IMAGING PERFORMED BY

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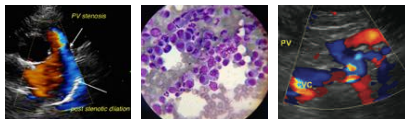

SonoPath
Clinical Sonography & Telecytology
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DATE
10/8/21

PATIENT
Kima Trotman

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Spayed Female

AGE
2016

WEIGHT

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

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Alayon

INVOICE
92276

PRESENTING CLINICAL SIGNS

Vomiting & Drinking Less.
History: Presented for not drinking, vomiting doing that.
Current Medications: Oral Buprenorphine 0.3mg/ml, Sucralfate Susp 1g/10mL
Date of Previous IntraPet Ultrasound: No previous
Sedation: utilized for AUS
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 (3.7 cm). Overall echogenicity is normal with adequate 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 (3.49 cm). Overall echogenicity is normal with adequate 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.34 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 subjectively normal in size, 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 homogenous echotexture. 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 gallbladder 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. The jejunum measured 0.24 cm. Visualized peristalsis appears appropriate.

In the region of ileocecal junction there is a very large, hypoechoic lobular mass effect involving the large and small bowel. This mass measures 6.4 x 4.71 cm and is surrounded by hyperechoic mesentery. The ileocecal junction is visualized and appears effaced by a large, midabdominal mass, which is hypoechoic and multi-lobulated measuring 6.64 x 4.71 cm. The size of the mass obscures visualization of the distal colon.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. The pancreatic duct is prominent at 0.18 cm. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

Free Abdomen

Evaluation of the peritoneal cavity revealed a scant amount of free fluid. There is a mild lymphadenomegaly present with lymph nodes measuring 0.53 cm, 0.29 cm and 0.33 cm as a cluster around the mesenteric root. There was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is generally of increased echogenicity particularly around the large midabdominal mass.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Large, hypoechoic mass effect involving the ileocecal junction. Primary rule out would be round cell neoplasia. Carcinoma would be the second most likely differential.

- Hypoechoic pancreas with prominent duct and surrounding hyperechoic mesentery. The pancreatic changes are most consistent with mild pancreatitis/pancreatic infiltration. I recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider FNA if not improving.

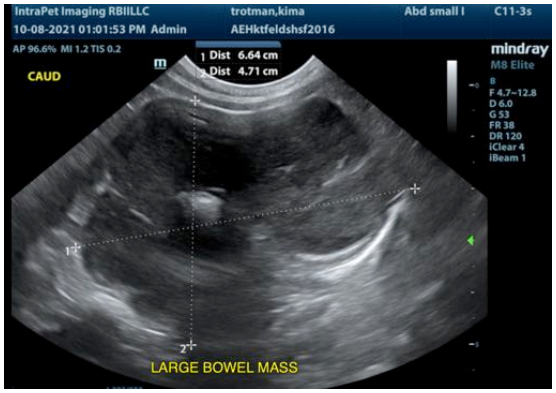
- Mild mesenteric lymphadenopathy. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

SECONDARY FINDINGS:

