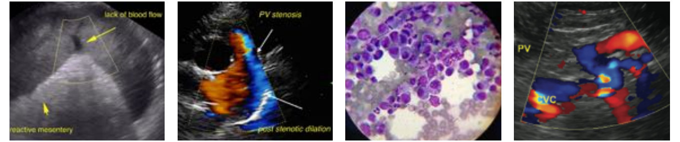


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Sebastian Toby

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

10 years

WEIGHT

9.7 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Chelsea Pastor

HOSPITAL NAME

Fredon AH

REFERRING VET

Dr. Roche

INVOICE

45027

DATE

6/28/23

PRESENTING CLINICAL SIGNS

History: Vomiting, lethargy, very dull
PE abdominal mass on palpation, severe muscle wasting Evaluate mass

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 4.6 cm and the right kidney measured 4.5 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient.

Spleen

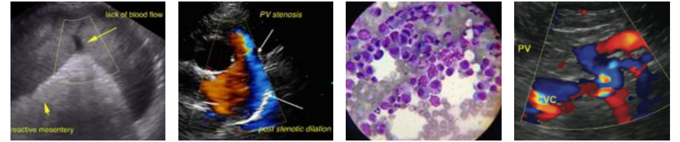
The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** was diffusely hyperechoic to the falciform fat. Minor dependent gallbladder debris was noted. . The liver revealed uniform parenchyma. This is consistent with lipidosis. A slight amount of free fluid was noted between the liver lobes.

Gastrointestinal

The **stomach** in this patient was severely over distended with a dilated upper duodenum. Over distension extended to the gastroesophageal inlet with suspended, largely anechoic fluid. The upper duodenum was dilated for the first 4.0 cm. The distal small intestine was empty and unreamkrable as was the colon.



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Pancreas

The right limb of the **pancreas** revealed extensive, hypoechoic, irregular parenchyma with an undifferentiated pattern and enhanced surrounding mesentery. This is suggestive for inflammation. The right pancreatic pathology appeared to develop the duodenum.

Free Abdomen

The midabdomen revealed what appeared to be a proximal jejunal, hyperechoic 1.0-1.5 cm linear structure at the termination of the small intestinal dilation, which was followed by empty small intestine. Reactive mesentery consistent with peritonitis was noted in this region.

ULTRASONOGRAPHIC FINDINGS

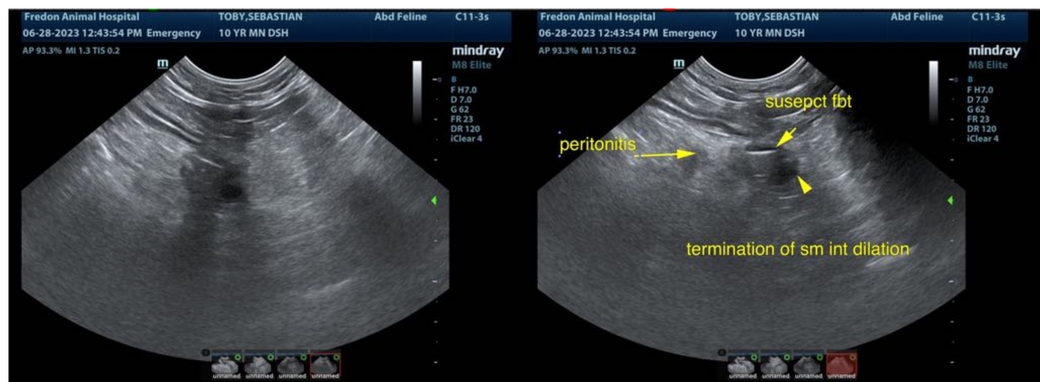
Extensive pancreatitis or the possibility of pancreatic carcinoma is less likely.

Severe upper gastrointestinal obstructive pattern with suspicion of sharp, linear foreign body such as a toothpick, sewing needle or similar.

Intestinal dilation/obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend exploratory surgery in this patient. J tube placement would be ideal with treatment for pancreatitis. GI and pancreatic biopsies are indicated. The prognosis is very guarded. At induction gastric reflux may be an issue. Evacuation may be appropriate prior to surgery.



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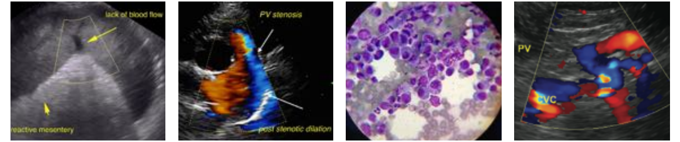

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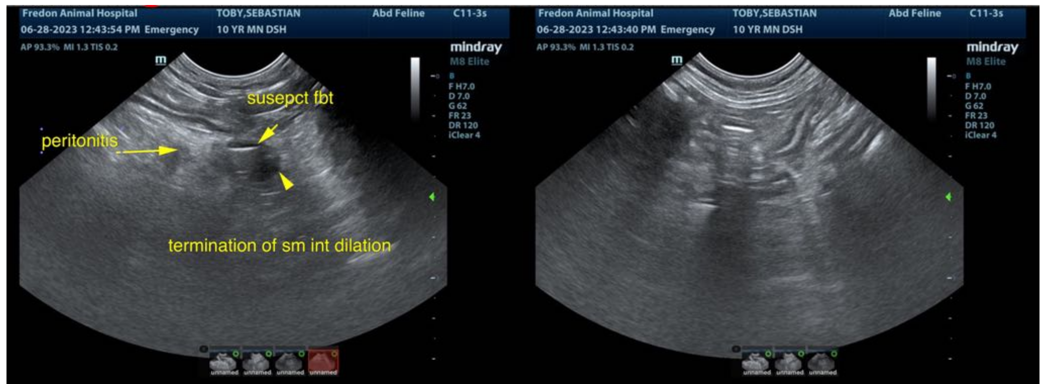

