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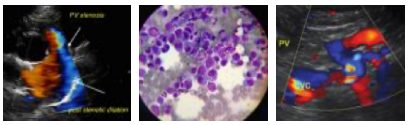

SonoPath
Clinical Sonography & Telecytology
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DATE

8/18/21

PATIENT

Marley Balk Huffines

SPECIES

Feline

BREED

Dometsic shorthair

SEX

Male, neutered

AGE

9/4/2006

WEIGHT

6.4 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Frederick Road Veterinary Hospital

REFERRING VET

Dr. Zakai

INVOICE

11904

PRESENTING CLINICAL SIGNS

History: severe weight loss, increased spec fpL, diarrhea, not eating well.
Current Medications: Mirtazapine 1/4 tab every 3 days

Lab Results: increased spec fpL.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Midazolam administered prior to scan.
Stat Report: STAT report not requested by the veterinarian.

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 mostly 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 (3.36 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is thickened and hyperechoic and there is poor corticomedullary distinction. Mild pyelectasia is present (0.22 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.74 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is diffusely thickened and hyperechoic and there is poor corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter.

Adrenal Glands

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

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

Spleen

The spleen is normal in size (0.58 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.51 cm hyperechoic nodule is observed at the medial aspect. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly mottled in appearance. There is an increase in portal markings. Hepatic vascular is of normal volume with no evidence of congestion. The gall bladder lumen is distended. The wall is normal in thickness. A large amount of aggregated, echogenic, adherent debris is observed within the lumen. The cystic and common bile ducts are severely dilated (0.89 cm at the level of the duodenal papilla). A large amount of echogenic debris is observed within the lumen, some of which is mobile and some of which appears inspissated. The duodenal papilla is thickened (0.62 cm in width).

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 is thickened (up to 0.42 cm) with a normal layering pattern. There is evidence of mucosal fogging in the proximal duodenum.

There is disruption in the normal 1:3 muscularis: mucosal ratio with a >1:1 ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. The lumen of the descending colon contains liquid appearing fecal material. No obstructive disease is noted.

Pancreas

The pancreas is diffusely enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is severely dilated (0.56 cm in diameter) and can be followed to the level of its connection with the common bile duct.

Free Abdomen

Trace free fluid is observed. Several prominent to enlarged mesenteric lymph nodes are visualized. The largest measures 2.83 x 1.42 cm and is irregular and hypoechoic. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The bowel pattern consistent with emerging lymphoma or severe inflammatory bowel disease.
- The enlarged abdominal lymph nodes could be consistent with infiltrative neoplasia (i.e., lymphoma), lymphoid hyperplasia or reactive lymphadenitis.
- The hepatic parenchymal changes could be consistent with inflammatory disease, hepatic lipidosis, infiltrative neoplasia (i.e., lymphoma), FIP or some combination thereof.
- Partial common bile duct obstruction, likely secondary to a mucous plug. However, an intraluminal mass cannot be completely excluded.
- The trace ascites is likely secondary to gastrointestinal, pancreatic and/or hepatic inflammation.

Secondary Findings:

