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Clinical Sonography & Telecytology
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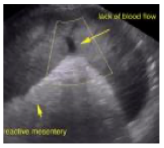
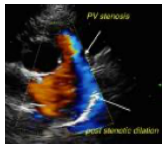
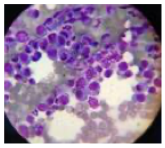
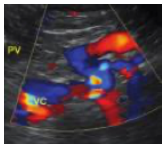





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Thomas Ducceschi

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 years

WEIGHT

10.5 lbs

INTERPRETED BY

Jessica Midence, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Jenny Parrish

HOSPITAL NAME

Local Mobile Vet

REFERRING VET

Jenny Parrish

INVOICE

12891

DATE

4.28.23

PRESENTING CLINICAL SIGNS

History: Weight loss from 13 to 10 lbs over the year, Hx of painful cranial abdomen, Hx of vomiting

Abnormal PE/Chem/CBC/UA Results: K 5.3 (5.2), AST 78 (67), T4 2.4 Monos 1020 (530), Lymphs high normal at 5440 (5850) got urine today if needed

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder mucosa, trigone, and visible urethra are normal in thickness and there is no evidence of mucosal irregularities. The bladder lumen is mildly distended with echogenic urine and bladder thickness is considered normal for volume of urine.

The left kidney is mildly enlarged in size (4.22 cm) and normal in shape and architecture with smooth peripheral margins. There is decreased corticomedullary distinction and normal echogenicity. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is large in size (4.90 cm) with normal shape and architecture with smooth peripheral margins. There is decreased corticomedullary distinction and normal echogenicity. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.35 cm) with a normal shape and is normal in appearance and echogenicity.

The right adrenal gland is normal in size (0.45 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

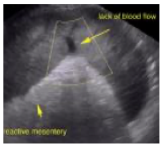
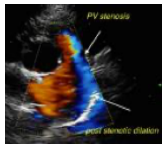
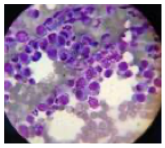
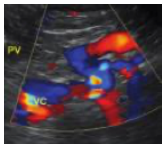
The liver is subjectively normal in size with normal contours, structure, with smooth peripheral margins. The echogenicity appears normal with normal portal markings. No overt evidence of inflammatory, infiltrative or regenerative pathology is evident. The visible portions of the vasculature and biliary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

The gallbladder lumen is mildly distended. There is a small volume of hyperechoic, dependent echogenic sludge, that is somewhat organized. 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 diffusely thickened and abnormal. The duodenum measures thick (0.27 cm) with distinct wall layering. The remainder of the small intestines also measure thick (up to 0.28 cm) and many intestinal loops (though not all) have blurring of layers, and have a diffusely hypoechoic wall. At the ileocecocolic junction, there is a circumferential mass, suspected to be arising from the ileocecocolic junction/cecococolic junction. It is difficult to discern the exact borders and

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the extent of the mass. The mass measures 1.23 cm crossing the lumen. The lumen of the small intestine was mostly empty, though there were several loops of small intestine that were dilated with echogenic fluid. The ileum measures thick (0.47 cm).

The sections of colon are visualized with formed fecal material and gas shadowing distally. The colon at the ileocolic junction is part of the mass described above. The descending colon measures normal (0.17 cm). There is no observed focal or generalized colonic wall thickening or loss of layering, aside from the mass.

Pancreas

The pancreas is hypoechoic with hyperechoic surrounding fat and mesentery. The borders of the pancreas are somewhat irregular and mottled. There is no evidence of nodules or cystic lesions The visible pancreatic duct was normal.

Peritoneum

The ileocecocolic lymph nodes are diffusely enlarged and hypoechoic (the largest measuring 2.00 cm in length / 1.20 cm thick). They are surrounding by hyperechoic fat.

ULTRASONOGRAPHIC FINDINGS

Findings

- Ileocecocolic mass, with associated lymphadenopathy
- Pancreatitis
- Thickened intestines with segmented blurring of layers
- Renomegaly with chronic degenerative renal changes
- Bladder debris
- Gall bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ileocecocolic mass is concerning for lymphoma or adenocarcinoma with concern for metastatic disease lymph nodes, though they could be reactive.

The diffuse thickening of the small intestinal areas that have loss of layering raises suspicion for lymphoma over carcinoma. Other differentials include a gist, mast cell tumor or eosinophilic sclerosing of fibroplasia. The ileum leading up to the mass is thickened and abnormal with a very thick muscularis layer. The mass at the ileocecocolic junction is amenable to fine-needle aspiration. The diffuse changes to the small intestines raise concern for more diffuse disease.

