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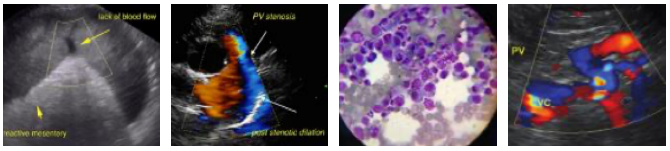

PATIENT
Gracie Steuber

SPECIES
Feline

BREED
Domestic shorthair

SEX
Female, spayed

AGE
11 Yrs.

WEIGHT
4.35 kg.

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

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Dr. Keller

INVOICE
13970

DATE
9/14/22

PRESENTING CLINICAL SIGNS

History: Has been anorexic and decreased water consumption for past 2-3 days; vomited once this morning (liquid) Went to primary care yesterday, had blood work and AXR performed; was prescribed prednisone (she's received 3 doses so far) Still not super interested in food or water, however she did eat 1 tsp of food this morning Primary care transferred here for possible AUS with concerns for lymphoma Owner unsure if voiding has been normal Current medications: Prednisone 5mg PO BID- Last dose this morning at 8am (only given for a few days).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately 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 (4.34 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Moderate pyelectasia is present (0.50 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (4.54 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Mild pyelectasia is present (0.26 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is upper limits of normal in size (0.53 cm width) with a normal shape and smooth peripheral contours. There is normal glandular echogenicity and detail. A pinpoint hyperechoic focus is observed. Surrounding vasculature appears normal.

The right adrenal gland is upper limits of normal in size (0.51 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is enlarged (1.29 cm in width at the level of the hilus) with mild scalloping of the medial contour. The parenchyma is subtly mottled in appearance. No distinct focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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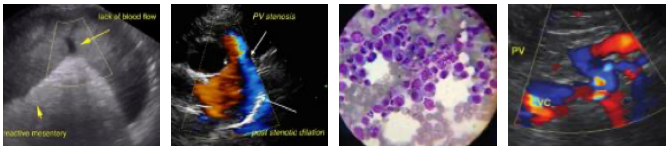

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The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. A 0.87 x 0.73 cm cystic nodule is arising from the serosal surface of the pylorus. The small intestinal lumen is not dilated. The small intestinal wall is normal thickness 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 cecum is mildly thickened (up to 0.28 cm). The wall of the descending colon is normal to borderline thickened (up to 0.29 cm). Small hypoechoic nodules are observed in the submucosal layer of the descending colon. No obstructive disease is noted.

Pancreas

The pancreas is diffusely enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat with numerous small hypoechoic nodules throughout the parenchyma. Cystic areas are also observed throughout the organ. The pancreatic duct is visible but not overtly dilated. Surrounding mesentery is hyperechoic.

Free Abdomen

Trace free fluid is observed. Several prominent lymph nodes are observed throughout the abdomen including gastric, mesenteric, colic and sublumbar nodes. The largest mesenteric node measures 3.52 cm in length. The mesentery surrounding the nodes is hyperechoic.

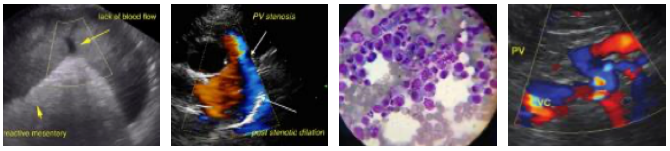
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes are consistent with chronic active pancreatitis with suspected benign nodular hyperplasia and parenchymal cysts. Neoplasia is possible but considered less likely. Adjacent peritonitis is present.
- The small intestinal wall changes are most consistent with inflammatory bowel disease with some potential for emerging lymphoma.
- The colonic wall thickening is most consistent with an inflammatory process. The hypoechoic nodules within the submucosal layer could be consistent with lymphatic tissue, granulomas, or less likely, emerging neoplasia.
- The cecal wall changes are most consistent with typhlitis.
- The significance of the cystic nodule arising from the pyloric wall is unclear. It may represent an emerging tumor, an inflammatory focus, granuloma, other.
- The abdominal lymphadenopathy could be consistent with reactive lymphadenitis, lymphoid hyperplasia or less likely, infiltrative neoplasia.
- The mild splenomegaly could be consistent with infiltrative neoplasia (i.e., lymphoma) or a benign process (i.e., lymphoid hyperplasia, extramedullary hematopoiesis or similar).

Secondary Findings:

- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.



