SonoPath
Clinical Sonography & Telecytology
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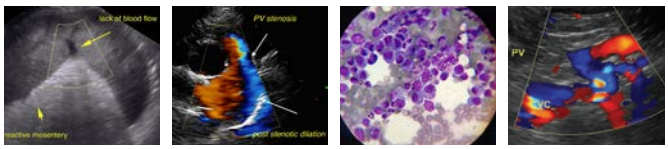

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1-800-838-4268 info@sonopath.com

**PATIENT**
Felix Antonelli

**SPECIES**
Feline

**BREED**
DSH

**SEX**
Neutered Male

**AGE**
16 Years

**WEIGHT**
10 Pounds

**INTERPRETED BY**
Beth Johnson, DVM
DACVIM

**IMAGING PERFORMED BY**
Prescott

**HOSPITAL NAME**
Rondout Valley Veterinary Associates

**REFERRING VET**
Dr. Laux

**INVOICE**
42036

**DATE**
10/13/22

## PRESENTING CLINICAL SIGNS

Anorexia that is worsening; weight loss. On methimazole for hyperthyroidism and not well controlled as not eating well (no meds for a few days). Mild azotemia.

Abnormal PE/Chem/CBC/UA Results: T4 7.2 Creat 2.5

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measures 3.9 cm. The right kidney measures 3.7 cm.

### *Adrenal Glands*

The adrenal glands are unable to be well visualized in these images.

### *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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

### *Liver*

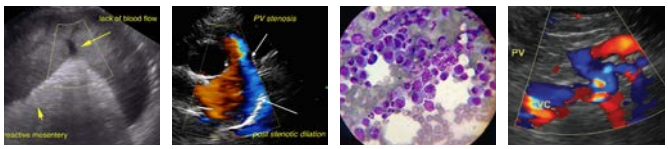
Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. A 1.0 cm anechoic cyst is noted in the caudal right liver. Visible vasculature and biliary tree appear normal without distension or congestion.

The 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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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 intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm), except for a focal small bowel loop in the mid abdomen that is mildly thick, measuring 0.35 cm, with loss of mural detail and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.



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

### *Pancreas*

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

### *Free Abdomen*

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

## PRIMARY FINDINGS

- **Small bowel mass** – most concerning for infiltrative neoplasia such as lymphoma, given the loss of layering. Other neoplasia such as adenocarcinoma versus other is also possible. A benign inflammatory lesion is possible but considered less likely, given the loss of layering.
- **Hyperechoic hepatomegaly with incidental hepatic cyst** – This appearance is most consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

## SECONDARY FINDINGS

- **Hyperechoic splenic nodules –** most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- Age related kidney changes

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Ideally, biopsies of the GI tract, focusing on the focally thickened loop with loss of layering using palpation if possible or intraoperative ultrasound, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.

If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).

Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Given the hyperthyroidism and kidney disease, a blood pressure is recommended if not recently evaluated.

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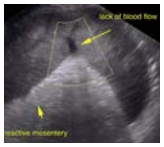
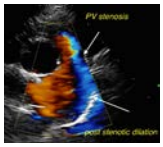
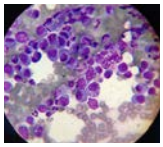
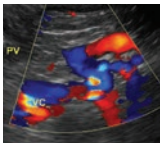