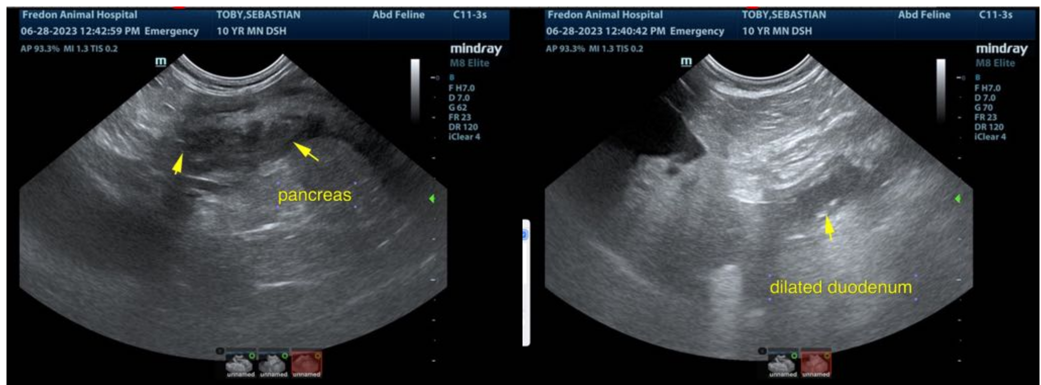

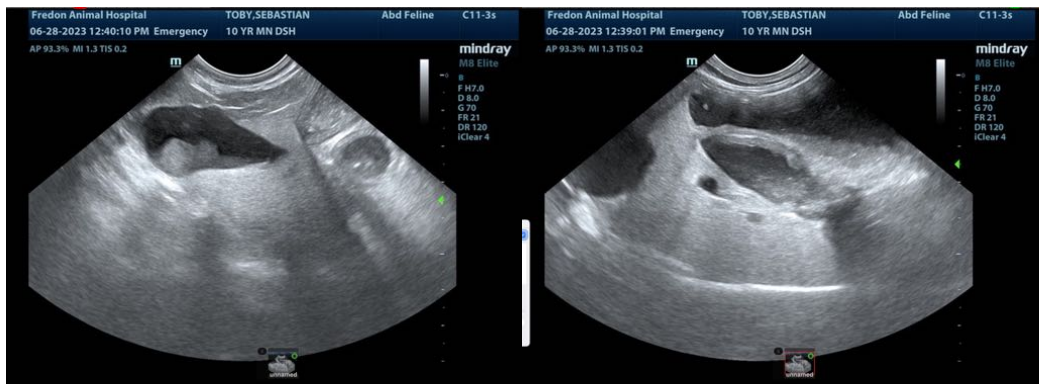

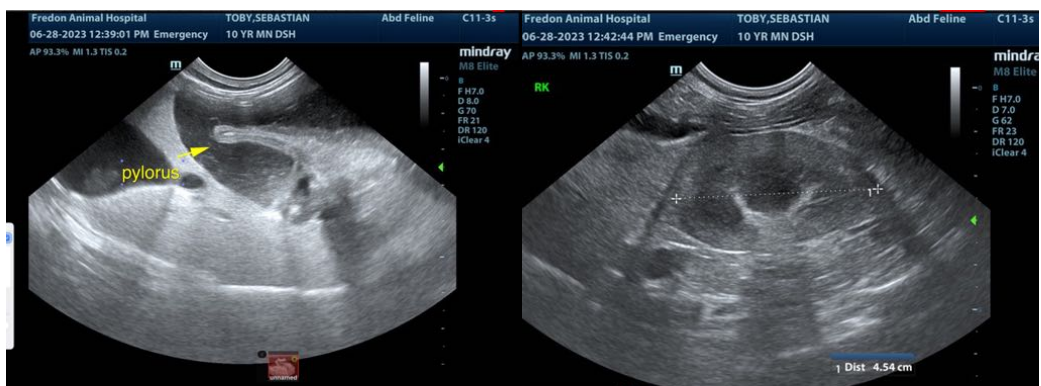

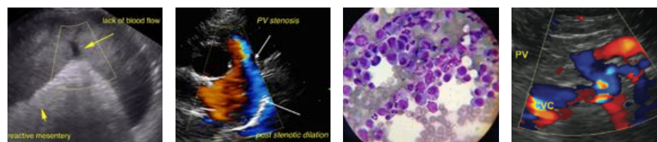

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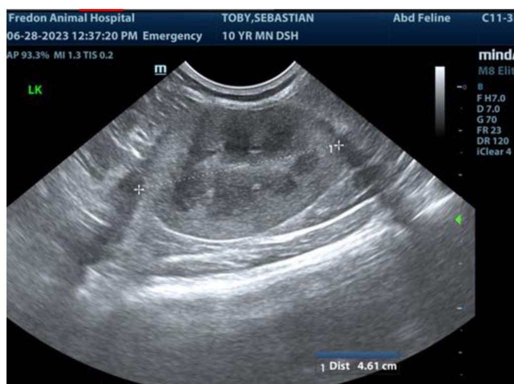

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com