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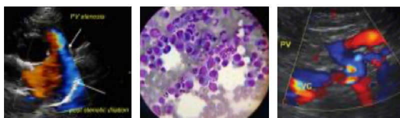
IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

4.27.2023

PATIENT

Prissy Hutt

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

4/19/2007

WEIGHT

6.5 lbs

INTERPRETED BY

Jessica Midence, DVM, DACVIM (SAIM)

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Unger

INVOICE

12877

PRESENTING CLINICAL SIGNS

Presented in Jan for stranguria and frequent urination. A small amount of blood and WBC detected in urine at that time. Pet was given Convenia injection. No improvement since then in symptoms. Pet has had a decrease in appetite and has lost 1/2 lb since Jan. Pet has a history of hyperthyroidism, pleural effusion and chronic renal disease- all stable. Possible mass effect seen when ultrasound used to try and obtain cystocentesis. On exam grade 3-4/6 murmur, 1/2 ln weight loss, bladder irritation with palpation and urinated readily.

Current Medications: Methimazole 2.5 mg SID
Lab Results: dilute urine, scant WBC and RBC on UA
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen contains a small volume of urine with a scant amount of echogenic speckling. In the midbody of the bladder there is a large (2.132 cm in length x 0.77 cm thick), hyperechoic, irregular mucosal mass that extends cranially towards the apex of the bladder. More towards the apex of the bladder, this mass contains a cystic portion that measures 0.60 cm x 0.45 cm. The mass is approximately 1.00 cm from the trigone of the bladder.

The left kidney is small in size (3.00 cm) with a slightly irregular shape and significantly abnormal architecture with smooth peripheral margins. There is evidence of prior renal infarcts. There is significantly decreased corticomedullary distinction. There is mineralization at the renal pelvis and mild pyelectasia.

The right kidney is small in size as well (3.00 cm) with a slightly irregular shape and significantly architecture with smooth peripheral margins, with evidence of prior renal infarcts. There is significantly decreased corticomedullary distinction. There are nonobstructive nephroliths (measuring 0.36 cm and 0.27 cm).

Adrenal Glands

The left adrenal gland is normal in size (0.33 cm) with a normal shape and is normal in appearance and echogenicity.

The right adrenal gland is normal in size (0.40 cm) with a normal shape and is normal in appearance and echogenicity.

Spleen

The splenic echotexture is homogeneous with parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule is smooth with no irregularities. The splenic vasculature is normal without signs of congestion or thrombosis.

Liver

The liver is subjectively normal in size with normal contours, structure, with smooth peripheral margins. The echogenicity appears normal with normal portal markings. No overt evidence of inflammatory, infiltrative or regenerative pathology is evident. The visible portions of the vasculature and biliary tract appear normal. No pathological hepatic lymphadenopathy observed.

The gallbladder lumen is mildly distended. The wall is a normal thickness and smooth. There is a small volume of dependent echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal Tract

The gastric lumen is empty. The stomach wall is of normal wall thickness with some variability due to rugal folds. There is normal gastric wall layering. There are no masses or focal lesions observed and the pyloric outflow tract appears normal.

The visualized areas of duodenum, jejunum and ileum appear subjectively thickened. The duodenum measures normal with distinct wall layering. The majority of the jejunum measures at the upper limit of normal (0.24 cm) with normal wall layering and subjectively thickened muscularis. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

The sections of colon are visualized with formed fecal material and gas shadowing distally.

Pancreas

The left pancreas is diffusely hypoechoic and heterogenous. The body of the pancreas measures thick (1.55 cm). The surrounding tissue is mildly hyperechoic. the pancreatic duct is also very dilated (up to 0.28 cm).

Peritoneum

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There were numerous enlarged hypoechoic mesenteric lymph nodes (the largest measuring up to 1.00 cm in length x 0.30 cm thick

ULTRASONOGRAPHIC FINDINGS

Findings

- Bladder mass with cystic apical portion, most consistent with transitional cell carcinoma
- Pancreatitis
- Chronic enteropathy with reactive lymph nodes
- Chronic degenerative renal changes

