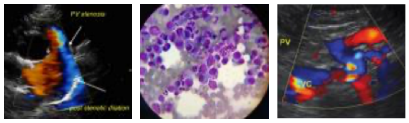
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

7.31.2022

PATIENT

Duke Kanekuni

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7/30/13

WEIGHT

11 lbs

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital-Kalwa

REFERRING VET

Alexandra Kalwa

INVOICE

11290

PRESENTING CLINICAL SIGNS

07-30-2022 Notes: PC: - Vomiting (Q3-4 hrs initially --> anti-nausea med helping), no blood - No feces - Lethargy - Weakness/ ataxia - Not eating/not drinking -48 hrs - 7/28/22: Emergency Animal hospital-Ellicott City PC: vomiting, disorientation, lethargy. Not taking medication Diagnostics: BNP, cbc, pcv, Fpl, UA, chem, lytes - CBC- mild leukocytosis 18k, lymphocytosis 9.23, monocytosis - CHEM- glu 199; ALT 254 - UA: >1050, trace protein - FPL normal - BNP normal - X-rays: States unremarkable- no obvious fb –

Medications: cerenia, convenia, baytril, buprenorphine, elura, LRS SQ 7/29/22: Hampden Vet hospital Drop off, sq fluids, mirtazapine History: - Urinary obstruction- on urinary diet - Seizures - on phenobarbital - Possible cholangiohepatitis few months ago- resolved- had AUS- showed inflammation of liver- not caused from medication - Cold ~1 month ago - Teeth pulled - Ear hematoma.
Current Medications: Pantoprazole, Ondansetron, Buprenorphine.

Lab Results:
Radiographs: extremely dilated stomach.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small to moderate amount of stranding, suspended, echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The **left kidney** is normal size (4.14 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with 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 (4.55 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.

Adrenal Glands

The **left adrenal gland** is enlarged (1.52 cm length; 0.71 cm width) with a relatively normal shape and smooth peripheral contours. A small hyperechoic focus is observed within the parenchyma. The remaining glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

The **right adrenal gland** is borderline enlarged (1.55 cm length; 0.54 cm width), with a normal shape, glandular echogenicity and detail. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The **spleen** is normal in size (0.64 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic

vasculature is normal.

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 **gall bladder** lumen is moderately distended. The wall is thin and smooth. A scant amount of suspended, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal
The **gastric lumen** is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not overtly dilated. A several centimeter segment of jejunum is thickened (up to 0.39 cm) with disruption of the normal muscularis: mucosal ratio (>1:1). The mesentery effacing the serosal surface of this segment is hyperechoic. In the remaining small intestinal segments, there is slight disruption in the normal 1:3 muscularis: mucosal ratio, and retention of the normal layering pattern. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas
The **pancreas** is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen
Trace free fluid is observed. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The focal jejunal thickening is concerning for emerging neoplasia (i.e., lymphoma). However, a focal inflammatory response cannot be excluded. Regional peritonitis is present.

Secondary Findings

- Bilateral chronic renal changes (similar to the previous sonogram).
- The bilateral adrenomegaly could be consistent with hyperplasia, stress, or may be a normal variant for this patient. The hyperechoic focus in the left adrenal parenchyma is likely a benign, age-relate incidental finding.
- The urinary bladder debris could be consistent with cells, crystals and/or exfoliated material (previously reported)

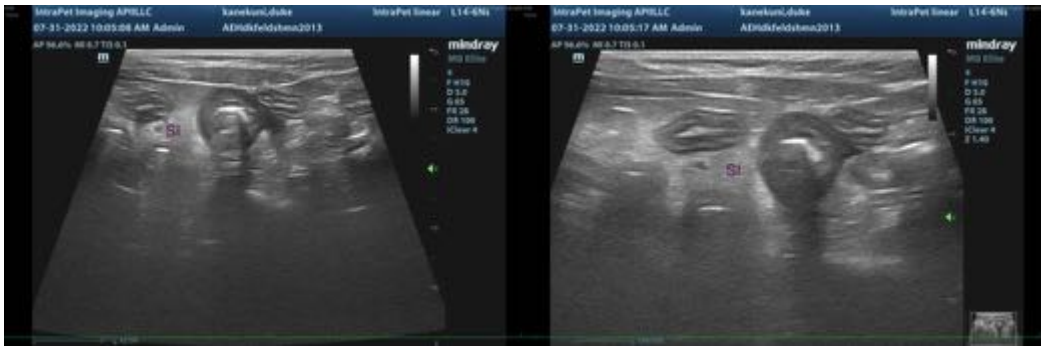
*The liver no longer appears hyperechoic.

