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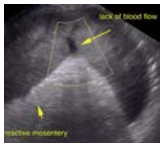
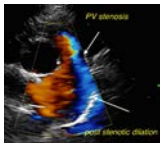
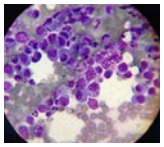
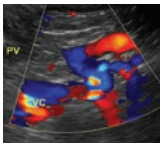





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Kitty Tucker

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
19

WEIGHT
5.1 kg

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Belan

HOSPITAL NAME
Alpine 24/7

REFERRING VET
Dr. Nelson

INVOICE
43807

DATE
7/5/23

PRESENTING CLINICAL SIGNS

Lethargic some weight loss and vomiting recently, hypexic. Urinating outside box. Cat has a large pendulous abdomen and seems content POCUS large abdominal mass seen.

Abnormal PE/Chem/CBC/UA Results: Blood work pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with primarily anechoic contents. There is a solitary homogeneous, hyperechoic soft tissue density lesion along the dorsal wall near the trigone that measures 1.1 cm long x 0.64 cm thick. The density contains mineral foci.

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 or mineral observed. Several small chronic infarcts are noted in the left kidney. The left kidney measures 3.29 cm. The right kidney measures 3.38 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.52 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.45 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.

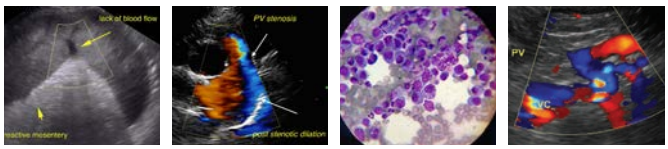
Liver

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. No focal lesions are observed. 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.



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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

A small amount of anechoic free fluid is noted throughout these images.

The medial iliac 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.

In the cranial to mid abdomen there is an approximately 6.0 cm in diameter, markedly heterogeneous, partially cavitated mass that appears to surround and/or be adhered to several bowel loops.

PRIMARY FINDINGS

- Heterogeneous mid abdominal mass – Appears most consistent with mesenteric root/lymph node origin. However, it encompasses several bowel loops, and primary bowel origin cannot be definitively ruled out. Regardless, the top differential is infiltrative neoplasia such as round cell neoplasia (i.e., lymphoma).
- The remaining bowel with the thick muscularis layer could also be suggestive of infiltrative round cell neoplasia such as lymphoma. However, benign inflammatory bowel disease can have a similar appearance and cannot be ruled out.
- 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.
- The urinary bladder soft tissue density/mass could represent mineralized mass secondary to infiltrative neoplasia such as carcinoma. However, a benign inflammatory or chronic cystitis lesion potentially with embedded small cystoliths cannot be ruled out without additional information.
- Reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Small amount of free abdominal fluid.

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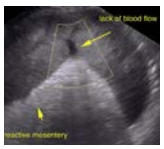
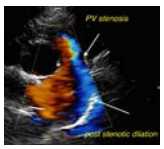
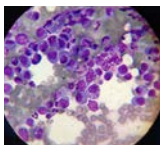
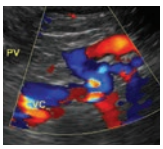

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SECONDARY FINDINGS

- Chronic infarcts in the left kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

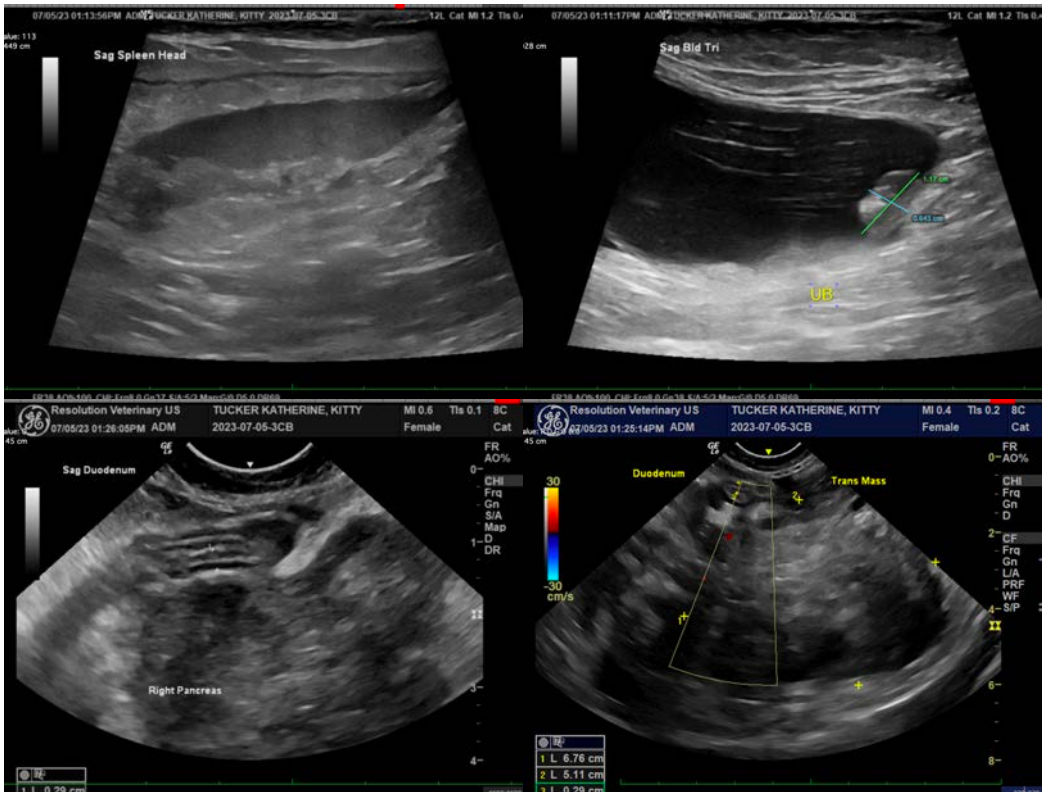
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the mid abdominal/mesenteric root mass +/- the spleen +/- the urinary bladder mass could all be considered if patient's coagulation status is appropriate, understanding the small risk of tumor seeding/trailing with sampling of the urinary bladder mass.

