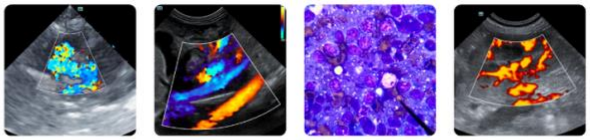

PATIENT

Ada Nesvit

SPECIES

Feline

BREED

DMH

SEX

Spayed Female

AGE

12 Years

WEIGHT

3.5 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti VMD

HOSPITAL NAME

East Bradford Veterinary Hospital

REFERRING VET

Dr. Meghan McGrath DVM

INVOICE

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DATE

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PRESENTING CLINICAL SIGNS

Double cavity scan. AUS to further evaluate significant weight loss (~3 pounds in 2 mos), mild ALP elevation, decreased appetite, some lethargy. Hx of chronic enteropathy. On PE, cardiac arrythmia noted. ECHO to further evaluate cardiac arrythmia concerning for a. fib vs other noted on auscultation. Diet: EN PMH and Meds: Hyperthyroid, managed on Methimazole; Enteritis, maintained on EN (since 2022) AUS and Echo Sedation: Butorphanol + Alfaxalone IV. Tolerated well.

Abnormal PE/Chem/CBC/UA Results: Time of Echo: Grade 1/6 left parasternal HM, Gallop rhythm. - Doppler BP: 100, 100, 98 mmHg - Chem: Alb 3.7-n, ALT 61-n, ALP 113 H (prev normal at 45 in Oct), remainder NSF - CBC: Hct 31%, mild low Hgb, Plts 49 L (clumping), Neut 2132 L, remainder NSF - T4: 0.5 L (controlled in Oct) - r/o euthyroid sick syndrome

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (3.73 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (3.09 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.28 cm at cranial pole and 0.35 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

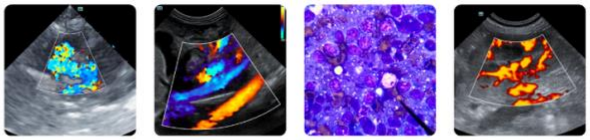
Right adrenal gland is normal in size (0.38 cm at cranial pole and 0.36 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted. Just medial to the spleen in what I believe is the left limb of the pancreas is a subtle 0.47 cm x 0.72 cm in size slightly more discrete hyperechoic density that could represent a pancreatic nodule versus complicated cyst versus other. See 'Free Abdomen'.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

In the right cranial abdomen, in most images especially near the end of this study, appears to be just medial to the proximal duodenum is an approximately 1.0 cm x 1.6 cm in size mildly heterogenous density/nodule/mass.

ULTRASONOGRAPHIC FINDINGS

- The right cranial abdomen density/nodule/mass as described above does not appear to originate from the bowel and appears to be associated with the right limb of the pancreas. Having said that, bowel involvement, or even duodenal papilla involvement cannot be definitively ruled out.
- Chronic low-grade smoldering pancreatitis is suspected with possible nodule/complicated cyst versus other involving the left limb.
- Moderate inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.

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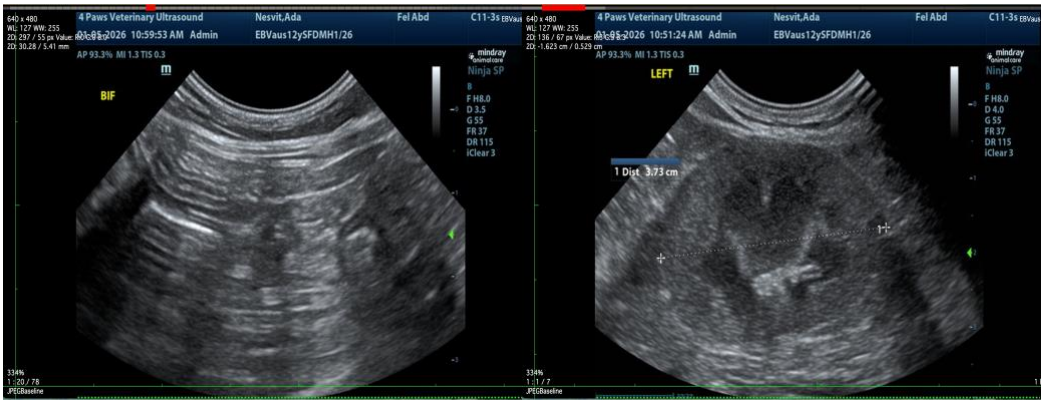
- Mildly mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- A mild amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Tissue sampling is recommended.
- Fine needle aspirates of the liver as well as the pancreas, especially the right cranial abdomen density, could be considered if patient's coagulation status is appropriate. Ultimately, however, biopsies of the GI tract being sure to include ileum if possible, may be necessary for a definitive diagnosis and to therefore help guide medical management depending on the results of above.
- In the meantime, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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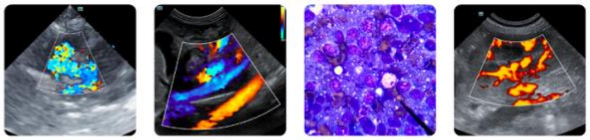

