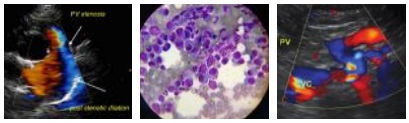
IMAGING PERFORMED BY

IntraPet.com



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DATE
12/5/22

PATIENT
Patches Santoro

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
3/13/2007

WEIGHT
10.6 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

HOSPITAL NAME
Essex Middle River VC

REFERRING VET
Dr. Zulty

INVOICE
19005

PRESENTING CLINICAL SIGNS

History: Poor appetite.

Current Medications: None.
Lab Results: 11/4/22 unremarkable exc ALT 285, AST 74, ALKP 91.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IM sedation: 0.15ml each of Dexmed./Torb./Ketamine.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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.

Left kidney is normal is size (3.96 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 is size (4.07 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 (0.5 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.44 cm), 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 normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

Diffusely, the fundus and body of the stomach wall is normal, and normal in thickness and layering, however, focally, in the area of the pyloric antrum, the wall is thick, measuring 0.7 cm – 0.8 cm thick with loss of mural detail/loss of layering and a hypoechoic appearance concentrically. The gastric thickening/mass is surrounded by enhanced hyperechoic fat and mesentery, as well as enlarged lymph nodes. 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. 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.

The visible colon is normal in wall thickness 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. Pancreatic duct dilation is noted.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

The gastric lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gastric thickening/mass most concerning for infiltrative neoplasia, such as lymphoma versus other. Benign disease is possible but considered much less likely.

- Aggressive gastric lymph nodes – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

