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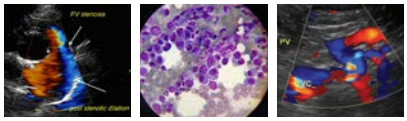

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DATE

10/15/21

PATIENT

Oscar Burrows

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2006

WEIGHT

12 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Fork Vet Hospital

REFERRING VET

Dr. Doherty

INVOICE

26344

PRESENTING CLINICAL SIGNS

History: 10/4/2021: Seen as ADR patient with weight loss, periodic vomiting and decreased appetite. History of pancreatitis but last known episode was 2016. Physical examination: Obvious loss of body condition/ muscle mass with unkempt hair coat and quiet demeanor. Slight URT congestion but no sneezing or nasal discharge. Vague clinical signs.
Current Medications: None currently, However was on Pepcid 2.5 mg BID and Cerenia 16 mg QD.
Lab Results: Blood panel 10/4/21: Slight anemia - HCT 23.5% (29.7-44.5). RBC -5.34 M/ul (5.30-10.6). Chem and T4 _ wnl.
Radiographs: Lg amount of gas throughout the SI tract, some loss of detail in the right cranial quad of the abd. on VD view. Some degree of cardiomegaly previous Echo over 10 years ago NR noted.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not needed.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.63 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.0 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.39 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.35 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is normal/large in size (1.2 cm, normal is <1.0 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm 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 uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measured 0.39 cm. Jejunum wall measured 0.28 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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.

Pancreas

The pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. In the cranial portion of the pancreas near the gastroduodenal junction, there is a large hypoechoic mass effect measuring 2.99 cm x 4.56 cm. This mass lesion is in the region of the pancreas and appears to be touching it. This mass could be of pancreatic origin or could be consistent with the hepatic or gastric lymph node. Prominent pancreatic duct noted at 0.21 cm.

Free Abdomen

No significant free fluid. There is a suspected severe cranial mesenteric lymphadenopathy. There is a previously mentioned hypoechoic mass effect in the cranial abdomen caudal to the liver and ventral to the stomach, measuring 2.99 cm x 4.56 cm. This mass is intimately associated with the pancreas and could be of pancreatic origin or could be an effaced large lymph node. The omentum is of increased echogenicity around the mass effect.

PRIMARY FINDINGS

- Large, hypoechoic cranial abdominal mass – most likely of pancreatic or lymph node origin. Recommend fine needle aspirate.

- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

- Prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

SECONDARY FINDINGS

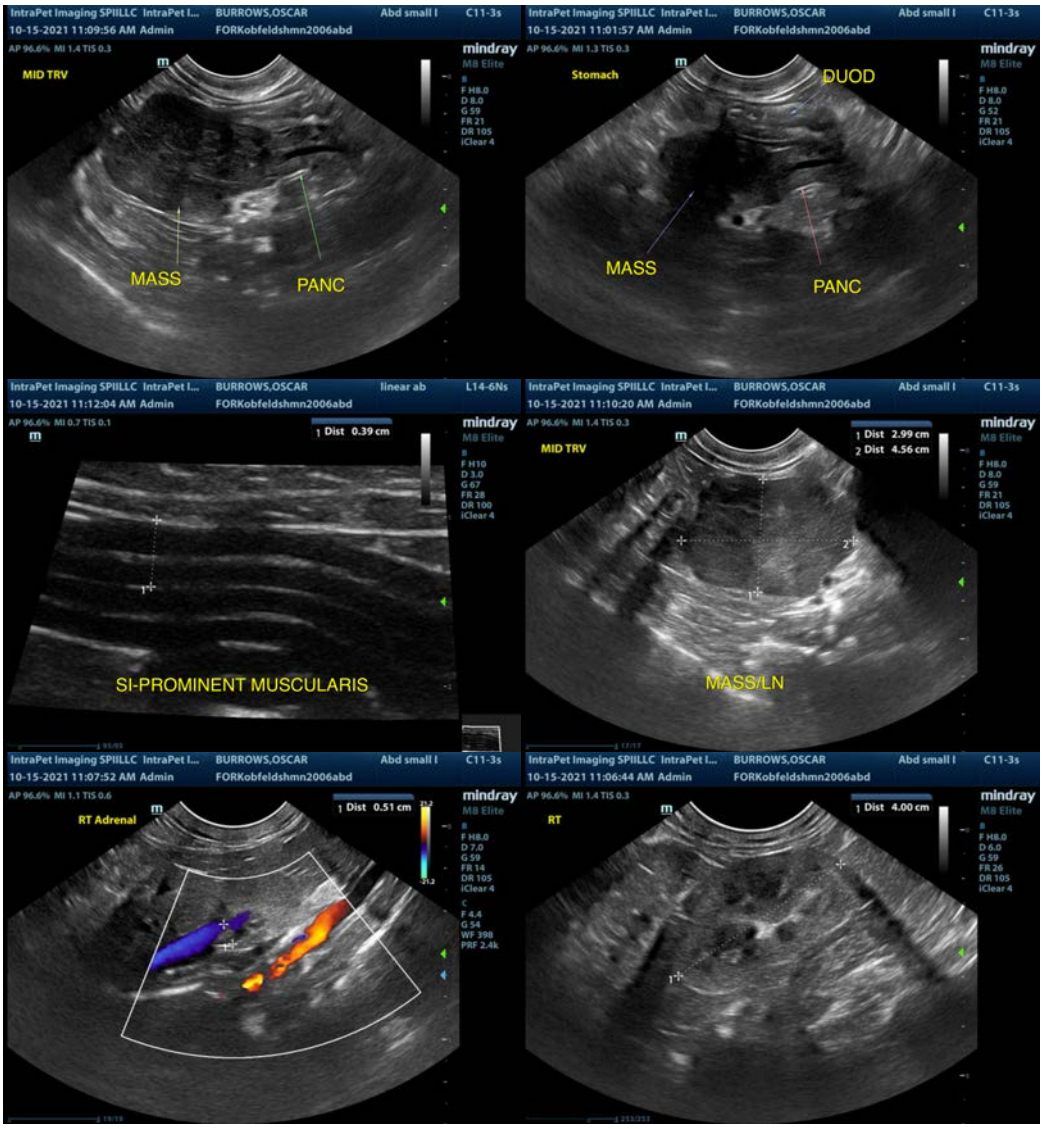
- Decreased corticomedullary distinction both kidneys – The bilateral renal findings are consistent with age-related change.

