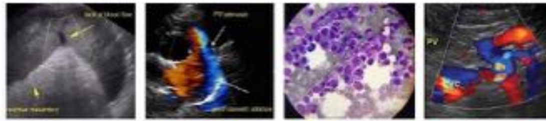


PATIENT

Evan Hough

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

1 Yr.

WEIGHT

2.8 kg..

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Stoney Ridge AH

REFERRING VET

Dr. Brooks

DATE
4/26/22

PRESENTING CLINICAL SIGNS

History: Underweight. Presented for 3rd opinion after being seen for inappetence, weight loss, vomiting, difficulty defecating by 2 other hospitals. Initially seen April 4th, radiographs showed mass effect and decreased serosal detail as per radiology report. Given only sulcrate, metronidazole, subq fluids Seen at 2nd clinic as no improvement at home April 15th and hospitalized. Improved slightly after 3 days of IV fluids, still hyporexic, and abdominal mass palpable. Bloodwork indicated elevated alt, globulins, and heart murmur noted that was not appreciated/not recorded at first clinic. Radiographs repeated still show mass effect and abnormal density in intestines, pattern does not seem to be moving. No fever ever documented. rx'd prednisolone On April 17 - distal colon feels empty (wanted to rule out constipation as difficulty defecating) abdominal mass palpable mid abdomen. No discomfort noted, No nausea noted, T 38.7, no fever. Hydration is adequate. ate few kibbles in clinic. dry form FIP is a ddx, vs FB and partial obstruction. want to rule out peritoneal effusion, intraluminal FB Meds;Prednisolone, FIP treatment (?)
Abnormal PE/Chem/CBC/UA Results: Bloodwork from April 15/22 Globulin 62 (28-51) ALT 155 (12-130) no anemia, sl decreased retics, no lymphopenia, felv/fiv neg/neg Radiology report from April 4 indicated decreased serosal detail and mass-effect suspected to be overlapping fluid filled intestine but a mass not ruled out. Ultrasound recommended. Radiographs from April 15 not read by radiologist - I appreciated decreased serosal detail on the lateral projection- mid to caudal abdomen, with possible mass effect shifting intestines cranially. Abnormal mottled density on lateral, ventral to kidneys - possibly fecal material in transverse colon but concerned this pattern seems to present and not moving from April 4th, just more pronounced on April 15th images.

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 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 (3.97 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.87 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

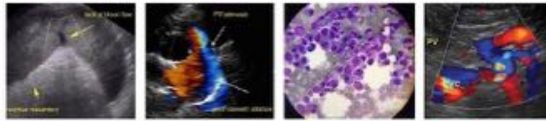
The region of the adrenal glands is evaluated. No obvious pathology is observed.

Spleen

The spleen is normal in size (0.85 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.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic



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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 gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. A >4 cm segment of small intestine is severely thickened (up to 0.78 cm) and irregular with a suspected loss of the normal layering pattern. The mesentery effacing the serosal surface in this region is hyperechoic. The remaining small intestinal segments are normal in thickness with a normal layering pattern and appropriate mural detail. The colonic wall is normal. The colonic lumen contains shadowing fecal material. No obstructive disease is noted.

Pancreas

The left limb is prominent in size with slightly irregular peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

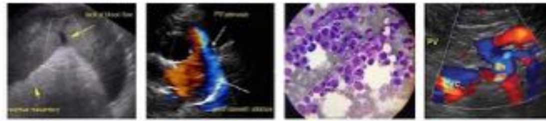
Trace free fluid is observed. A few prominent jejunal lymph nodes are visualized, the largest measuring 0.82 cm in length. A 0.87 cm sublumbar lymph node is also seen.

ULTRASONOGRAPHIC FINDINGS

- The thickened small intestinal segment is concerning for infiltrative neoplasia (i.e., round cell tumor). However, a severe inflammatory process (i.e., pyogranulomatous) cannot be completely excluded. Regional peritonitis is present.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- The pancreatic changes are suggestive of mild chronic pancreatitis but may be a normal variant for this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If accessible, a fine needle aspirate of the thickened segment of small intestine is recommended (if clotting status is appropriate). If the region is not accessible or if cytology results are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis.



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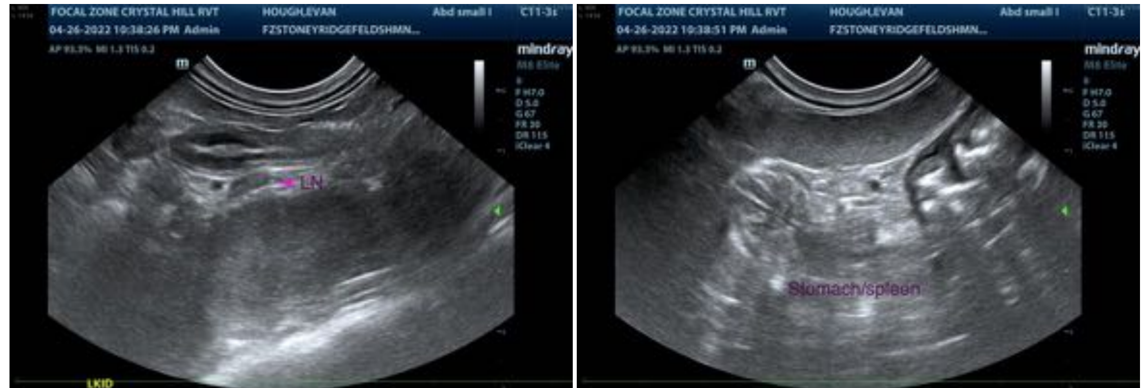