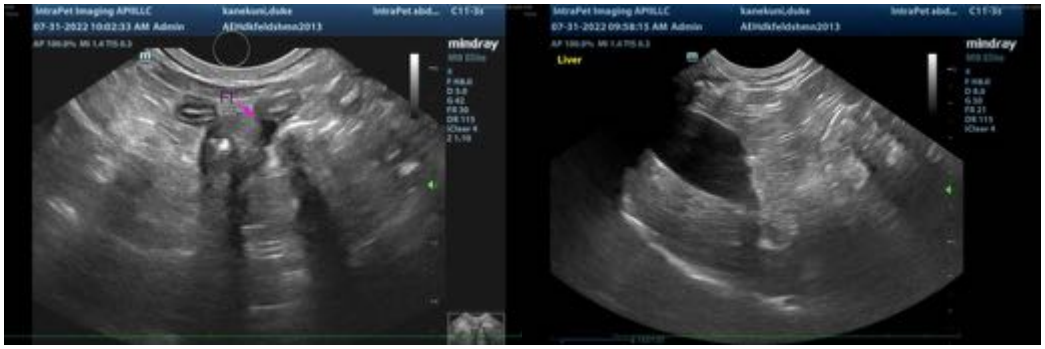
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

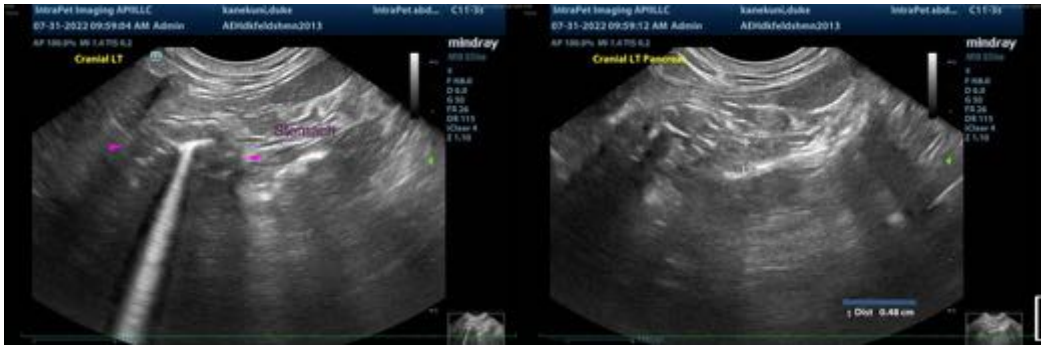
Given the lymphocytosis, a CBC with clinical pathology review is recommended.

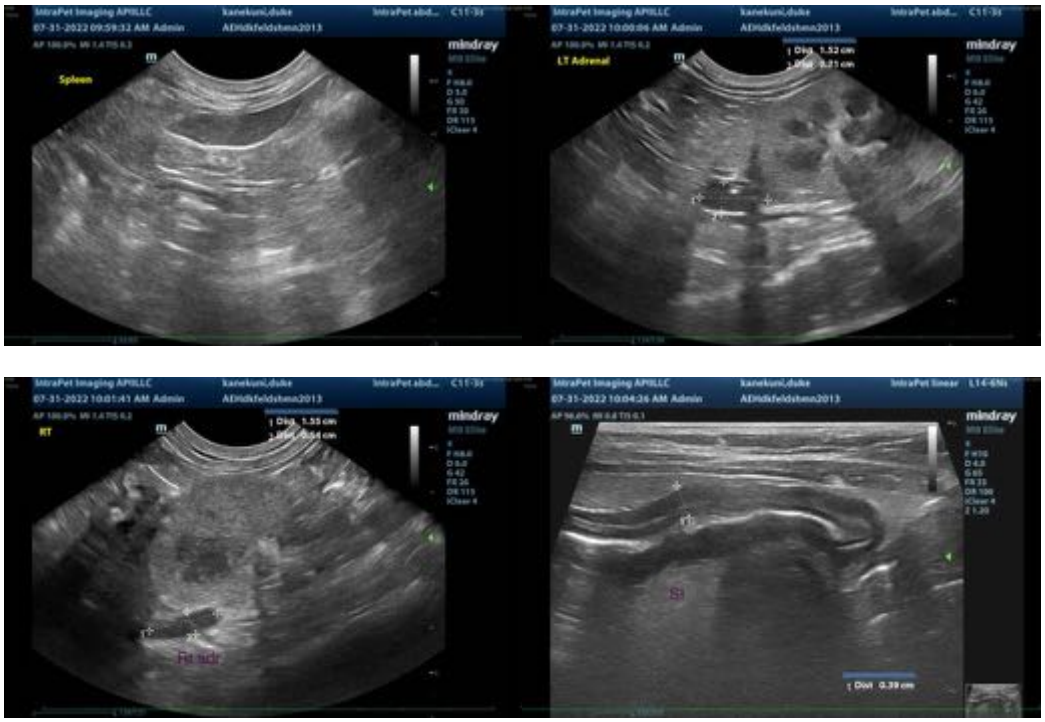
In order to get a definitive diagnosis, surgical biopsies of the abnormal jejunum would be necessary. Thoracic radiographs are recommended prior to anesthesia. If surgery is pursued, a liver biopsy is also recommended, given the history of an elevated ALT.

Also consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI.









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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