



PATIENT PRESENTING CLINICAL SIGNS

Zoey Dunkman

SPECIES

Feline

BREED

Domestic longhair

SEX

Female, spayed

AGE

18 Yrs.

WEIGHT

7.56 lbs.

History: P has dental disease and is in need of general anesthesia. P has hx of peritoneal-pericardial hernia. Grade 2/6 SHM Radiographic Findings Assessment: Likely similar peritoneopericardial diaphragmatic hernia. Consider ultrasound for further evaluation Suspect intermittent focal accumulation of oesophageal material/gas. A pulmonary nodule is considered less likely Small accumulations of gastrointestinal material that could represent normal ingesta, foreign material, or both. No definitive evidence of a gastrointestinal mechanical obstruction is present at this time. Mild variation in small intestinal diameter is considered likely secondary to passage of normal ingesta or a functional ileus that is slightly variable in severity throughout the gastrointestinal tract, with an early or partial mechanical obstruction considered possible but less likely at this time. The possibility of a concurrent non-specific gastroenteritis is also not excluded. Abdominal ultrasound may assist in further evaluating these findings. Depending on the clinical status of the patient, repeat 3 view abdominal radiographs or abdominal ultrasound could be considered after 8-12 hours of strict fasting and IV fluid therapy to monitor for passage of material/interval changes as clinically indicated. Abdominal ultrasound should be considered sooner if the patient deteriorates clinically. Poor abdominal serosal detail; this finding is likely incidental due to the low body condition score and subsequent minimal intra-abdominal fat. The possibility of peritoneal fluid or peritonitis cannot be definitively excluded but is considered less likely. Consider abdominal ultrasound for further evaluation as clinically indicated Similar osteoarthritis, right elbow Primary Question/Differential to Be Answered in This Exam pre-anesthesia evaluation
Abnormal PE/Chem/CBC/UA Results: BUN 61, SDMA 20, Creat 2.2, T4 2.9 (grey zone), proBNP 1175, USG 1.104

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is small in size (2.63 cm in length) with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Mild pyelectasia is present (0.23 cm in the longitudinal plane). A few pinpoint hyperechoic to mineralized foci are visualized. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is normal in size (xxx cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Mild to moderate pyelectasia is present (0.21 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.35 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh

HOSPITAL NAME

West Hills AH

REFERRING VET

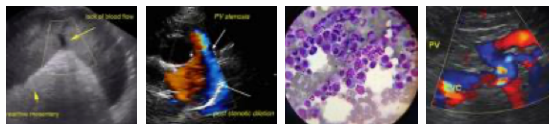
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The spleen is normal in size (0.71 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

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Liver

Hepatic size is difficult to evaluate due to the peritoneal pericardial diaphragmatic hernia. A portion of the liver is herniated into the thorax. In this segment, an approximately 3 cm septated cystic mass is present. In the abdominal portion of the liver, a 2.29 cm hyperechoic to heterogeneous multi-septated cystic nodule/mass is observed on the right side. The lesion causes capsular expansion. In the remainder of the liver, the parenchyma is hypoechoic relative to the spleen and homogeneous in appearance.

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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. Luminal contents are anechoic. The cystic and common bile ducts are visible/tortuous but not overtly dilated.

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Gastrointestinal

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 duodenal and jejunal walls are diffusely thickened (up to 0.37 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments with a 1:1 ratio in several areas. In 1-2 regions, there is a questionable trend toward the loss of the normal layering pattern. The ileum is thickened (up to 0.48 cm) with a thickened muscularis layer and a questionable trend toward loss of layering. The ileocecolic junction and colonic wall are normal. No obstructive disease is noted.

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Pancreas

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely hypoechoic 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.

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Free Abdomen

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

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ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Peritoneal-pericardial diaphragmatic hernia with herniation of a portion of liver (containing a cystic mass) is present. A second intra-abdominal cystic hepatic mass is also seen. These lesions may represent biliary cystadenomas, biliary cystadenocarcinomas, other.
- Bowel pattern consistent with severe inflammatory bowel disease or emerging lymphoma.
- Trace ascites.

