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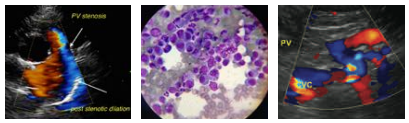

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DATE
11/26/21

PATIENT
Ronin Wynn

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
11/24/10

WEIGHT
9.36 lbs

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

IMAGING PERFORMED BY
Andi Parkinson RDMS

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Roper

INVOICE
94133

PRESENTING CLINICAL SIGNS

1-24-2021 Notes: Patient was fine this morning. Owner came home from work and Patient was laid out and not being able to walk. PE severe dehydration. Appears jaundice today.

Current Medications: Oral Buprenoprhine, Vitamin B, Convenia, Maropitant.
Lab Results: Attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Sedated Tobugesic & Acepromazine.
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 (4.33 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 (4.67 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 left adrenal gland is normal in size measuring XXcm 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. 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 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 gallbladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The bile duct appears tortuous and dilated measuring 0.52 cm distally. No intraluminal obstruction is observed. I suspect pathology at the level of the duodenum is causing an obstruction.

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 duodenum appears severely thickened and irregular with hypoechoic wall with reduced detailed layering. The duodenal wall measures 0.84 cm. Additionally in the caudal abdomen there is a mid jejunal mass that measured 3.78 x 2.63 cm. In cross section this mass effect shows a wall thickness of 0.89 cm.

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 mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity revealed a small, echogenic free fluid. There is no lymphadenopathy. The mesentery is of increased echogenicity around the pancreas and abnormal bowel masses.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Large jejunal mass and focal thickening of the duodenum. This is most consistent with duodenal wall mass. These changes are most consistent with neoplastic lesions, round cell neoplasia or carcinoma would be primary differentials. I recommend FNA.
- Hypoechoic, prominent pancreas with dilated pancreatic duct. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation. While no focal mass lesions are observed this can also be consistent with infiltrative disease.
- Distended gallbladder with large sludge and dilated, tortuous common bile duct. I suspect that there is at least a partial obstruction of the biliary tract due to duodenal pathology.
- Echogenic free fluid in the abdomen. I recommend sampling for fluid analysis, cytology and culture. This can be considered with peritonitis (sterile or bacterial or neoplastic effusion).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large, focal, small bowel mass visualized in addition to a mass effect involving the duodenal wall. I suspect this lesion is causing a secondary biliary obstruction. Surgical resection of both of these areas would be challenging, but if a FNA of the bowel mass can be considered chemotherapy may be effective for round cell neoplasm. If FNA is not diagnostic then consider referral to a veterinary surgeon for exploratory surgery, biopsies and resection of what can be addressed.


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Liver
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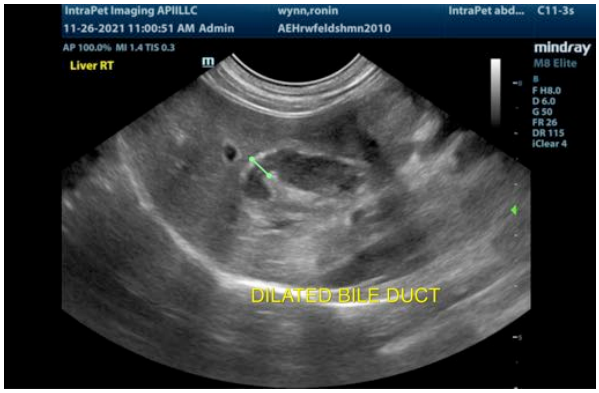

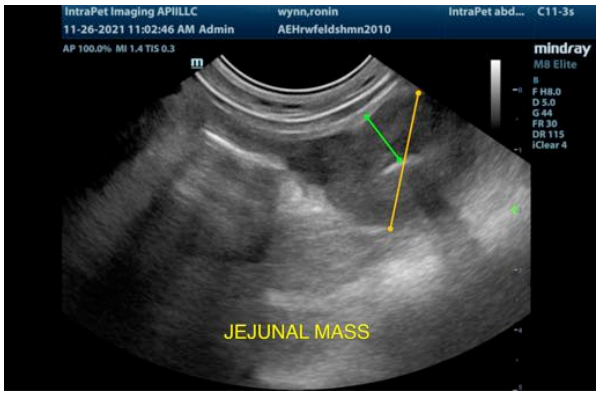

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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