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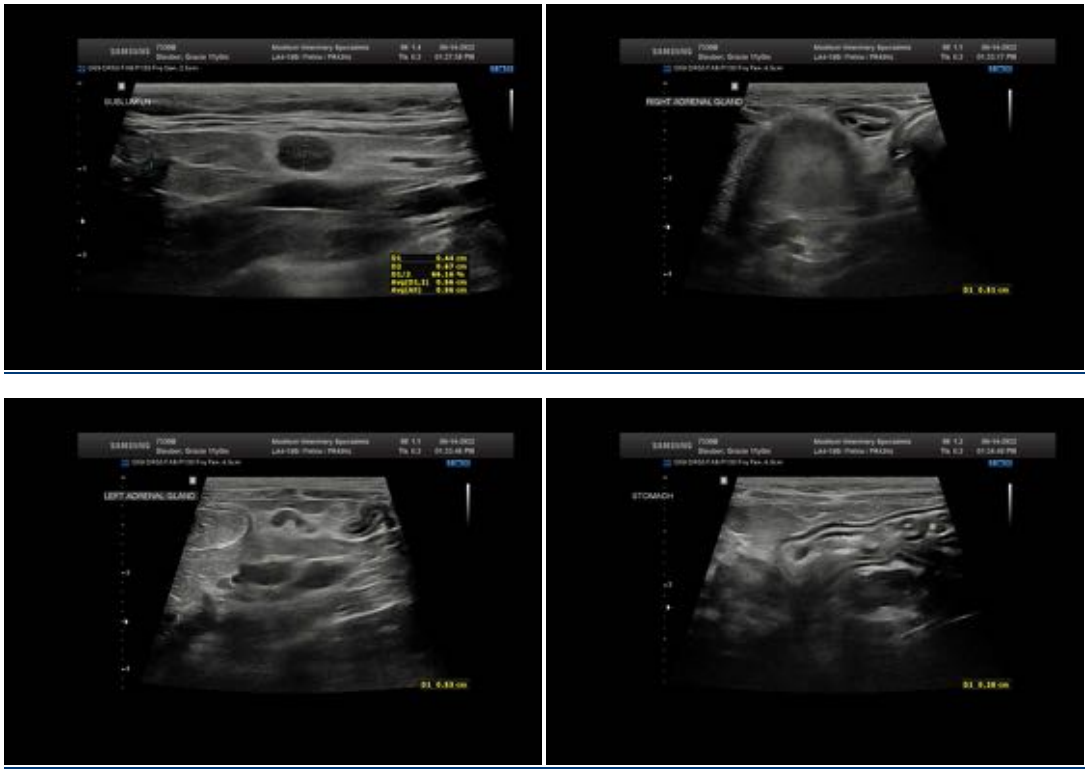
- The bilateral adrenomegaly could be consistent with hyperplasia, stress, or may be a normal variant for this patient.
- Bilateral renal changes are most consistent with chronic interstitial nephrosis/nephritis. The pyelectasia may be secondary to pyelonephritis, age-related remodeling, fluid therapy or some combination thereof.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider fine needle aspirates of the spleen and liver (if clotting status is appropriate). 25 gauge needles should be used.
- Three-view thoracic radiographs are also recommended to assess cardiopulmonary status.
- While awaiting test results, supportive care for pancreatitis/gastroenteritis/typhlitis is recommended. If cytology results are inconclusive, an abdominal exploratory with hepatic, lymph node, GI, pancreatic +/- splenic biopsies may be warranted. Biopsy of the pyloric mass should also be considered at the time of surgery.
- A GI panel is also recommended including serum cobalamin, folate, TLI and PLI.



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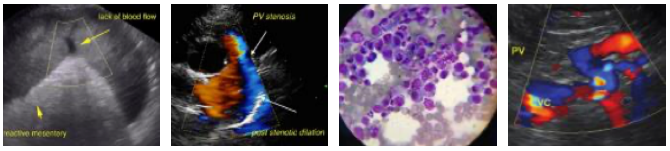

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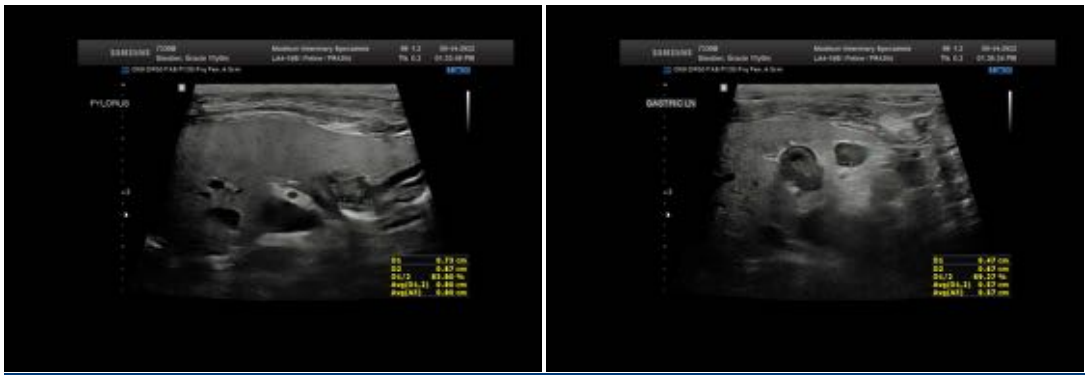