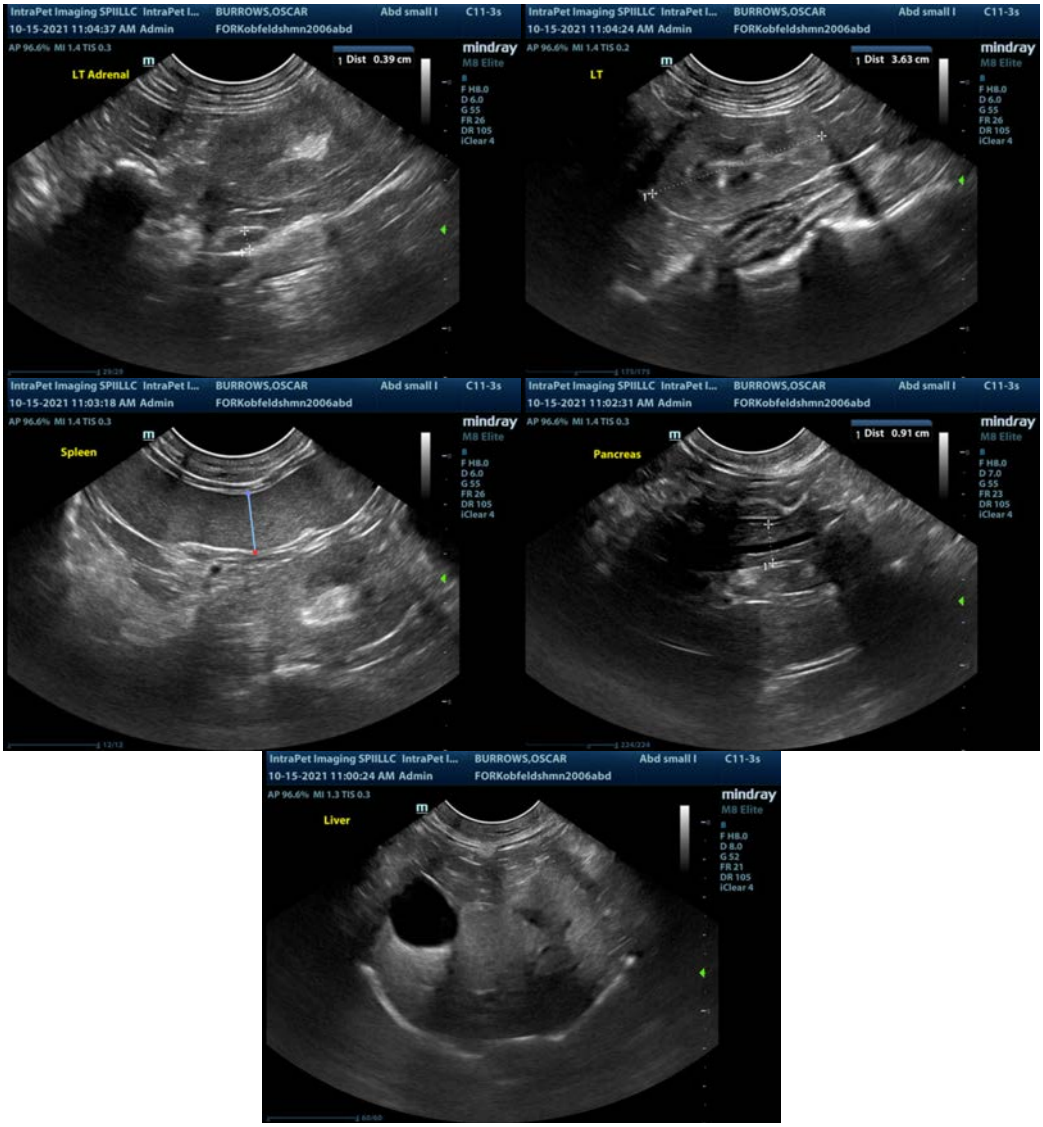
- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis,

extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large cranial abdominal mass effect, which is likely the source of the reported symptoms. I suspect this is either pancreatic in origin or an efface large cranial abdominal lymph node. Recommend a fine needle aspirate with cytology for further evaluation. Recommend 3-view thoracic radiographs and a GI panel to evaluate a quantitative fPLi, TLI, cobalamin and folate.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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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