



PATIENT

Maeve Thurow

SPECIES

Feline

BREED

Domestic longhair

SEX

Female, spayed

AGE

12 Yrs.

WEIGHT

8.7 lbs.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Jessica Bailes

HOSPITAL NAME

All Creatures Great
and Small VC- Corvallis,
OR

REFERRING VET

Dr. Chantel Litalien

INVOICE

11873

DATE

8/12/21

PRESENTING CLINICAL SIGNS

History: Hx of frequent intermittent vomiting w/ possible hematoemesis (mild). Had a MCT removed by previous DVM (not sure when); clean margins. No diarrhea. Has continued to vomit daily despite being on EN diet.

Abnormal PE/Chem/CBC/UA Results: Progressive weight loss, generalized sarcopenia, unkempt haircoat; 1/6 systolic murmur, possible enlarged thyroid gland on exam BW/UA done 7/26/21: BC: NAF Chem: elevated amylase 1620 (100-1200) and PSL 66 (8-26) Creat - 1.7, BUN - 22 T4: 2.5 (grey zone) UA: USG - 1.017, pH - 8.0, neg protein, pyuria, marked rod bacteriuria Free T4 by ED: 60.4 (10-50) Prescribed 10 day course of clavamox for UTI and cerenia for vomiting - now done w/ all meds for the last 3 days.

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 mildly distended with anechoic urine. 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 (3.66 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. Trace pyelectasia is present (0.17 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.09 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. Trace pyelectasia is present (0.14 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.36 cm cranial; 0.31 cm caudal; 1.31 cm length). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.35 cm cranial; 0.34 cm caudal; 0.91 cm length). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively prominent in size (1.17 cm in width at the level of the hilus) with slightly swollen peripheral contours. 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen with minor changes consistent with age-related remodeling. 2 small anechoic cysts are visualized. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. A bi-lobed confirmation is present. The gall bladder is normal in thickness. Luminal contents are anechoic. The cystic and common bile ducts are normal.



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Gastrointestinal

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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 proximal duodenal wall is thickened (up to 0.39 cm) with apparent retention of the normal layering pattern. In the remaining small intestinal segments, the walls are normal in thickness with a normal layering pattern and appropriate mural detail. There is slight disruption in the normal 1:3 muscularis: mucosal ratio and mild thickening of the submucosal layer in some segments. Discreet masses are not identified. A focal area in the wall of the descending colon is thickened (up to 0.34 cm) with apparent retention of the normal layering pattern. No obstructive disease is noted.

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Pancreas

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The pancreas is diffusely enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. Several hypoechoic to anechoic nodules are observed throughout the parenchyma. The pancreatic duct is visible but not overtly dilated (0.20 cm in diameter). Mesentery effacing the serosal surface is hyperechoic. See also *Other*.

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Free Abdomen

There was no obvious evidence of free fluid. See *Other*.

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Other

A 4.10 x 2.03 cm echogenic irregular mass is observed in the right cranial quadrant.

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Medicine*)

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Mass in the right cranial quadrant, the origin of which is unclear. It may be arising from liver, pancreas, lymph node, mesentery, other. The pancreatic changes could be consistent with pancreatic neoplasia or chronic active pancreatitis with nodular hyperplasia and parenchymal cysts.
- The small intestinal wall and colonic wall changes are most consistent with inflammatory bowel disease with potential for emerging lymphoma.

**IMAGING
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Jessica Bailes

Secondary Findings:

- Age-related hepatic and renal pathology.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- Bi-lobed gallbladder- incidental.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

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- If there is no evidence of pulmonary metastatic disease and aggressive approach is desired, an abdominal exploratory with mass removal or debulking along with pancreatic and gastrointestinal biopsies can be considered. An abdominal CT scan would be useful in pre-surgical planning.

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- If a more conservative approach is desired, fine needle aspirates of the right cranial abdominal mass and pancreas (with care to avoid the cavitated areas) could be considered if it is accessible and if clotting status is appropriate. 25-gauge needles should be used.

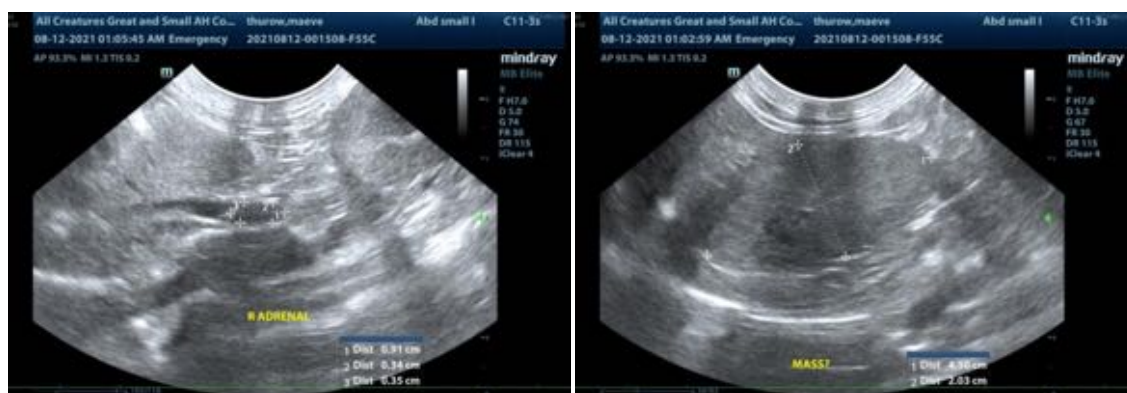
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- Malabsorption panel is also recommended.