- Prominent muscularis layer t 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a very large midabdominal mass that appears to be involving both the large and small intestine at the ileocecal junction. I recommend FNA of the mass as round cell neoplasia would be a likely differential. There is concern for complete obstruction. If lymphoma is diagnosed I recommend consultation with a veterinary oncologist regarding chemotherapeutic options. If the FNA is not diagnostic or consistent with carcinoma then consider advanced imaging (CT scan) and referral to a veterinary surgeon to see if there are surgical options to explore. I recommend three view thoracic radiographs.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trotman,kima
Abd small I
C11-3s
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AEHktfeldshsf2016
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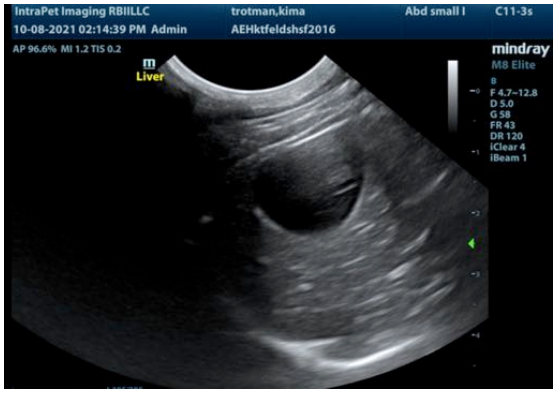
Dist 6.64 cm
Dist 4.71 cm
CAUD
mindray
M8 Elite
LARGE BOWEL MASS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Liver
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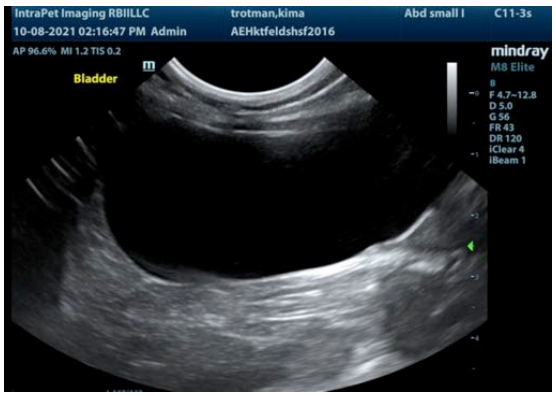
