to caudal vena cava ratio is approximately 1: 1.

The **gall bladder** is mildly distended. The wall is slightly thickened (up to 0.20 cm), irregular and hyperechoic. A small amount of suspended, echogenic debris is observed within the lumen. The common bile duct is borderline dilated (up to 0.32 cm). The common bile duct can be followed to the level of the duodenal papilla. There is no obvious evidence of an intraluminal obstruction. The duodenal papilla is normal in size (0.37 cm in width).

Gastrointestinal

The **gastric lumen** is distended with ingesta. 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 segmentally dilated with chyme. The small intestinal wall is normal to mildly thickened (up to 0.30 cm) with retention of the normal layering pattern. 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.

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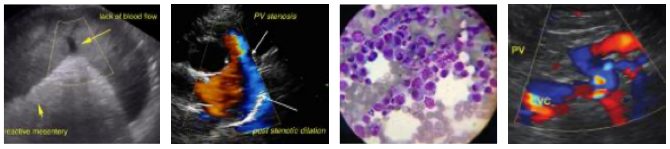

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Pancreas
The **pancreas** is diffusely prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.17 cm in diameter). The mesentery effacing the serosal surface of the left limb is questionably hyperechoic

Free Abdomen
There is no evidence obvious evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.99 cm in length. Surrounding mesentery is hyperechoic. In addition, a 0.55 cm cranial abdominal lymph node is seen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Splenomegaly with a medial swelling/mass effect. Differentials include neoplasia (i.e., round cell tumor) versus a benign process such as extramedullary hematopoiesis, lymphoid hyperplasia or similar.

Secondary Findings

- The urinary bladder debris could be consistent with cells, crystals and/or exfoliated material.
- Minor age-related chronic renal changes
- The gall bladder changes could be consistent with cholecystitis and/or benign age-related hyperplasia. Correlation with the patient's clinical history is recommended.
- The pancreatic changes are consistent with chronic pancreatitis +/- active pancreatitis.
- The small intestinal wall changes are suggestive of inflammatory bowel disease. Emerging neoplasia is also possible but considered less likely.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider thoracic radiographs to assess cardiopulmonary status.
- A fine-needle aspirate of the splenic swelling is recommended (if clotting status is appropriate). A 25-gauge needle should be used. If cytology results are inconclusive, a splenectomy with submission of the spleen for histopathology may be necessary to get a definitive diagnosis. If surgery is pursued, also consider biopsies of the prominent abdominal lymph nodes, GI tract, +/- pancreas.
- If the patient is exhibiting gastrointestinal signs, consider further work-up (i.e., malabsorption panel, fecal evaluation for ova and Giardia).

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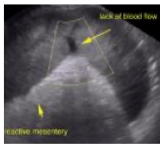
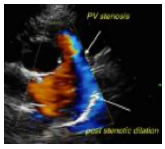
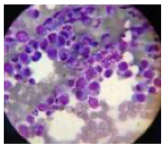
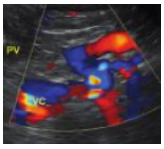

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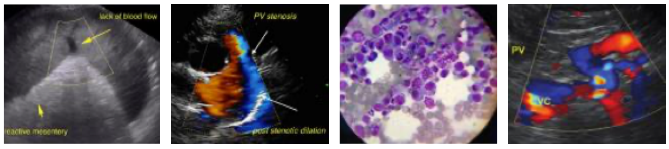

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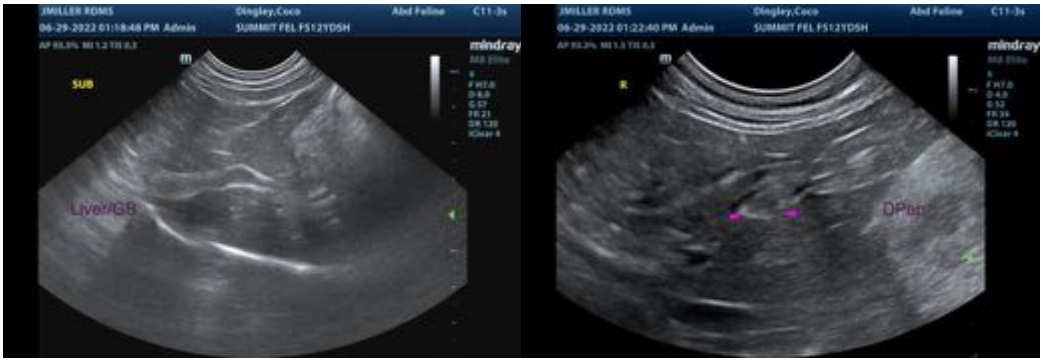

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 DACVIM (Small Animal Internal Medicine)
info@SonoPath.com