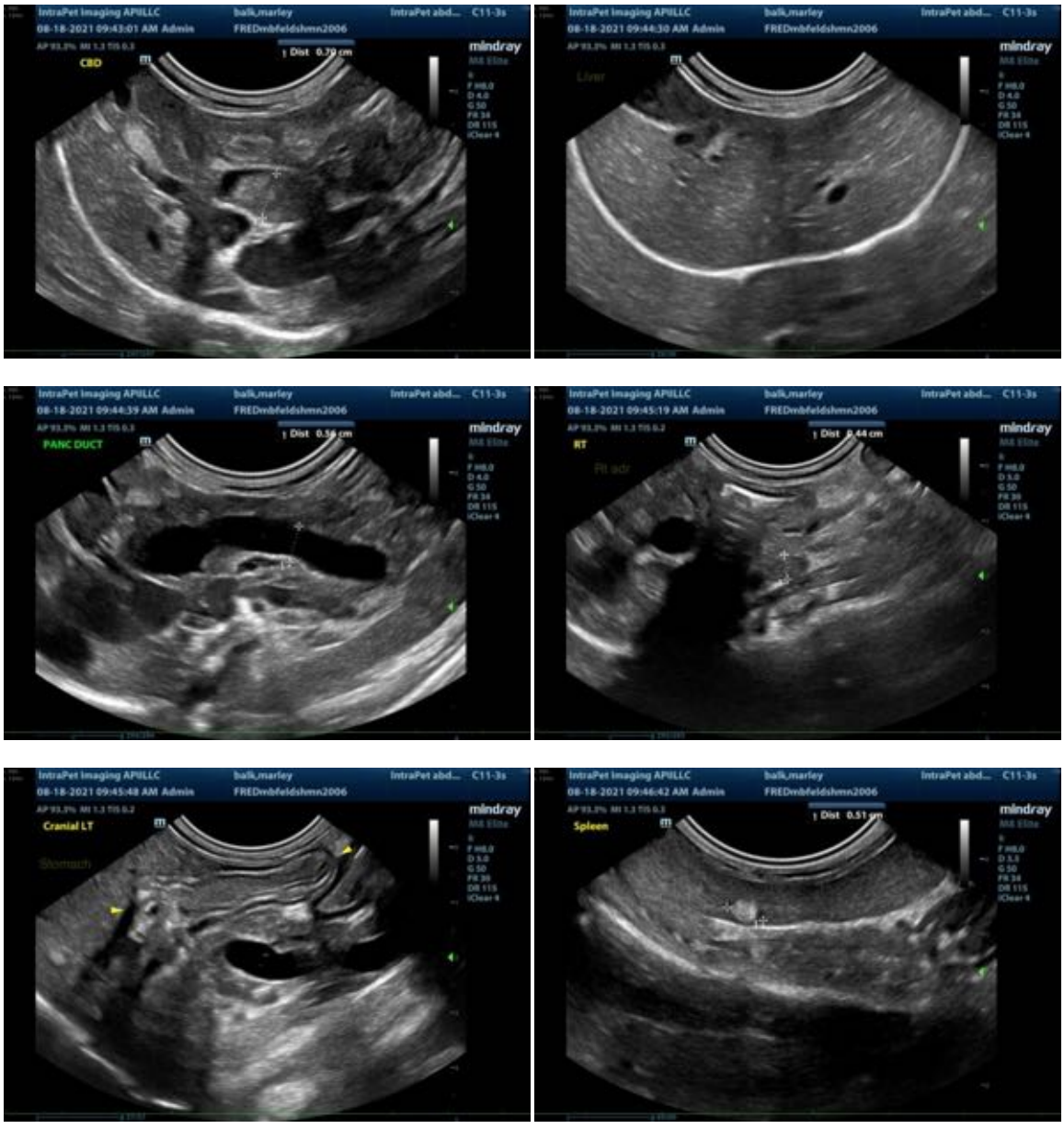
- The bilateral renal changes are most consistent with chronic interstitial nephrosis/nephritis with right dystrophic mineralization.
- The hyperechoic lesions adjacent to the splenic vessels are most consistent with myelolipomas. Although a neoplastic process within the spleen cannot be excluded, it is considered unlikely in this patient.

*Given the sonographic changes, “triaditis” is a consideration in this patient

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fine needle aspirate of the enlarged mesenteric lymph nodes is recommended (if clotting status is appropriate). A 25-gauge needle should be used. If cytologic evaluation is inconclusive and an aggressive approach is desired, consider an abdominal exploratory with gastrointestinal, abdominal lymph node, hepatic +/- pancreatic biopsies can be considered. If surgery is pursued, evaluation of common bile duct patency is recommended.
- Three-view thoracic radiographs should be performed prior to any anesthetic event.

- A malabsorption panel is also recommended.

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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.

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 ACVIM (*Small Animal Internal Medicine*)
Andrea.nicastro@sonopath.com