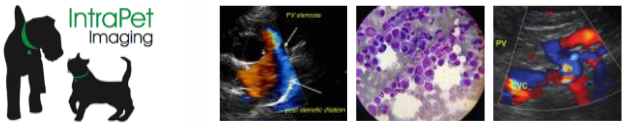
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

**DATE**
7/14/22

**PATIENT**
Amos Jones

**SPECIES**
Feline

**BREED**
DSH

**SEX**
MN

**AGE**
3/1/2013

**WEIGHT**
11 lbs.

**INTERPRETED BY**
Beth Johnson, DMV DACVIM

**HOSPITAL NAME**
Alexander AH

**REFERRING VET**
Dr. Alexander

**INVOICE**
14295

## PRESENTING CLINICAL SIGNS

1lb weight loss with decreased appetite.

Current Medications: None.
Lab Results: Precision PSL 66.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV sedation.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

## 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. The amount of debris appears much more significant / severe than Is typically seen with just suspended lipid.

The right kidney is normal in size (3.89 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.

The left kidney is normal in size (3.68 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*

The right adrenal gland is normal in size (0.61 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.33 cm), shape and contour. Corticomedullary structure is unremarkable. 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 stomach wall is normal in thickness (< 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 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 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. Near the area of the ileocecocolic junction, there is a 2.0 cm slightly heterogeneous primarily hypoechoic mass that may be lymph node but can't be ruled out as a bowel mass at the ileocecocolic junction.

### *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*

The reactive 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. No appreciable free fluid Is noted in these images. No post aspirate complications are noted.

## ULTRASONOGRAPHIC FINDINGS

### *Primary Findings*

- A mass in the area of the ileocecocolic junction concerning for infiltrative neoplasia however tissue of origin cannot be definitively determined between bowel vs. lymph node
- Concurrent diffusely thick muscularis is present, differentials for which include; infiltrative lymphoma with the aforementioned lymphadenopathy vs. diffuse inflammatory bowel disease on top of the focal mass

- 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.

***Secondary Findings***

- Urinary bladder debris
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely

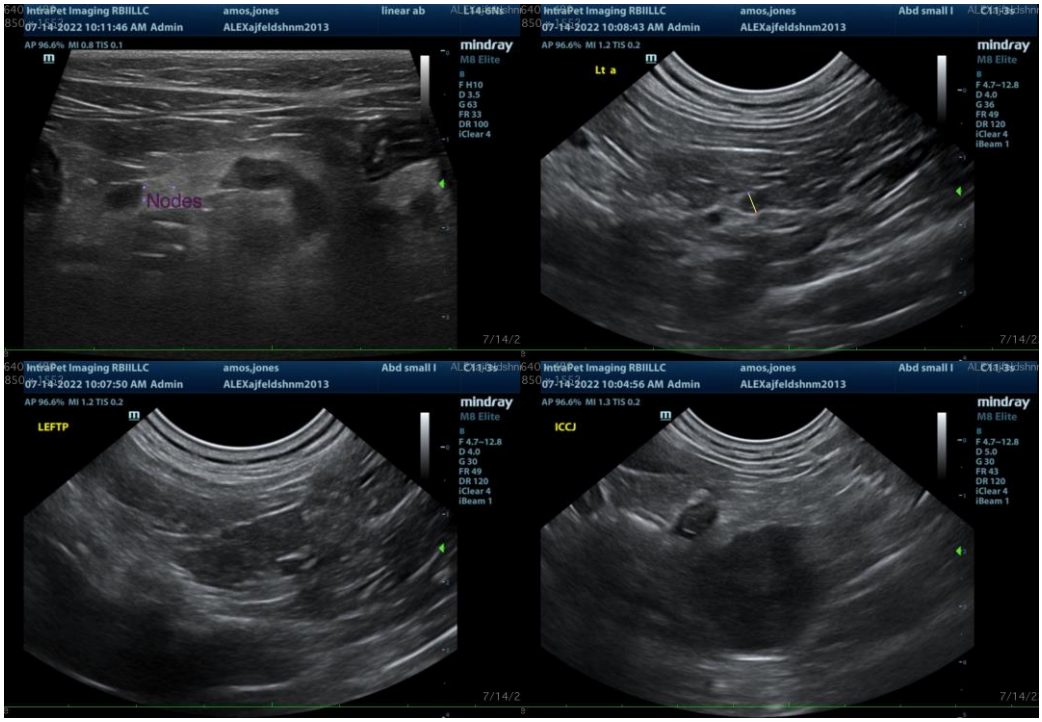
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

