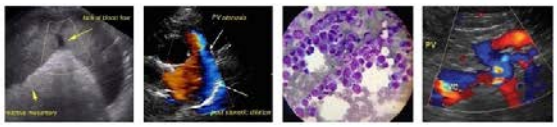


PATIENT

Mardi Segovia-Rivas

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

18 Years

WEIGHT

4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

East Credit VH

REFERRING VET

Dr. Webster

INVOICE

43212

DATE

6/15/23

PRESENTING CLINICAL SIGNS

Sudden onset of vomiting, inappetence, but weight loss over past several weeks to months. Had similar but more severe episode in May 2022 at previous vet. was diag with pancreatitis-though markedly elevated ALT and decreased potassium at that time. Symptoms resolved with symptomatic care. Palpable thickening in cranial abd meds: metro, ampicillin, cerenia, potassium;/IV fluids

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (3.26 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. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal in size (3.0 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. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

The right adrenal gland is normal in size (0.24 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.17 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

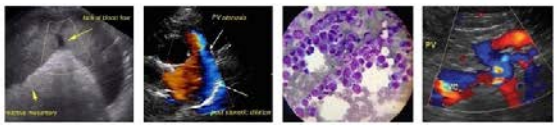
Liver

The 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. In the deep left liver, an irregularly margined, approximately 3.8 cm in diameter, heterogeneous, non-cavitated, primarily hypoechoic mass is noted. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is difficult to fully evaluate in these images and is believed to be empty with a suspected small amount of echogenic debris.

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.



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The visible small intestine demonstrates areas of 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 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

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.

ULTRASONOGRAPHIC FINDINGS

- Solid hypoechoic liver mass – most concerning for infiltrative neoplasia such as round cell neoplasia (i.e., lymphoma versus other). A benign inflammatory nodule, nodular hyperplasia, etc. is possible but considered much less likely.
- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- 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 aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirates of the liver mass +/- the spleen are recommended if patient's coagulation status is appropriate.

Additionally, if not recently evaluated and to complete kidney evaluation, a 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.

The bowel changes may be related and suggestive of round cell neoplasia (i.e., lymphoma) as well, or an unrelated benign inflammatory response. Regardless, further evaluation of absorption is recommended to help guide therapy via a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory.

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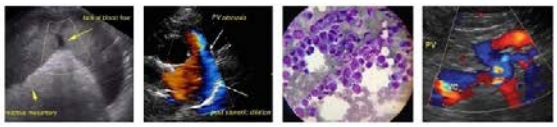

THE FOCAL ZONE
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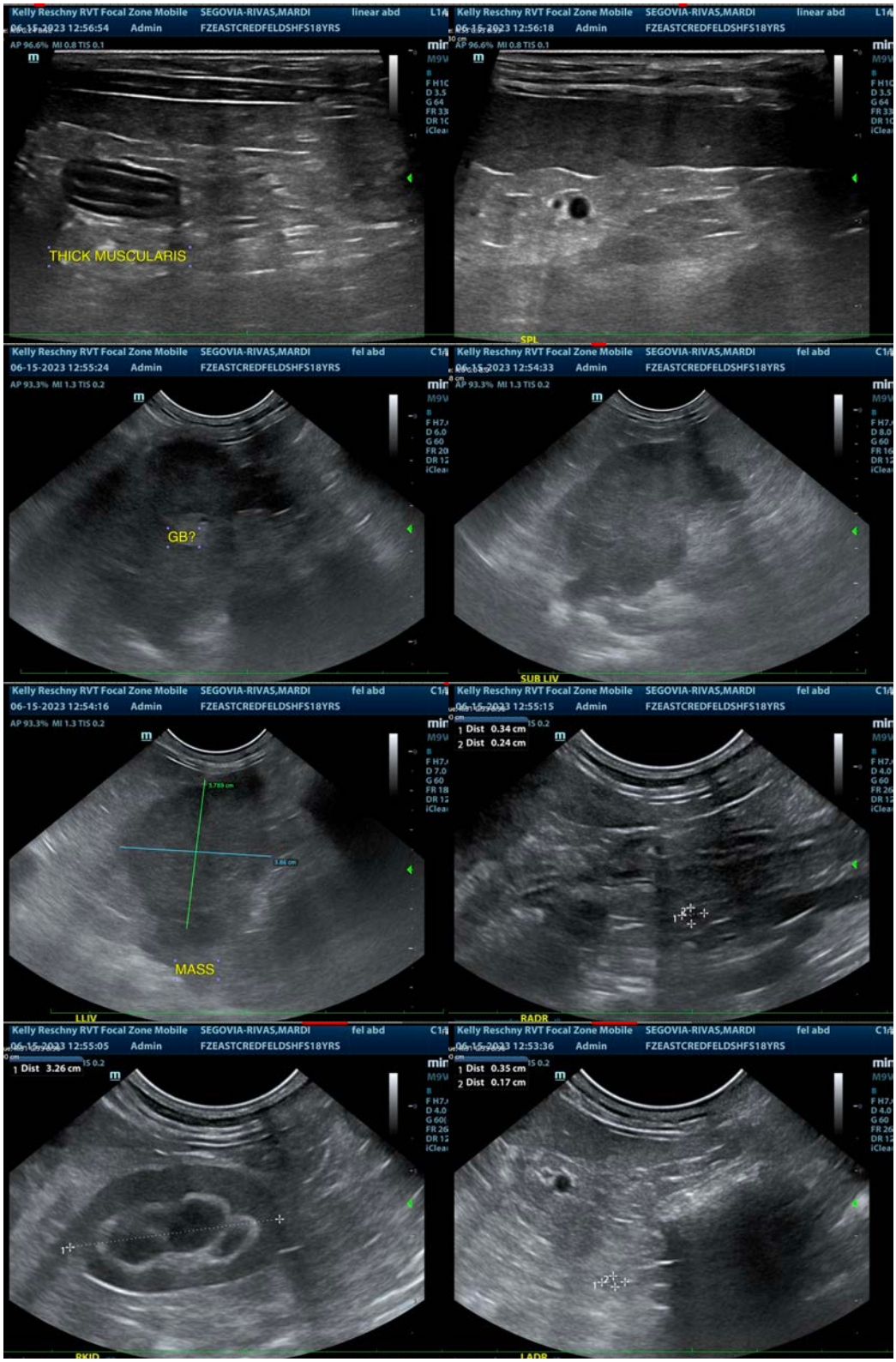

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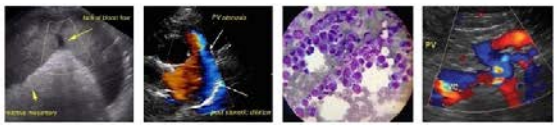

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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