PATIENT

Roadie Robertson

SPECIES

Feline

BREED

Domestic shorthair

SEX

Female, spayed

AGE

6/1/2012

WEIGHT

3.7 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Kind CAH

REFERRING VET

Dr. Marino

INVOICE

13492

DATE

2/18/26

PRESENTING CLINICAL SIGNS

Pt presented with decreased appetite, weight loss, dehydrated.

CBC/CHEM17/LYTES/T4: NEU 11.6 K/uL
PLT 54 K/uL (Difficult blood draw)
CREA 1.7 mg/dL
BUN 49 mg/dL
Na 147 mmol/L
Cl 107 mmol/L
GLOB 5.9 g/dL
AMYL 1,635 U/L
TT4 4.5 ug/dL
U/A (cysto): pH 6.0, USG 1.013, inactive sediment

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 is normal.

The left kidney is enlarged (4.36 cm in length) with swollen peripheral contours. The cortex is mildly thickened with moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter. Renal vasculature is normal. A moderate amount of subcapsular fluid is present. A small amount of echogenic debris is suspended within the subcapsular fluid.

The right kidney is normal size (3.69 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is mild to moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.56 cm width) with swollen peripheral contours. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.82 cm in width at the level of the hilus) with a normal capsular contour. Using the high frequency probe, the parenchyma is subtly mottled in appearnace. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is normal to prominent in size with a slightly irregular cranial margin. The parenchyma is isoechoic relative to the spleen. A 1.2 x 1.0 cm hypoechoic, slightly expansile nodule is observed on the right side adjacent to the diaphragm. In addition, 1-2 small cystic lesions are observed, the largest measuring 0.53 cm in its longest dimension. A few intrahepatic biliary stones are present. Vascular is of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

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The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal. The duodenal papilla is normal in size (0.20 cm in width).

Gastrointestinal

The gastric lumen is mildly distended with ingesta. 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 normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The left limb is visible with normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and homogeneous in appearance. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

Other

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Bilateral nonspecific chronic renal changes with dystrophic mineralization. The left renomegaly, in conjunction with the subcapsular fluid, could be consistent with an inflammatory process, emerging neoplasia (i.e., lymphoma), other. An emerging perinephric pseudocyst can also not be excluded.
- The hypoechoic hepatic nodule could be consistent with an emerging tumor or a benign focus (i.e., inflammatory lesion, other). The small hepatic cysts are likely benign incidental findings. Intrahepatic biliary stones are also present, likely incidental.

Secondary Findings:

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- The right adrenomegaly may be secondary to stress hyperplasia or less likely an emerging tumor.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

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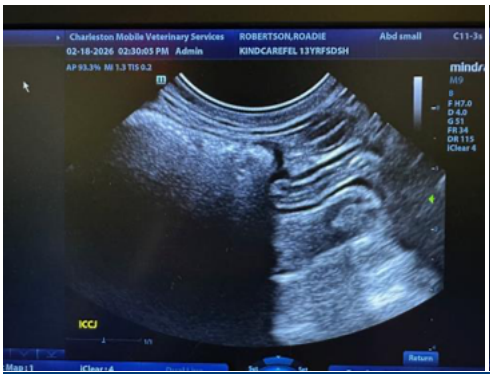
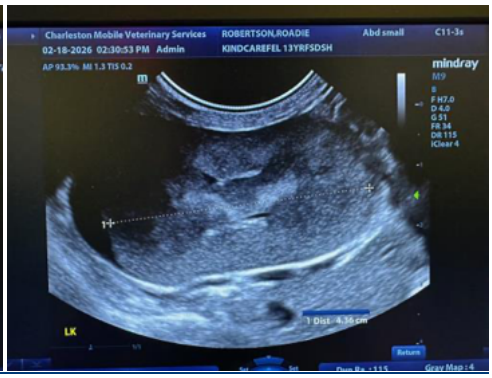
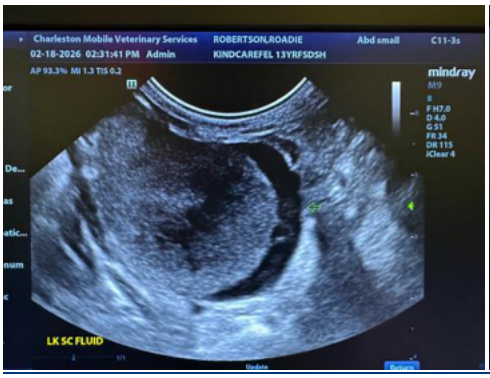
*Ultrasound guided fine needle aspiration of the left kidney was performed at the end of this study without incident (with the patient under general anesthesia).