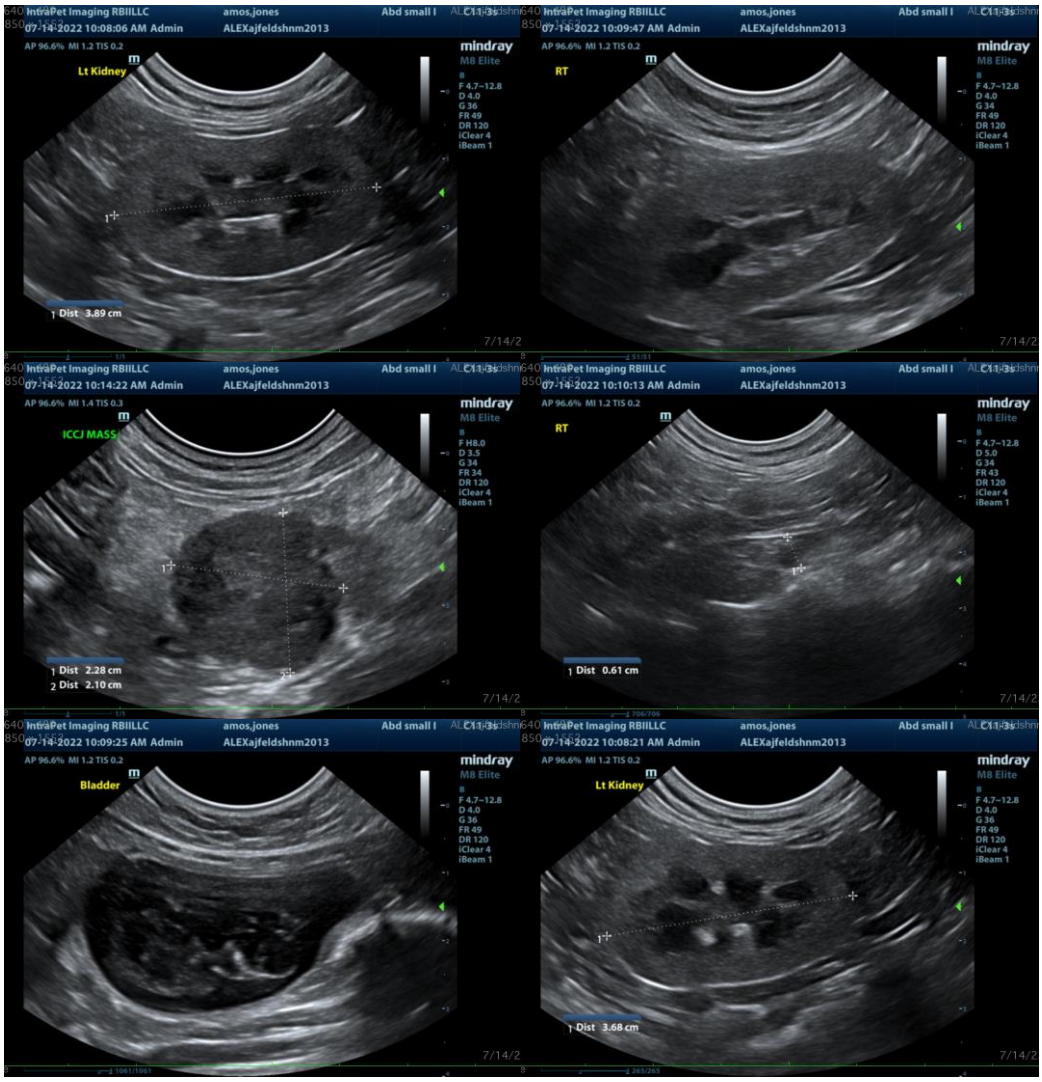
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

A fine needle aspirate of the mass is recommended and was visibly performed in these images with cytology reportedly pending.

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.

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 ratio is recommended.






**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
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