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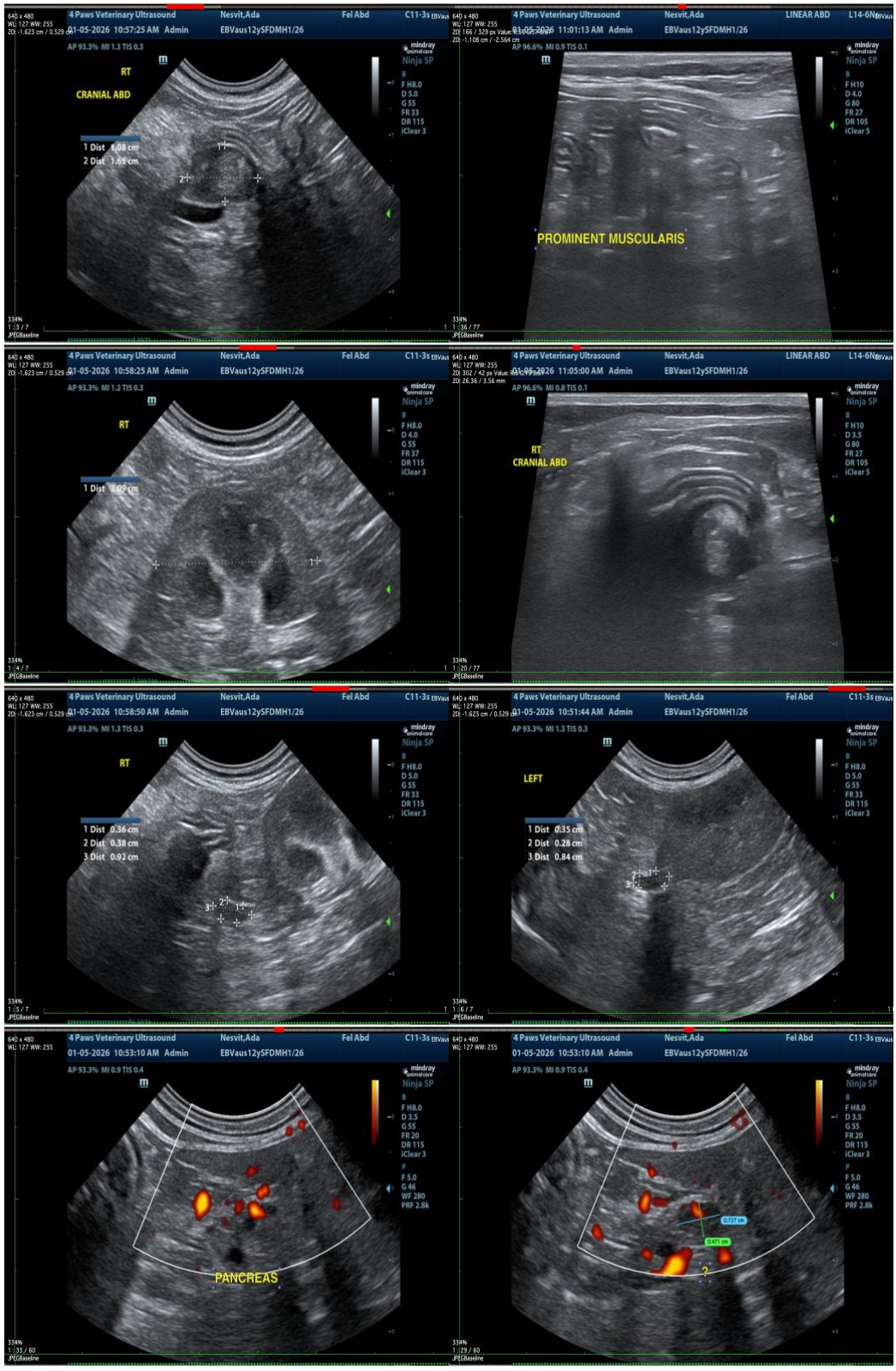

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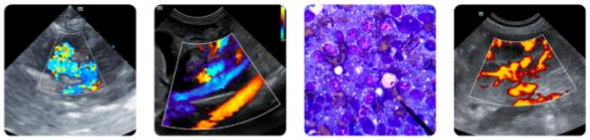

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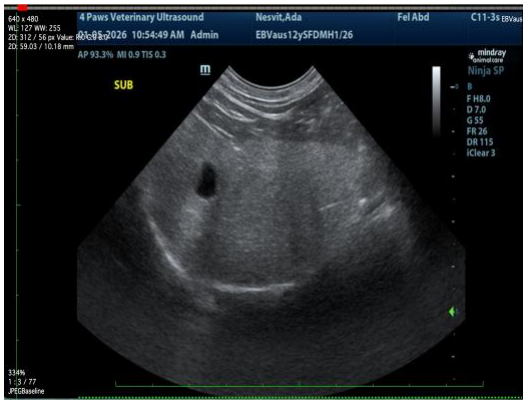

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

info@sonopath.com