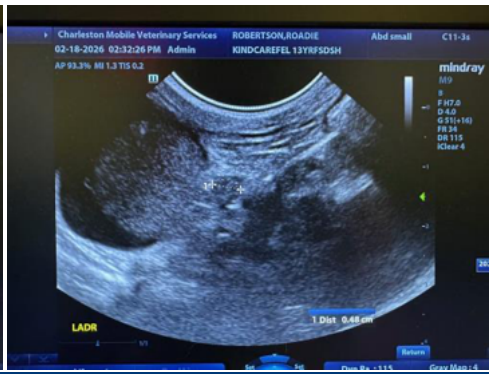
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Submission of the left renal aspirates for cytologic evaluation is recommended along with a urine culture and sensitivity.
2. Also consider three-view thoracic radiographs to assess for occult pathology in the chest.
3. Depending on the results of the above diagnostics, further workup (i.e., fecal evaluation, orthopedic and neurologic examinations, GI panel, +/- GI biopsies) may be indicated to further evaluate for causes of weight loss.









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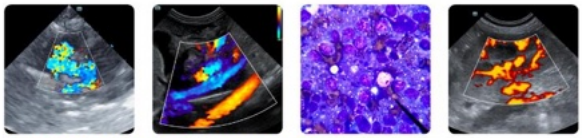

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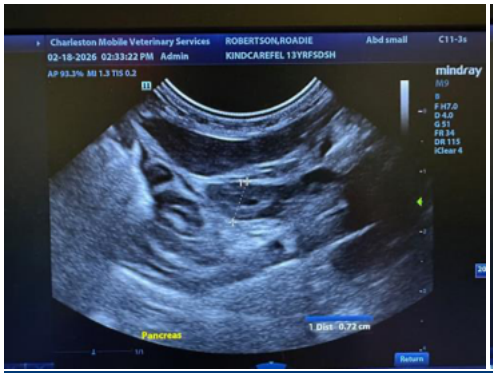