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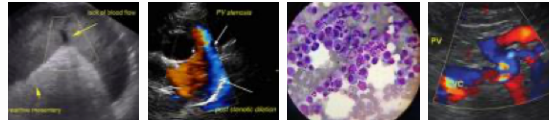
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Secondary Findings:



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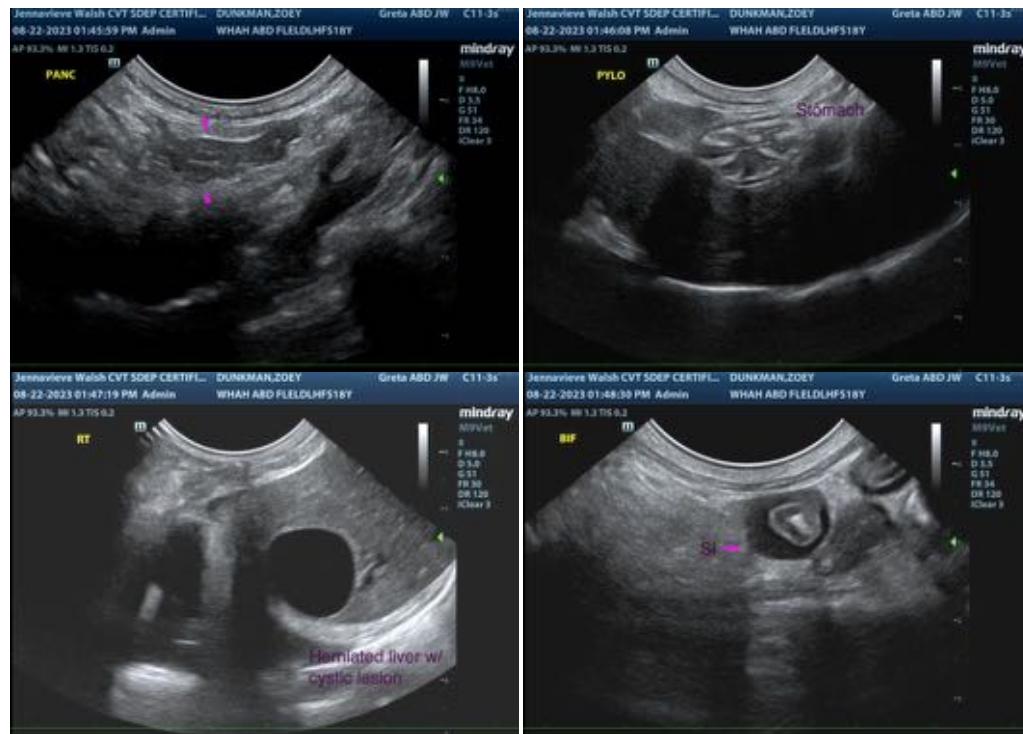
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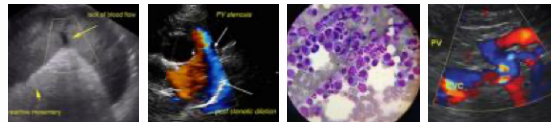
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- Bilateral chronic renal changes with non-obstructive nephrolithiasis. The pyelectasia may be secondary to pyelonephritis, age-related remodeling, PU/PD (if applicable) or some combination thereof.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the azotemia, consider a urinalysis with culture and sensitivity, UPC (if proteinuria is present in the absence of infection) and baseline blood pressure measurement.
- Regarding the bowel changes, consider the following:
 1. A fecal evaluation for internal parasites.
 2. Texas GI panel including serum cobalamin, folate, TLI and PLI.
 3. Endoscopic or surgical biopsies. Surgical biopsies are more likely to yield a definitive diagnosis.





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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.

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