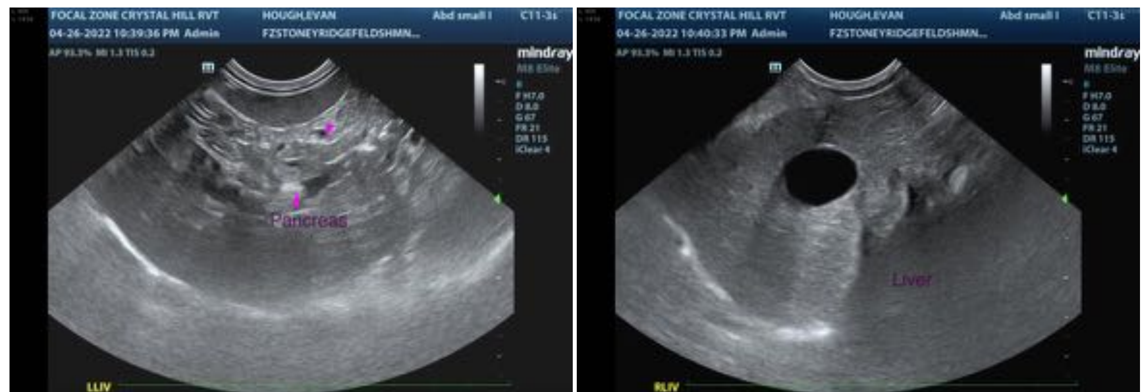

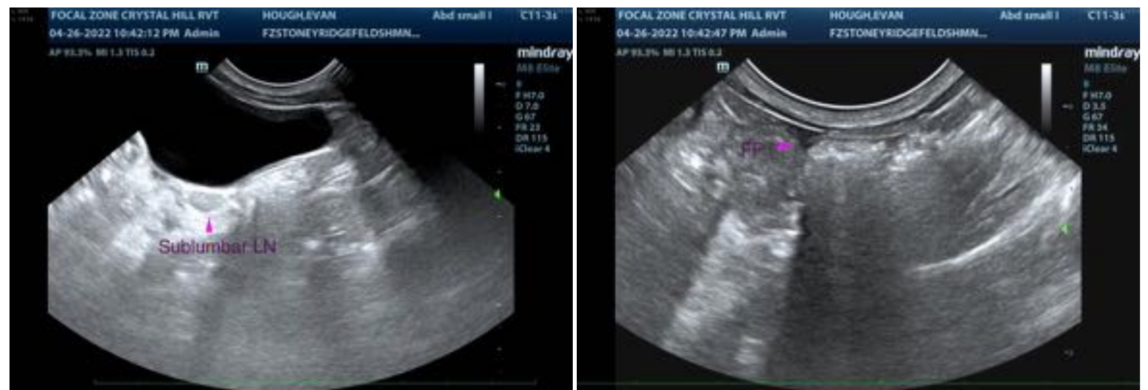

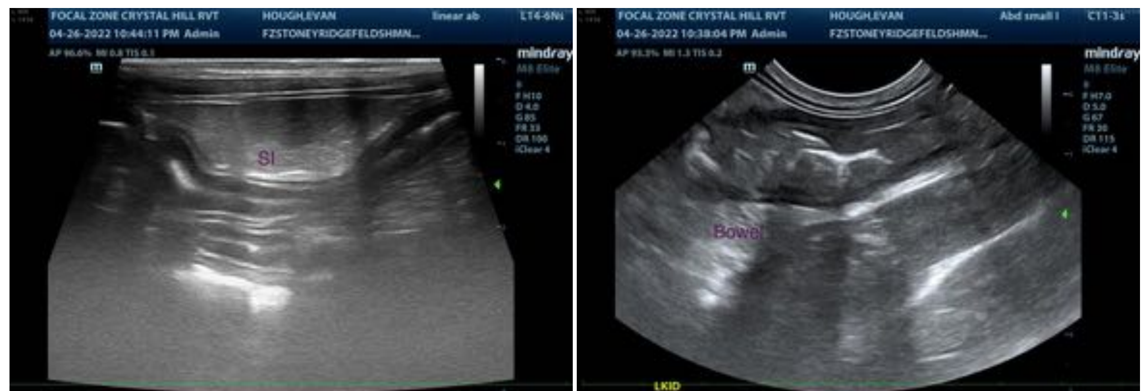

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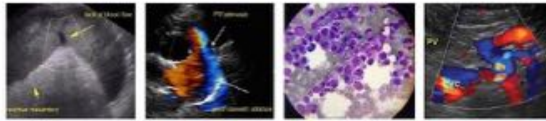

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

Andrea.nicastro@sonopath.com