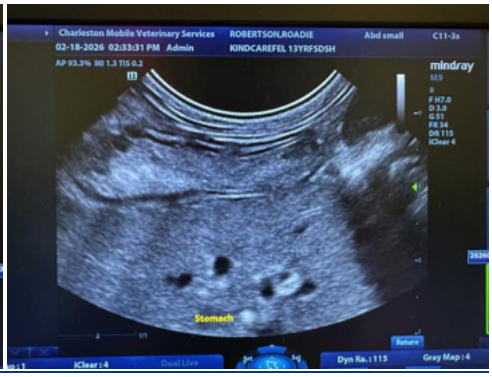

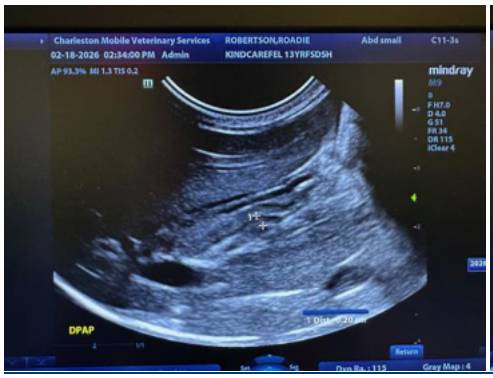

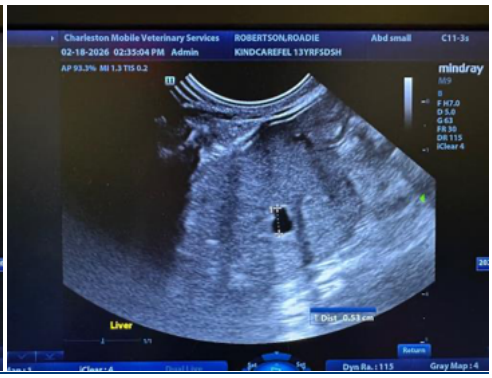

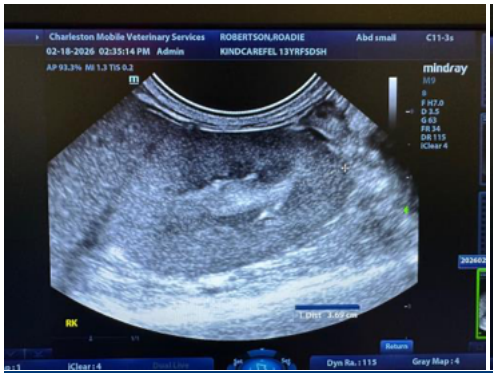

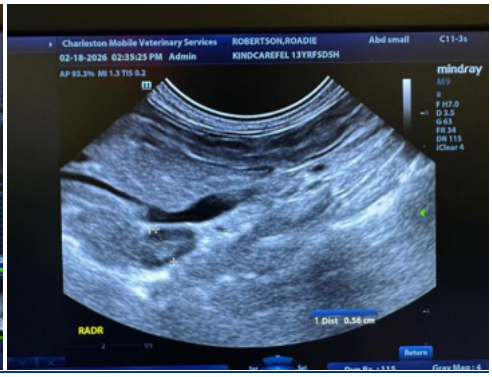

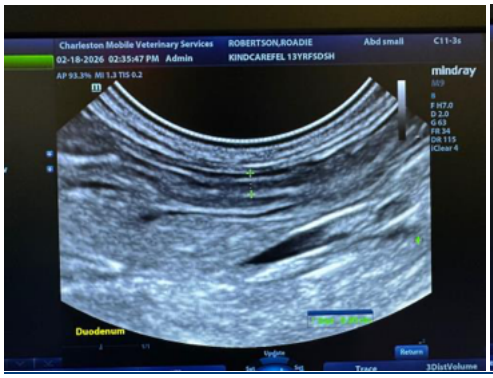

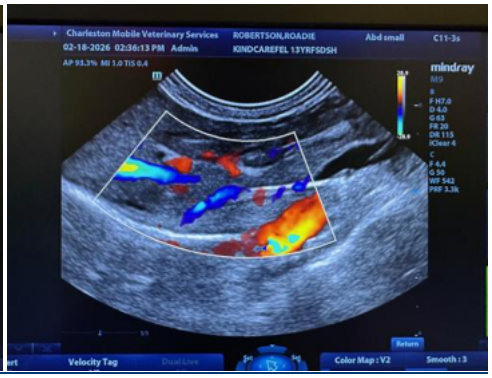

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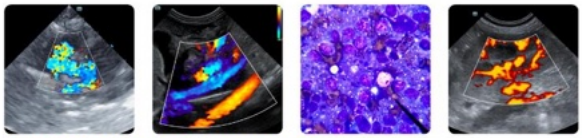

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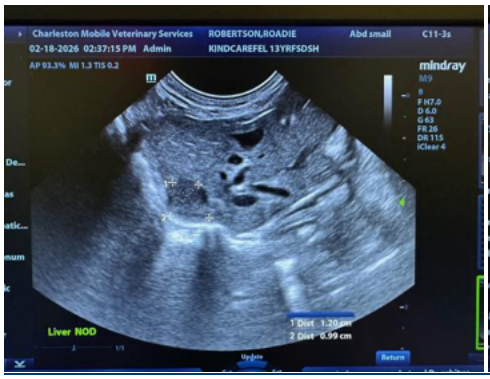

