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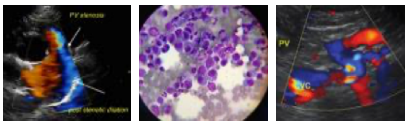

SonoPath
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DATE
8/9/21

PATIENT
Dominic Werner

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
7/21/09

WEIGHT
11.5 lbs

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

HOSPITAL NAME
Cat Hospital at Towson

REFERRING VET
Dr. Fitzgerald

INVOICE
11846

PRESENTING CLINICAL SIGNS

History: History: P presented for hyporexia and decreased defecation that started after second cat in home passed away 1 month prior. When O takes P to beach house symptoms resolved for entire week, when brought back symptoms returned. P has lost 3# in 5 months but otherwise normal on examination - no palpable stool or abdominal pain, normal TPR – strong pulse and no murmur.
Current Medications: Mirtazapine 1.5inch TD SID, Gabapentin 10mg PO BID.
Lab Results: elevated proBNP and suspect stress leukogram that has been historic vs inflammation. USG 1.031, T4 normal, F-leuk/FIV/heartworm negative.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not needed.
Stat Report: Not requested.

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. A small amount of 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 in size (4.20 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. The cortex is mildly thickened. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (3.95 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. The cortex is mildly thickened. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is upper limits of normal in size (0.51 cm width) with a normal shape and smooth peripheral contours. The parenchyma is heterogeneous with hyperechoic foci. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is prominent in size (0.63 cm width) with a normal shape and smooth peripheral contours. The parenchyma is heterogeneous with hyperechoic foci. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is contracted (0.57 cm 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.

Liver

The liver is subjectively prominent in size with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and homogeneous in appearance. No focal lesions are observed. Intrahepatic biliary stones are visualized. Hepatic vascular appears normal. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of mostly gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately distended with fluid and hypomotile. 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. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some 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 small amount of free fluid is observed. Several prominent mesenteric lymph nodes are visualized. Surrounding mesentery is hyperechoic.

Other

Pleural effusion is noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Pleural effusion and ascites. Considerations include congestive heart failure, bi-cavitary neoplasia, other.
- Gastric stasis.
- The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The hepatic changes could be consistent with passive congestion (i.e., secondary to congestive heart failure), inflammatory disease, infiltrative neoplasia (less likely), other hepatopathy. Intrahepatic biliary stones- incidental.

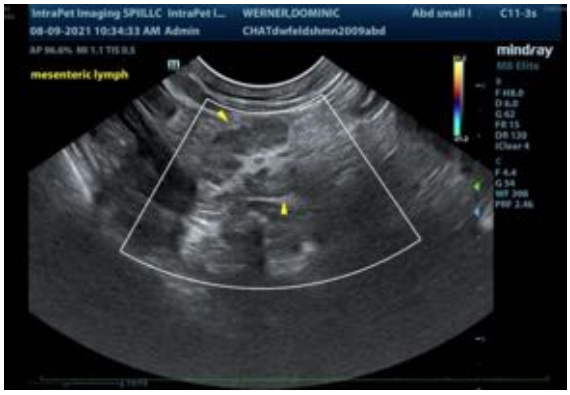
Secondary Findings:

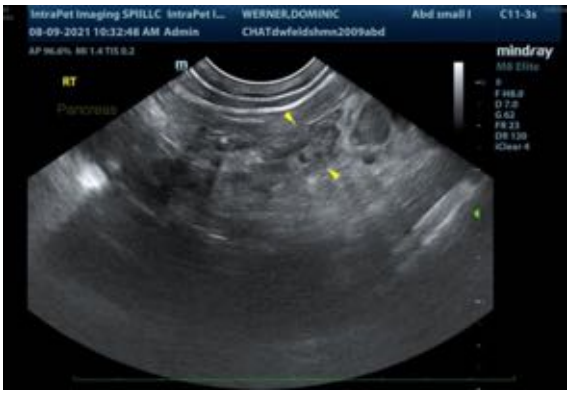
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The splenic contraction is likely secondary to dehydration.
- The bilateral adrenomegaly may be a normal variant for this patient or may be secondary to stress or hyperplastic change. The hyperechoic foci are likely a benign age-related incidental finding.
- Bilateral age-related renal pathology with dystrophic mineralization.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended if not already performed.

- Further recommendations should be based on the echocardiogram report. Depending on those results, further GI workup (i.e., malabsorption panel, fecal evaluation for ova/Giardia, endoscopic or surgical gastrointestinal biopsies) can be considered.





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*)
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