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Bladder
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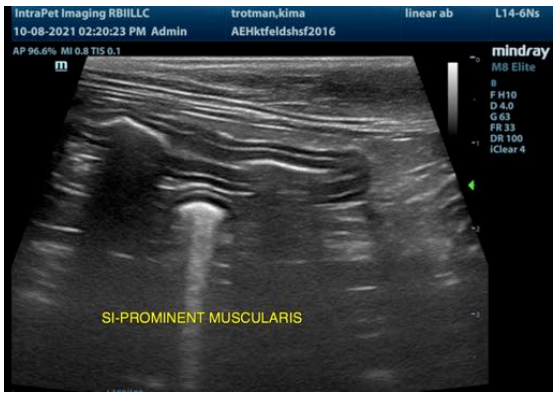
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linear ab
L14-6Ns
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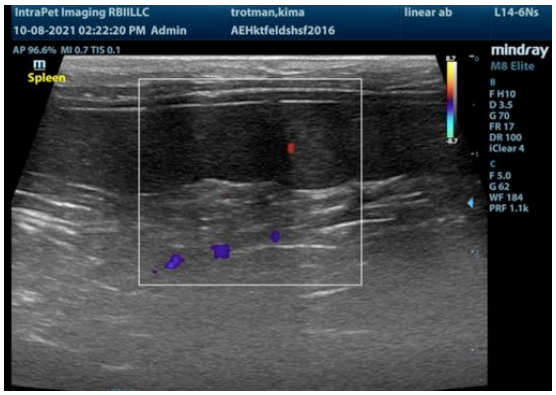
SI-PROMINENT MUSCULARIS
mindray
M8 Elite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linear ab
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Spleen
mindray
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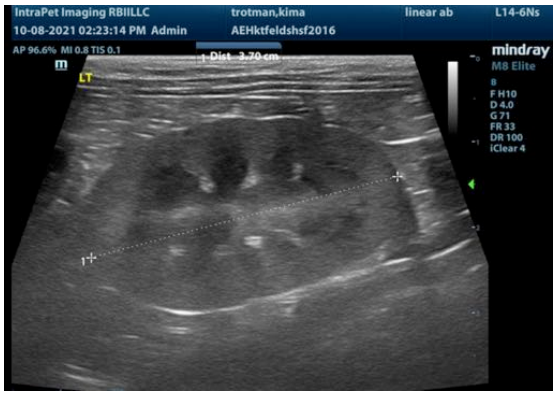
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linear ab
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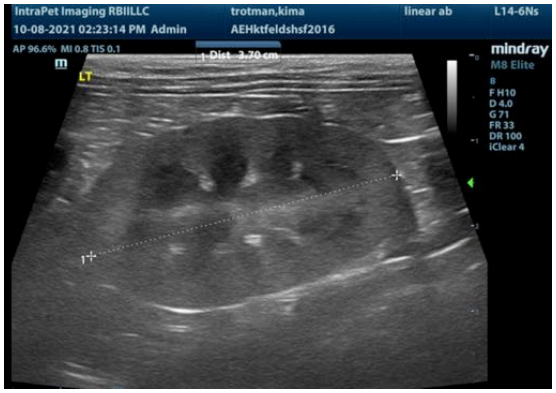
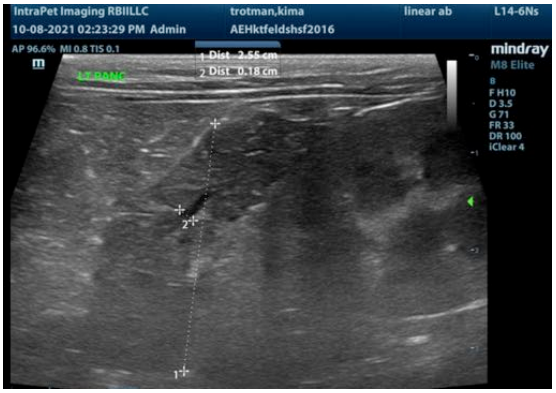
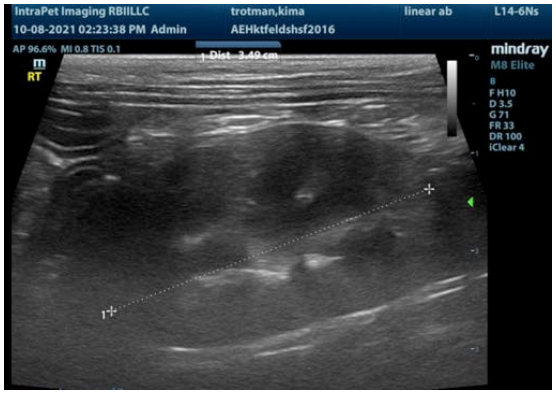
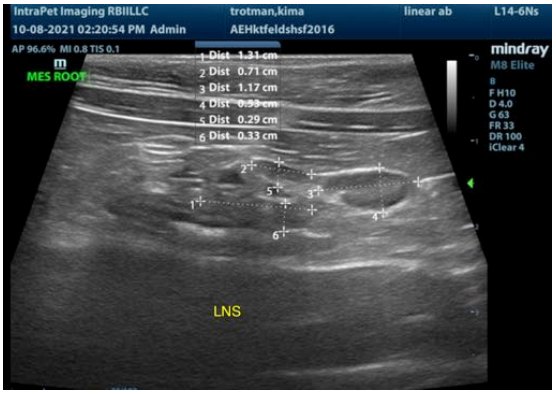
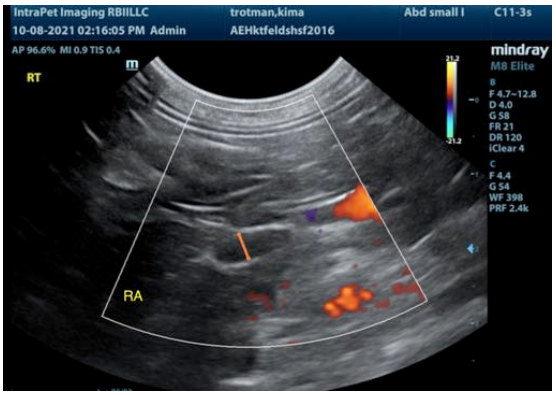
Dist 3.70 cm
LT
mindray
M8 Elite











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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com