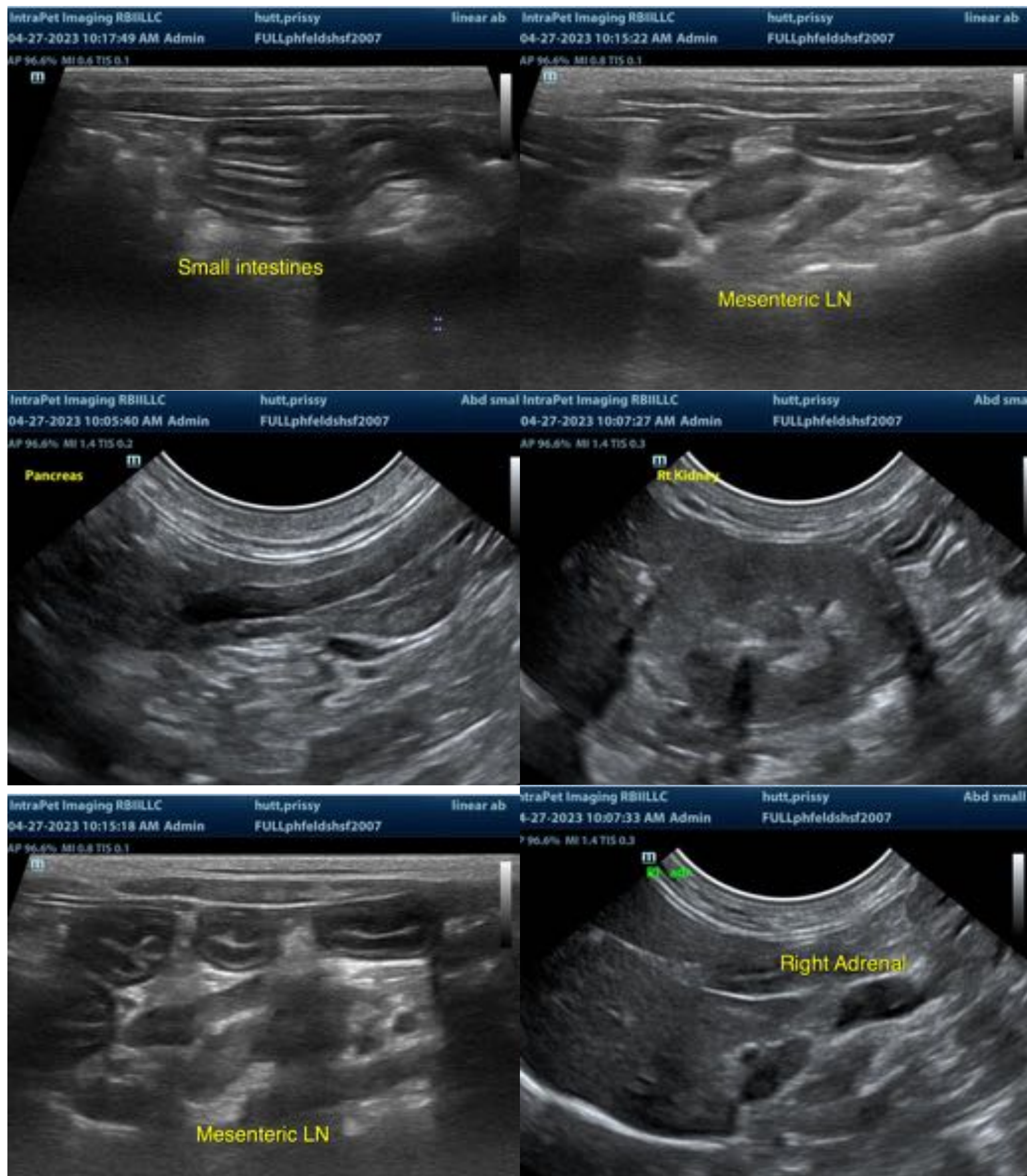
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

