IMAGING PERFORMED BY

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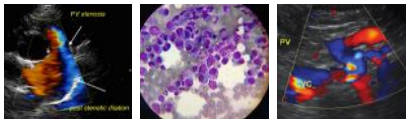

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DATE
7/11/22

PATIENT
Fred Buckingham

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
2012

WEIGHT
N/A

INTERPRETED BY
Beth Johnson, DVM DACVIM

HOSPITAL NAME
Festival VC

REFERRING VET
Dr. Davies

INVOICE
16576

PRESENTING CLINICAL SIGNS

History: Inappetance, abdominal mass, T 103.5.

Current Medications: None.
Lab Results: Mild decreased K, Amylase. Increased WBCs 22K, Increased Neutrophils 14.14, Monos 1.04.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Declined.
Imaging Performed By: Stephanie Pearce RDCS, RVT.

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 cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (3.93 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 significantly enlarged (5.2 cm), with increased cortical echogenicity and disruption of normal corticomedullary architecture. A hypoechoic subcapsular rim (halo) is present. The pericapsular area is enhanced by hyperechoic fat and mesentery. No mineral is observed.

Adrenal Glands

Left adrenal gland is normal in size (0.34 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.39 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 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 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. A focal thickening in the mid abdomen with hypoechoic loss of layering combined with a larger 3.0 cm x 5.0 cm heterogenous, primarily hypoechoic bowel mass.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas
The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen
There is a scant amount of anechoic free fluid. No appreciable aggressive lymphadenopathy is noted in these images.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Renal lymphoma of the right kidney – This appearance is highly suggestive of renal lymphoma. Other malignant neoplasia, severe nephritis and feline infectious peritonitis can at times mimic this presentation, but it's less common.

- A focal heterogeneous bowel mass combined with a focal thick loss of layering in another part of the bowel, most concerning for infiltrative neoplasia, such as round cell neoplasia (i.e., lymphoma), especially given the concurrent kidney appearance.

Secondary Findings

- Urinary bladder debris

- Pancreatic age-related remodeling – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

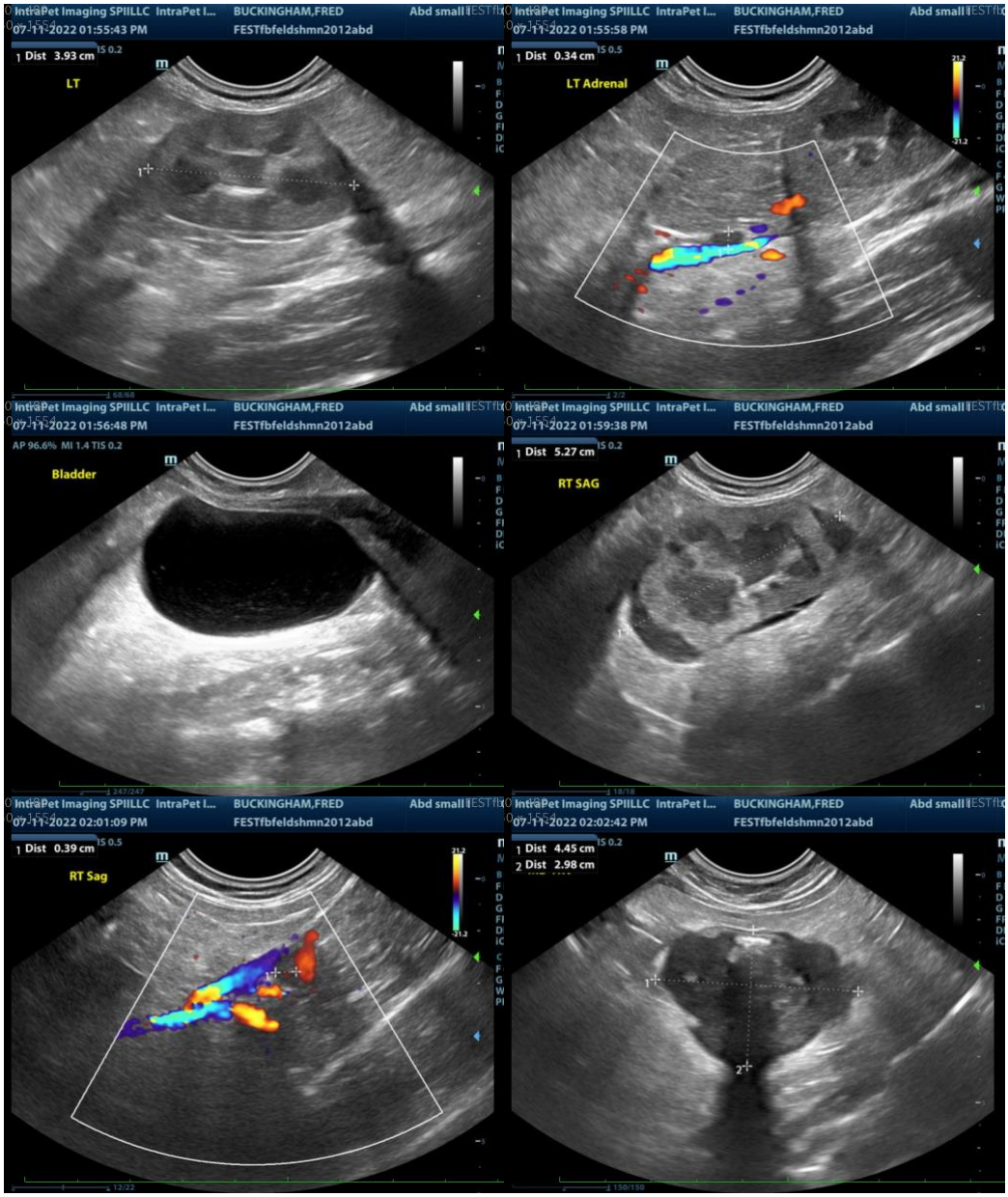
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