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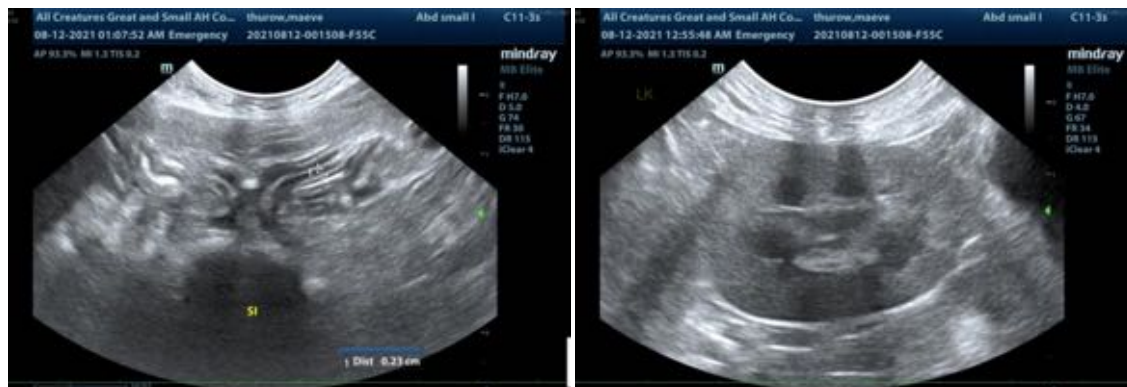


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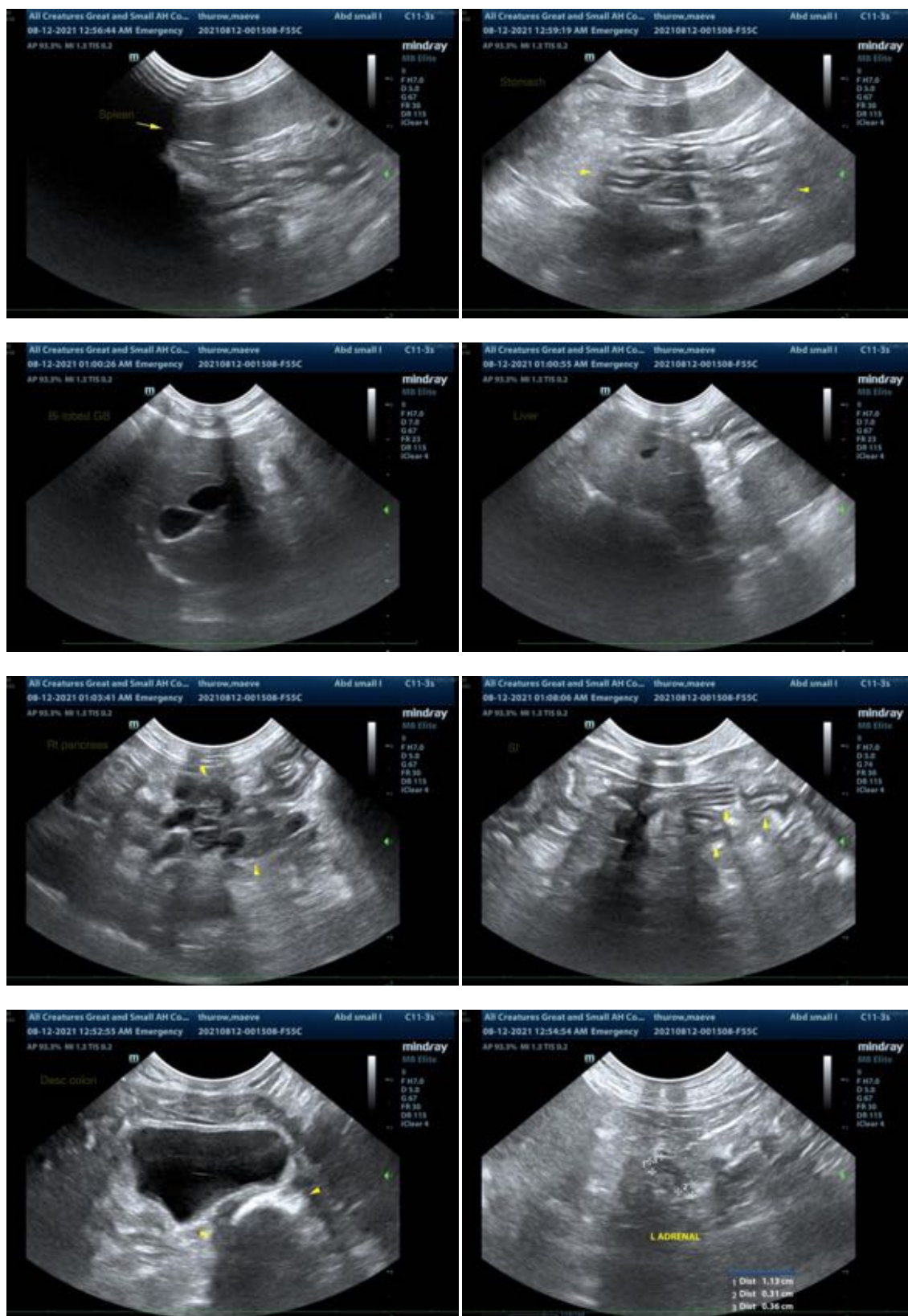
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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Andrea.nicastro@sonopath.com

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