There is also pancreatitis. Consider supportive care with gastric protectants, such as antiemetics, appetite stimulants, rehydration therapy, etc.

There are degenerative changes to the kidneys, though they are enlarged overall. This could be consistent with nephritis of any kind but could also be consistent with emerging round cell neoplasia. There are no other changes to the kidneys to suggest neoplasia, except their size. Consider fine-needle aspirate to evaluate further, as well as a urinalysis and urine culture to evaluate for pyelonephritis.

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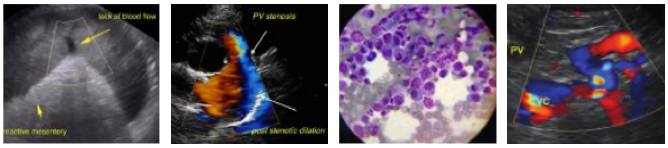

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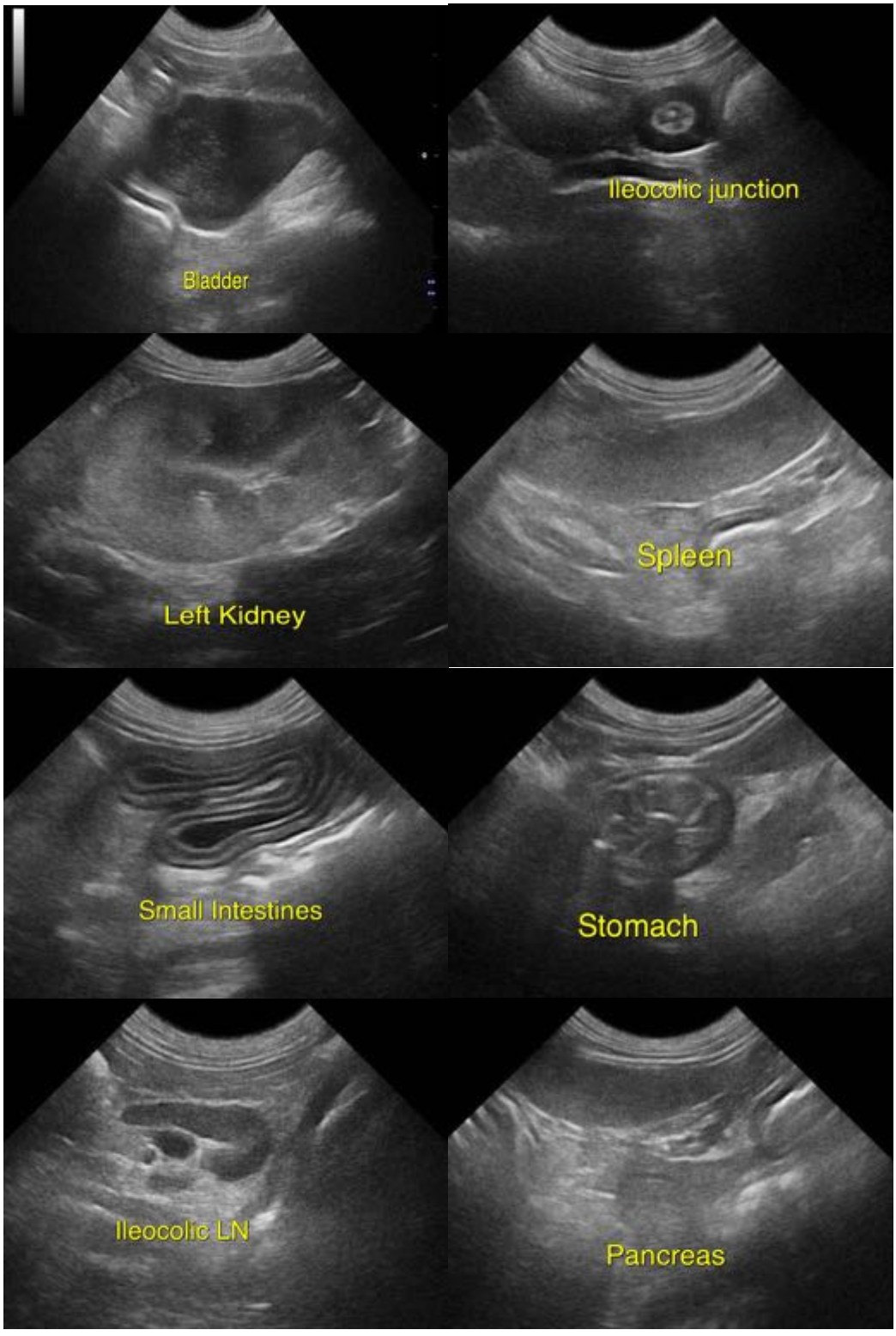