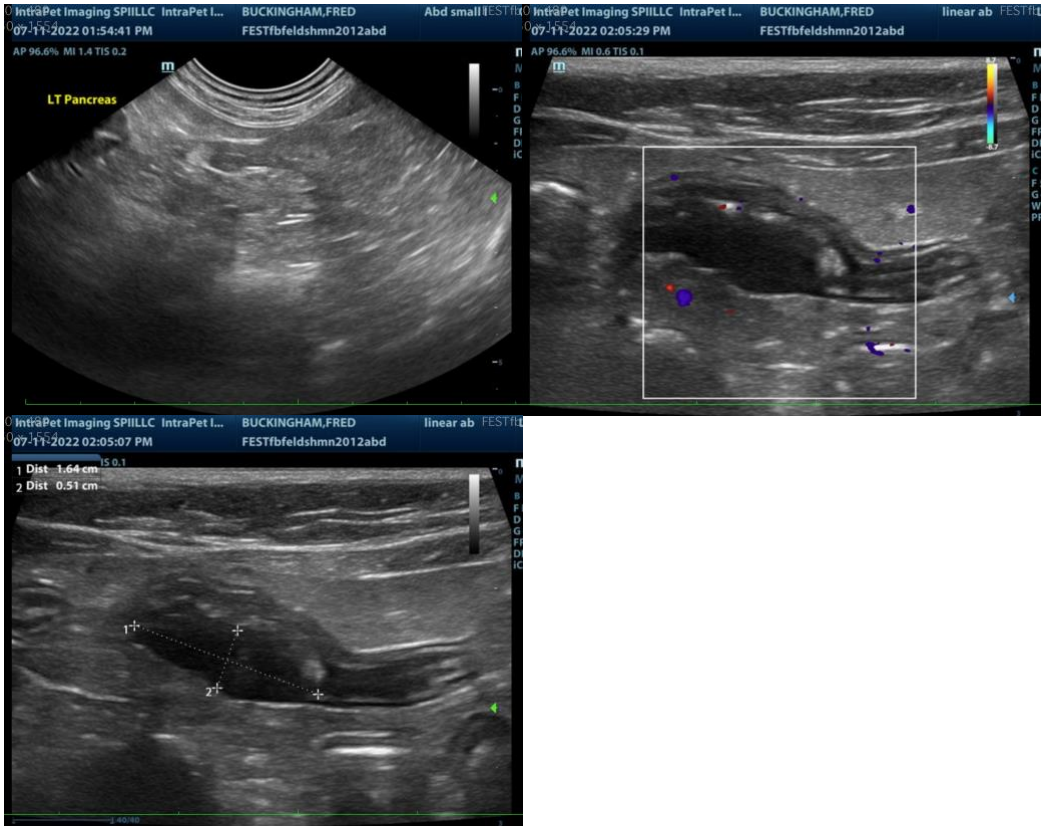
- Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

- A fine needle aspirate of the bowel mass is recommended, if patients coagulation status is appropriate. If a diagnosis of lymphoma is not obtained, a fine needle aspirate of the right kidney could be considered as well. Ultimately, if a diagnosis is not obtained, an exploratory for bowel mass removal, resection and anastomosis, being sure to include the smaller emerging bowel mass

as well.

- 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 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
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