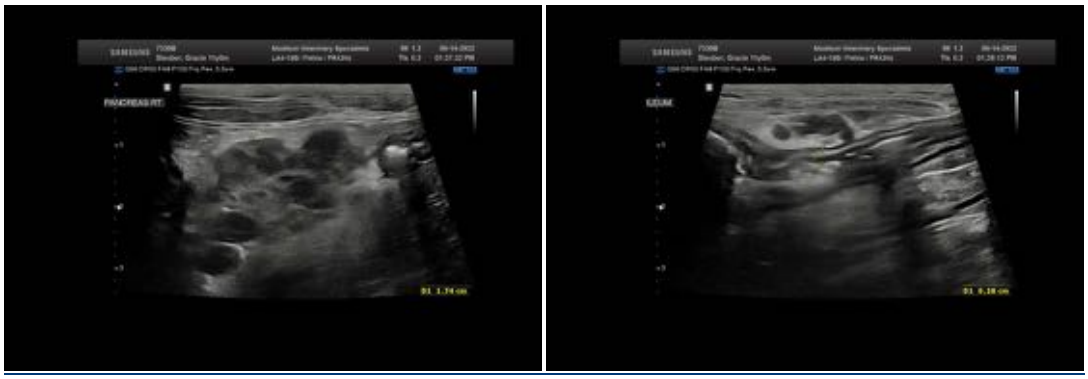

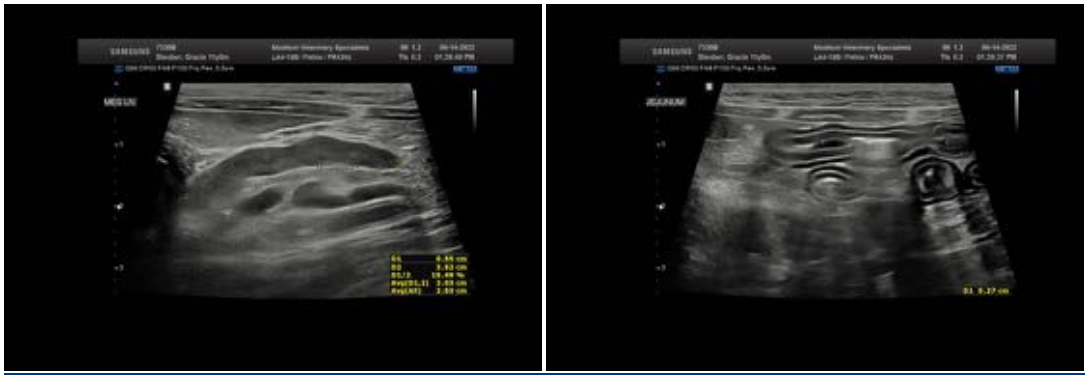

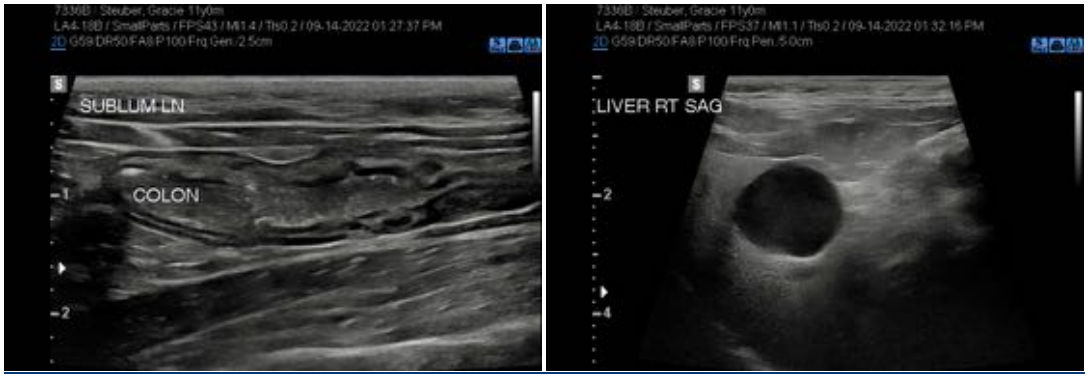

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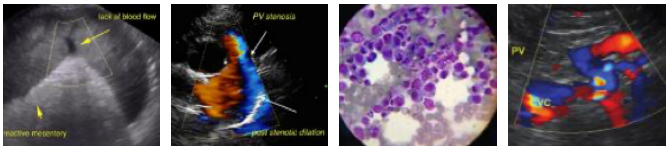

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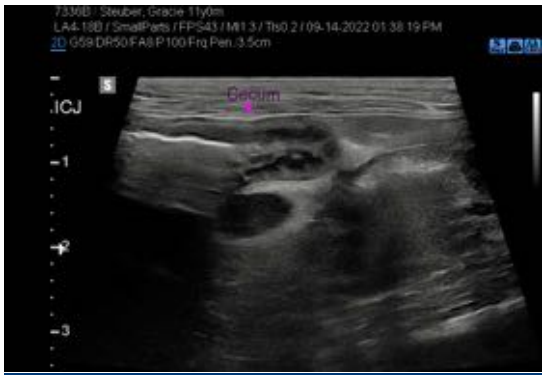

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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