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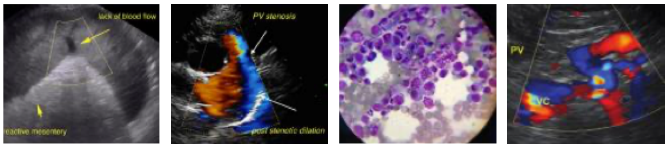

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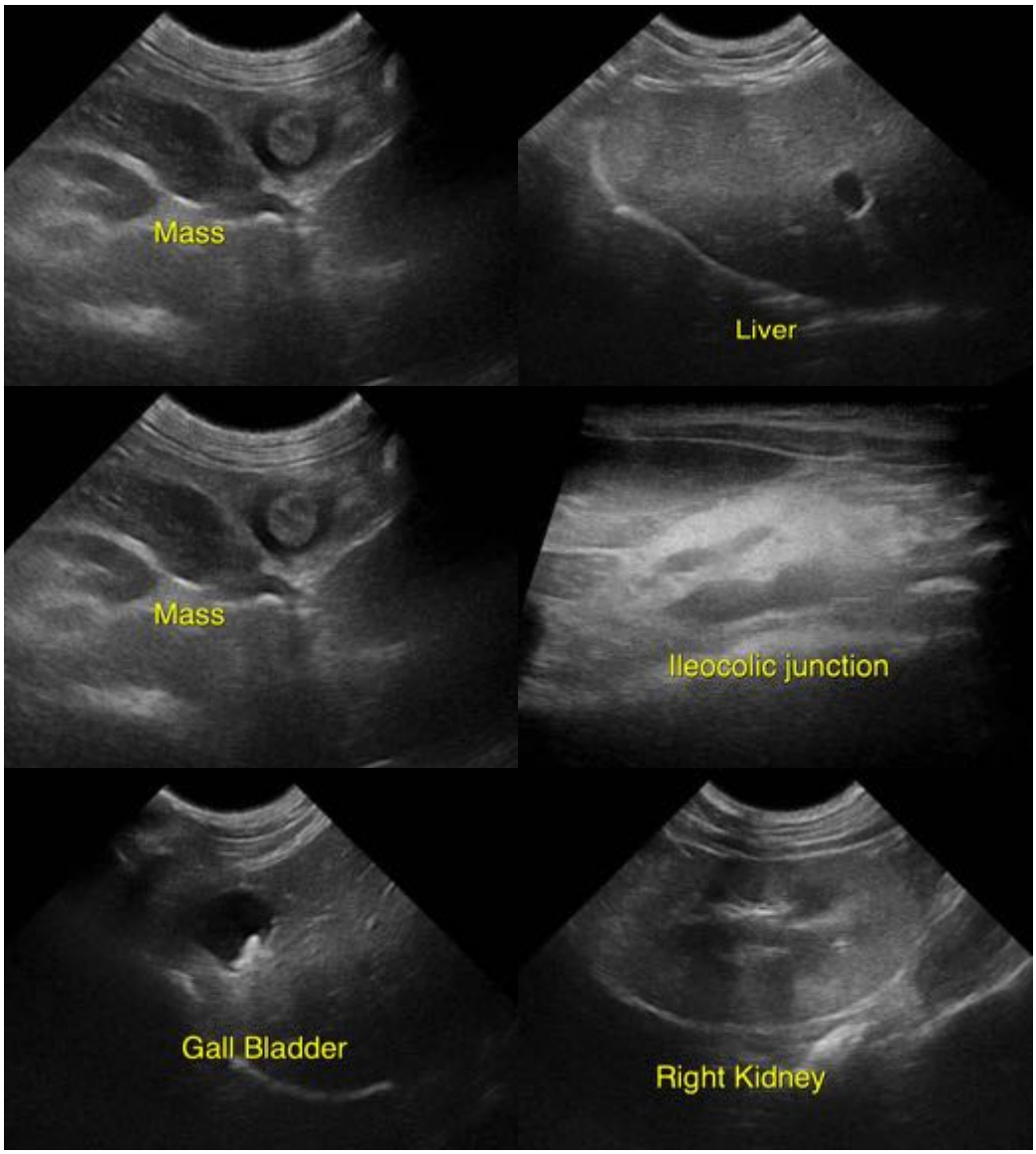

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Jessica Midence, DVM, DACVIM (SAIM)
info@SonoPath.com