Secondary Findings

- Gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

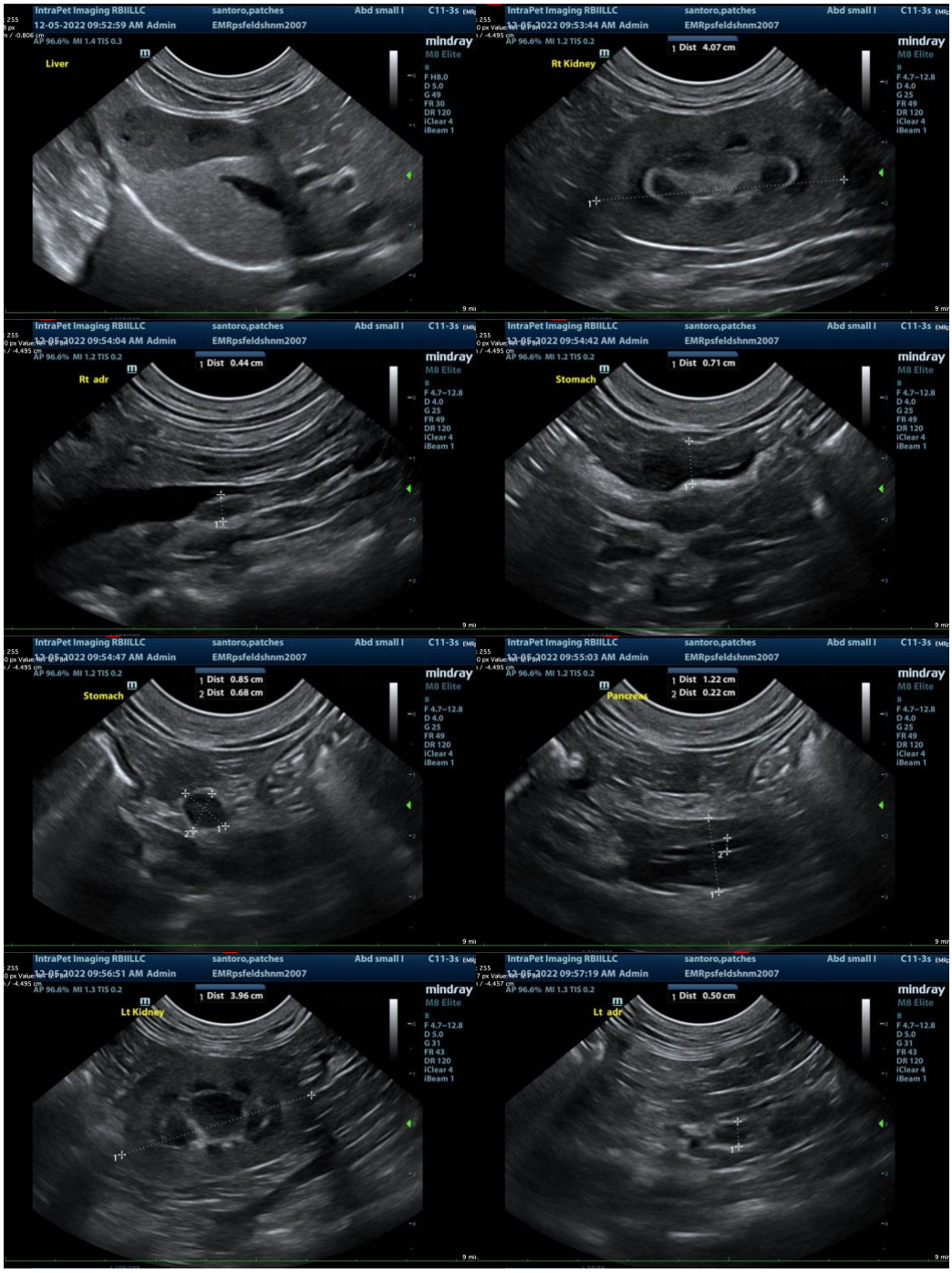
- Chronic active pancreatitis

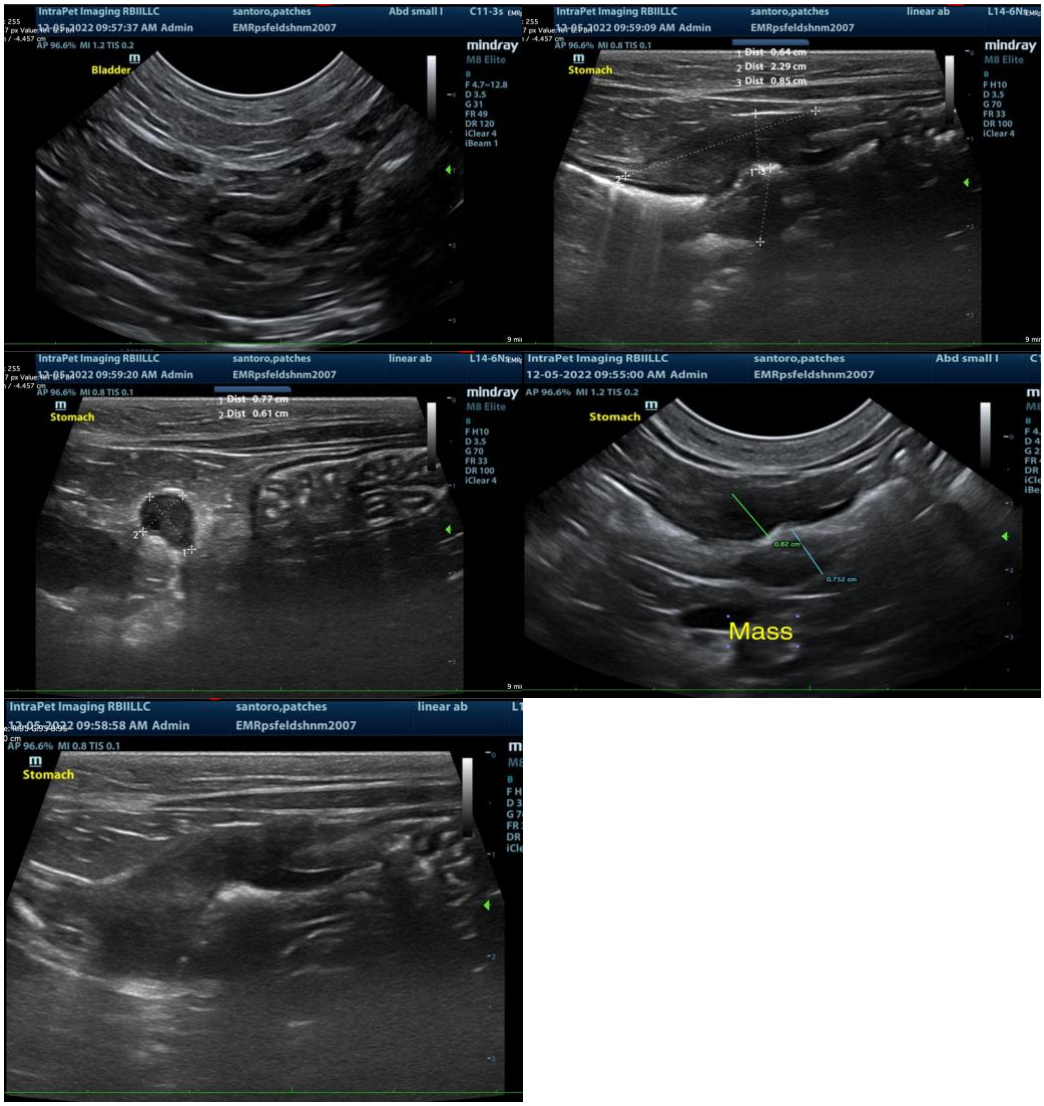
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the location of the gastric mass, resectability may be unlikely without an aggressive surgical approach. Therefore, recommendations include a fine needle aspirate of the gastric mass +/- concurrently enlarged lymph nodes, if patients coagulation status is appropriate, to determine whether or not

lymphoma is present, and management may be able to be medical with chemotherapy.

If a diagnosis is not obtained cytologically, either upper GI gastroscopy/endoscopy could be considered for biopsies or an exploratory laparotomy could be planned for biopsy and excision if possible.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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