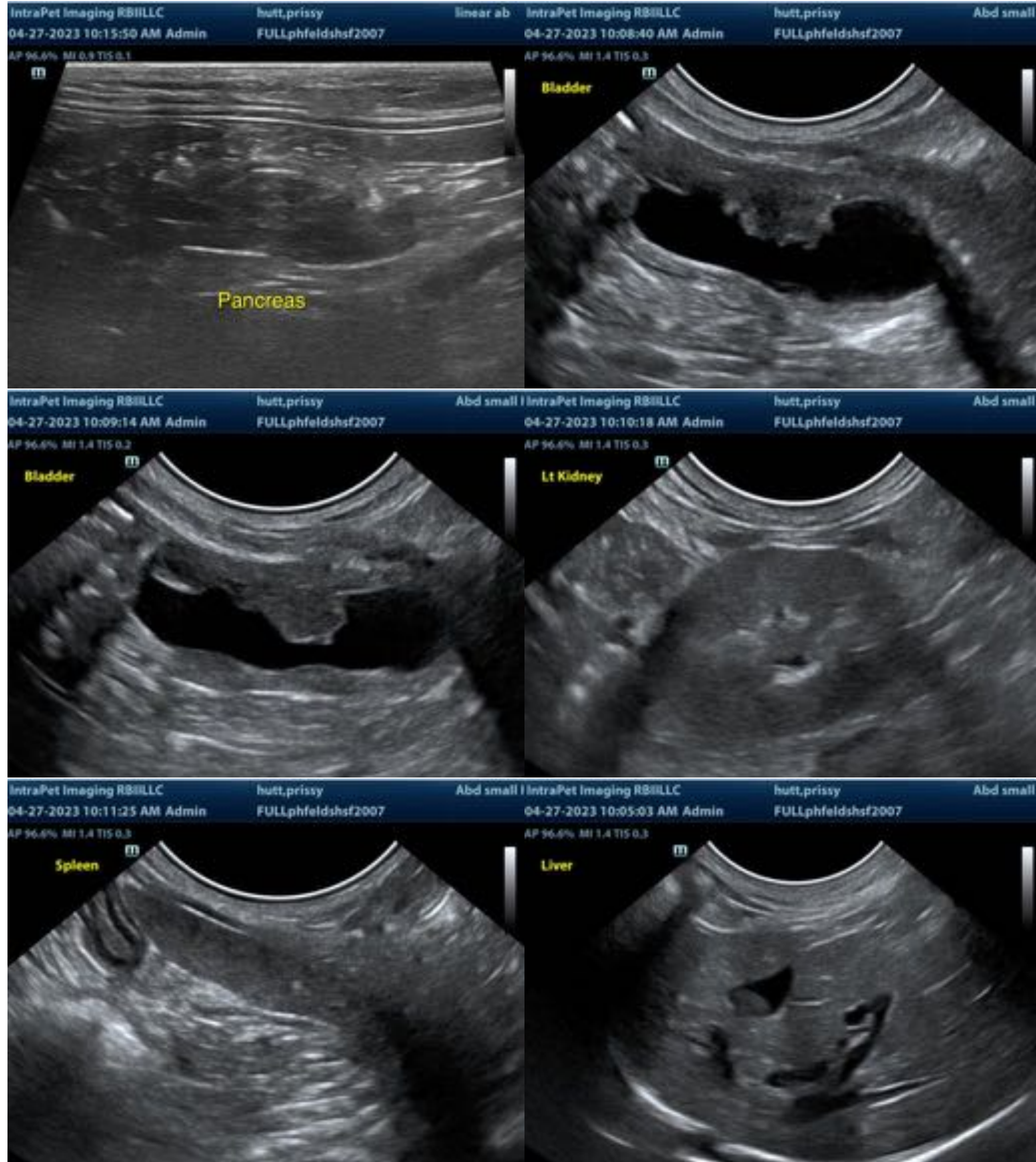
The appearance of the bladder mass is most consistent with transitional cell carcinoma. To diagnosis more definitively, consider urine cytology fine-needle aspiration (with associated risk of seeding the needle tract) or biopsy via cystoscopy. This mass measures approximately 1.00 cm from the trigone of the bladder. Although ultrasound is often under-representative of the extent of urothelial carcinomas, and complete surgical excision is often not possible at the time of surgery, consider consultation with an oncologist for treatment options.

There is also evidence of pancreatitis, which could be acute-on-chronic given the dilation of the pancreatic duct.

The intestines are thick and the muscularis thickening would support a chronic enteropathy, as do the enlarged mesenteric lymph nodes, which are likely reactive. Inflammatory bowel disease vs small cell lymphoma would be suspected based on this ultrasound (the two cannot be distinguished based on ultrasound alone). Consider a GI panel, diet trial/ and endoscopic, or surgical biopsies could be considered for further characterization. Empirical treatment with steroids could also be considered (if not contraindicated in this patient).

Lastly, the change to the kidneys are consistent with significant degeneration of the kidney. Consider ongoing monitoring of renal values as well as a renal diet (if the patient will tolerate this and it is not if not contraindicated in this patient).





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.

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