Alternatively, an exploratory laparotomy could be considered for excisional biopsy of the mesenteric root mass, as well as further evaluation/biopsy of the urinary bladder mass, etc. Having said that, given the location of the mesenteric root mass and the visible involvement of several bowel loops as well as great vessels, full resectability of the mass is considered unlikely.

If surgery is pursued, a pre-surgical planning abdominal CT scan could be considered.

In the meantime, if not recently evaluated, 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.



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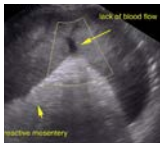
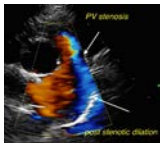
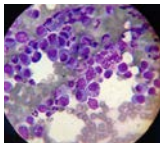
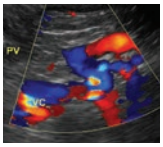

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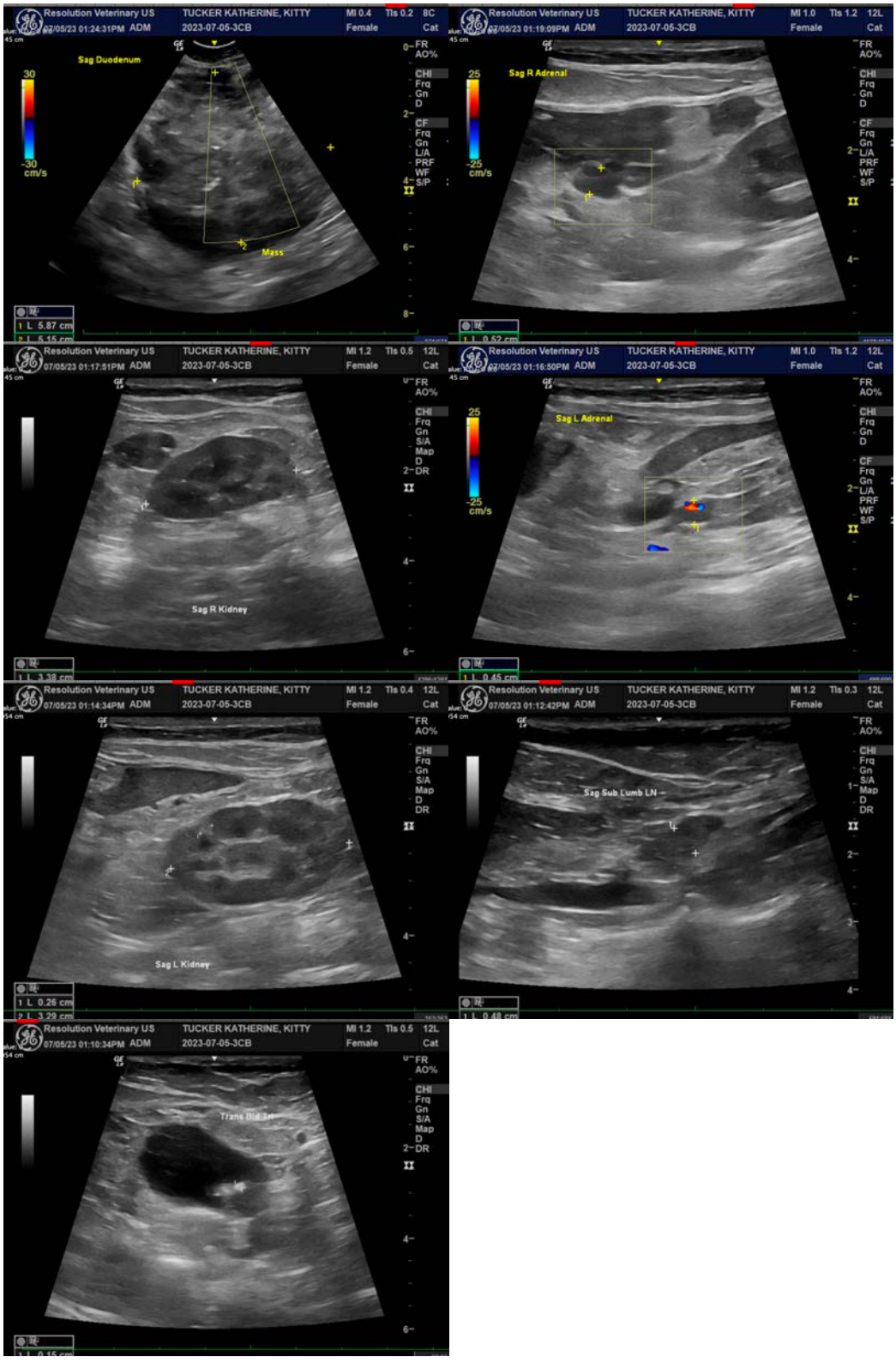

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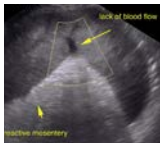
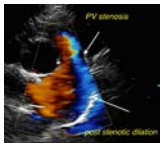
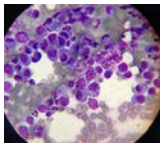
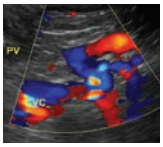

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com