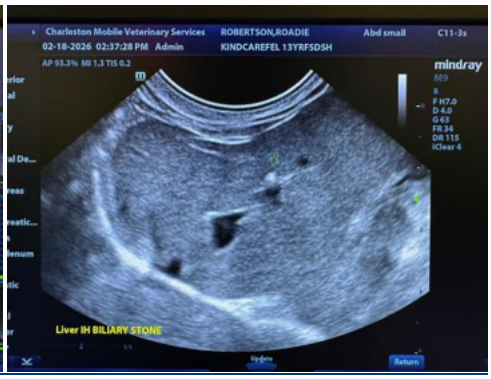

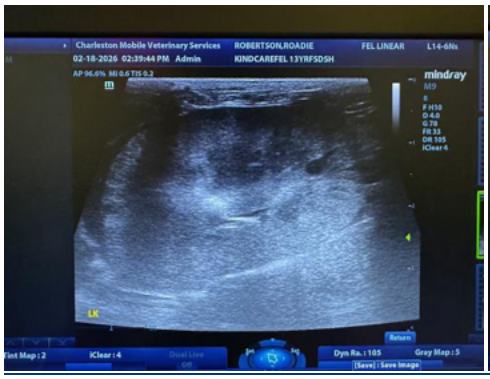

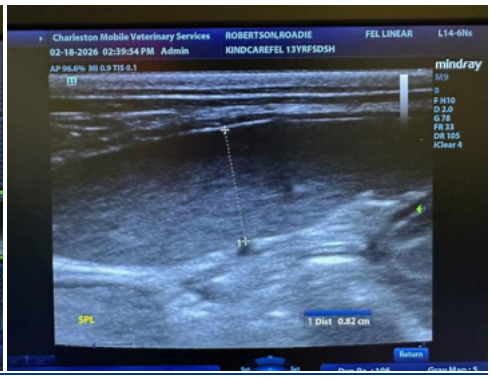

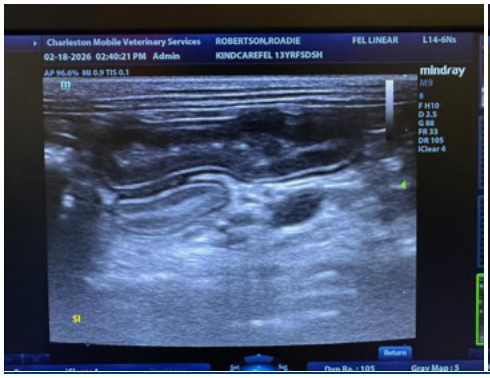

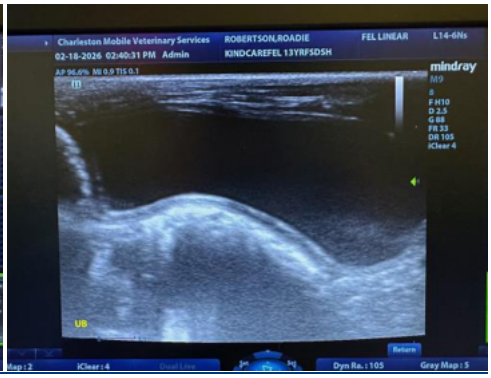

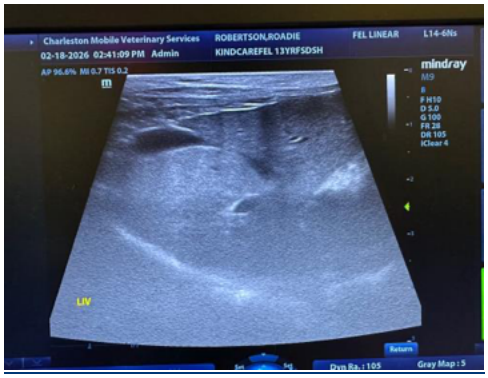

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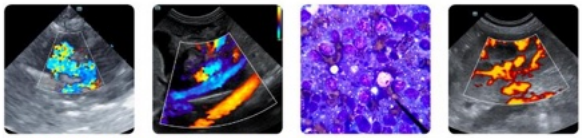

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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