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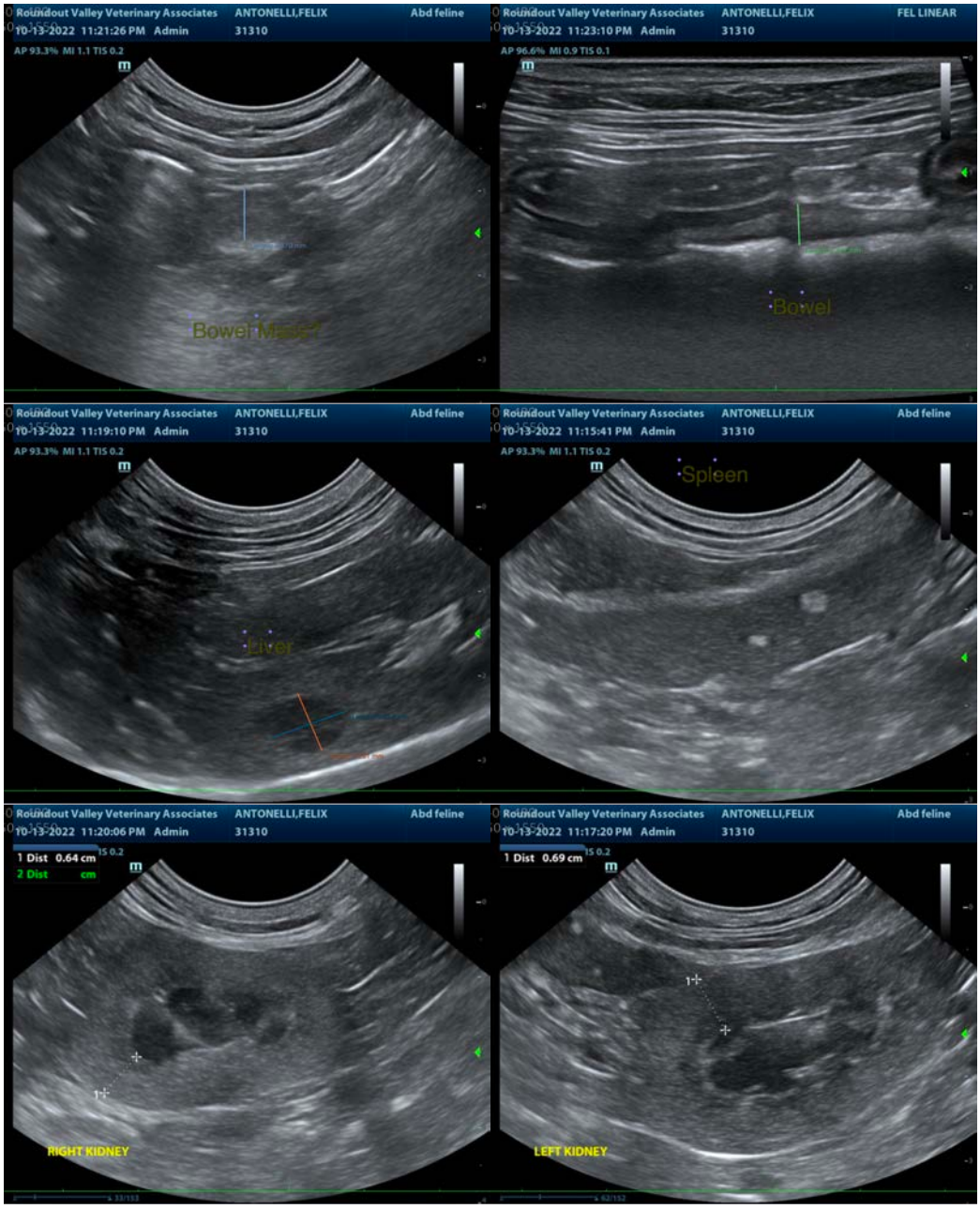

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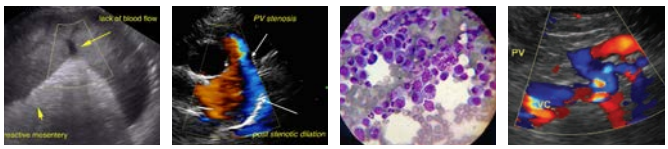

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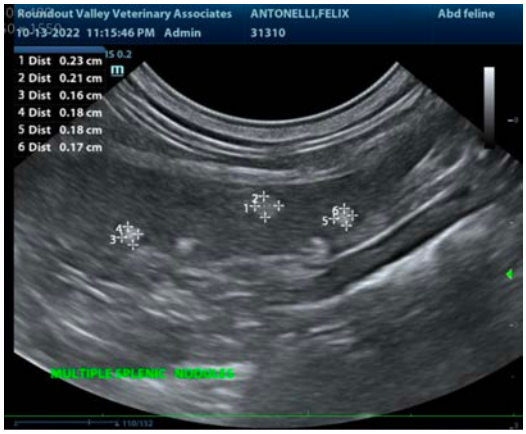


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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
Beth.Johnson@sonopath.com