



PATIENT

Jackson Boschert

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

13 years

WEIGHT

9.82 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons), DACVECC

IMAGING PERFORMED BY

Kelly Vasquez

HOSPITAL NAME

Westwood Regional
VH

REFERRING VET

Dr. Hartwick

INVOICE

45012

DATE

6/28/23

PRESENTING CLINICAL SIGNS

History: Patient presented today at 12:30pm for lethargy, decreased appetite, weight loss, weakness, and trouble jumping. Patient is icteric, generalized muscle wasting, weak, temp = 99.9. No current meds. Abnormal PE/Chem/CBC/UA Results: RDW 27.7, neutrophils 10.55, monocytes 1.81, glucose 180, ALT 642, ALP 1,809, GGT 39, bilirubin - total 16.3, cholesterol 324.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Multiple nephroliths are present in the left kidney with the largest measuring 0.69cm in the left renal pelvis. The left kidney measured 3.92 cm and the right kidney measured 3.64 cm.

Adrenal Glands

Adrenal glands were not distinctly visualized. The area of the adrenal glands and surrounding vasculature were normal.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

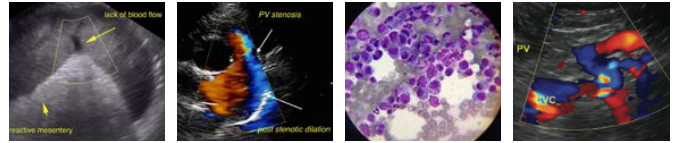
The liver is subjectively enlarged in size with slight rounding of lobes and homogenous hyperechoic parenchyma with no specific nodules or masses. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

Gall bladder contains anechoic contents and dilated common bile duct measuring 0.3cm proximal to the mass. A hypoechoic to heterogenous slightly irregular structure measuring 0.98x1.21cm is present at the level of the duodenal papilla most consistent with neoplastic growth.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall



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layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

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Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

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Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

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Free Abdomen

An ovoid hypoechoic to partially cystic structure is present in the left cranial abdomen in the area of the left limb of the pancreas measuring 2.4x1.6cm small intestine and splenic hilus. This is suspected to represent an inflamed mesenteric lymph node, though a free floating mass such as is seen with carcinoma cannot be excluded. FNA is strongly recommended to further define this lesion. The visible left limb of the pancreas appears normal and this is not suspected to be associated with the pancreas, but this cannot be entirely excluded as the origin of the lesion.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

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1. Mass at duodenal papilla
2. Left cranial abdominal mass effect – suspect mesenteric lymph node
3. Hyperechoic hepatomegaly
4. Degenerative renal changes
5. Left nephrolithiasis

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Mass at duodenal papilla is most concerning for a neoplastic lesion and given severe hyperbilirubinemia and CBD distension, obstruction of biliary outflow tract is suspected. Primary differential is biliary adenocarcinoma given the location of the mass. FNA could be attempted though these lesions are often poorly exfoliative the and anatomic location makes FNA very challenging. Definitive diagnosis often requires abdominal exploratory surgery and biopsy. At the time of surgery a biliary stent can be placed to relieve obstruction. Unfortunately prognosis is poor and surgery in this location generally carries high morbidity and mortality.

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The mass in the left cranial abdomen is suspected to be lymph node in origin, a free floating mass such as is seen with metastatic omental carcinoma cannot be excluded. The visible left limb of the pancreas appears normal and this is not suspected to be associated with the pancreas, but this cannot be entirely excluded as the origin of the lesion. FNA is strongly recommended to further define this lesion.

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Hepatic parenchymal changes are a common finding in the face of endocrinopathies, infectious or inflammatory hepatitis (bacterial, viral, auto-immune other), and neoplasia among other things. In the face of the other abnormal abdominal findings and in the presence of elevated liver enzymes, fine needle aspirate is recommended to further define. Coagulation testing prior to FNA is recommended.

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Renal changes are likely age related degenerative changes. Correlate clinical significance with blood work/urinalysis findings and clinical signs. Nephroliths may act as a nidus of infection and predispose to urinary tract infections. They can also cause sterile inflammation leading to renal hematuria. They have the potential to move into the ureters or bladder causing obstructive uropathy.

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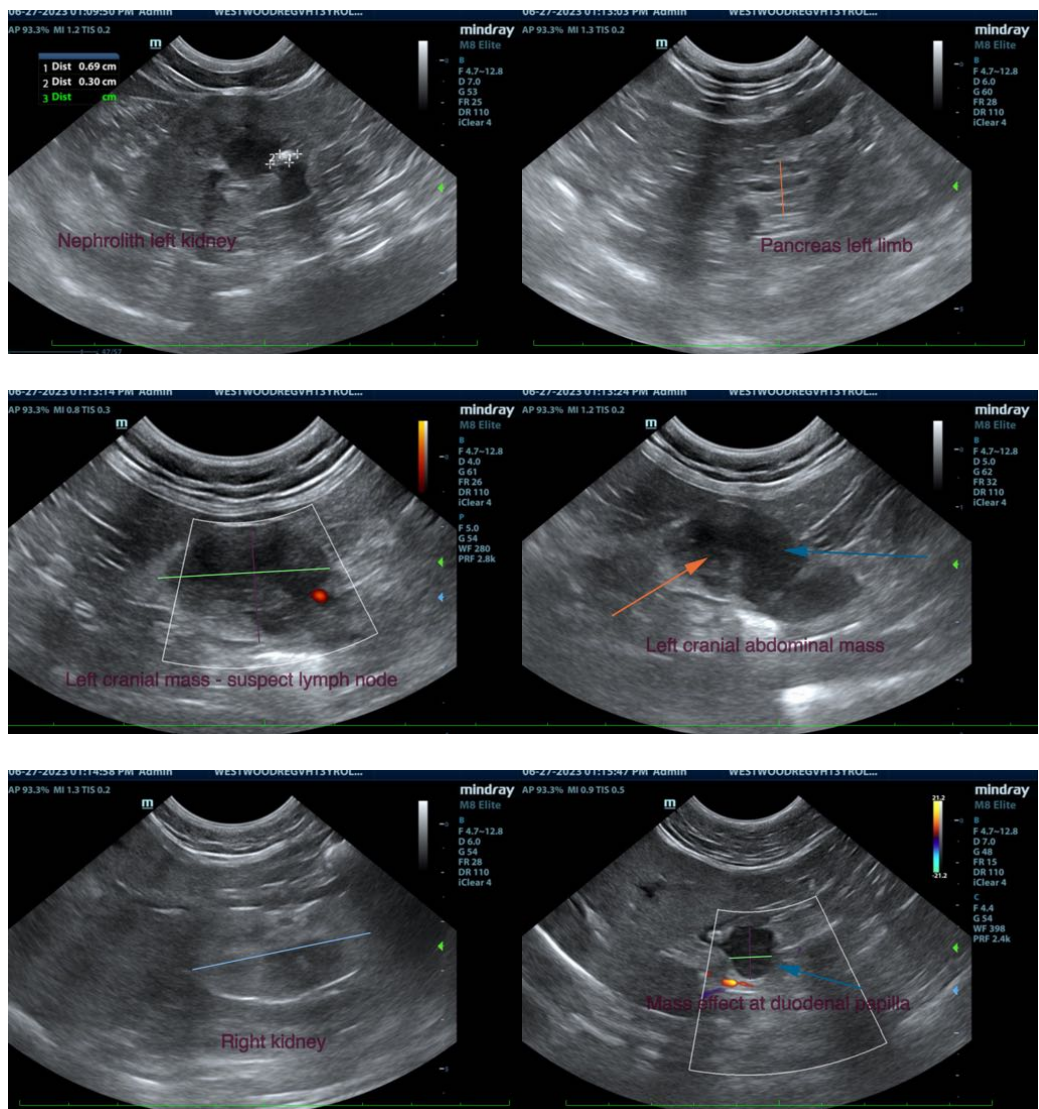
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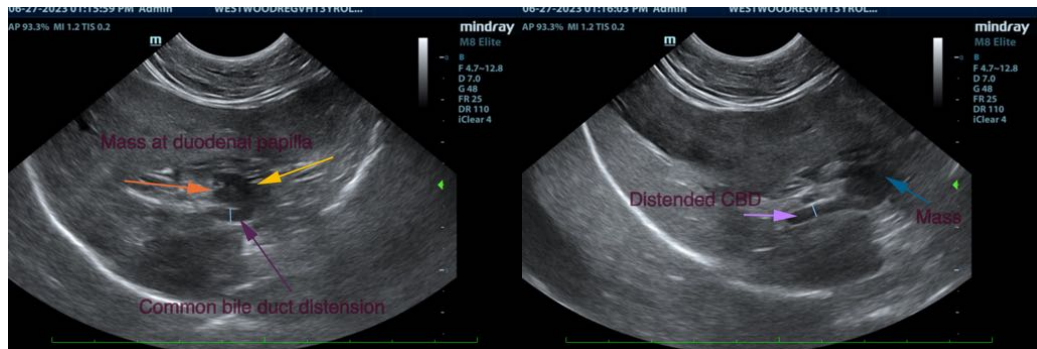
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
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