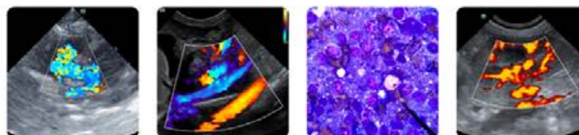


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Mr. GS Biscuits Anderson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10 Years

WEIGHT

6.44 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Judy Schroeder, DVM

HOSPITAL NAME

Animal Health Associates

REFERRING VET

Judy Schroeder, DVM

INVOICE

72906

DATE

2/11/26

PRESENTING CLINICAL SIGNS

Patient being treated for hyperthyroidism, currently 10 mg methimazole BID. Anemia. Weight loss. Chronic diarrhea. Palpable abdominal masses.

Abnormal PE/Chem/CBC/UA Results: Seen yesterday for continued weight loss, respiratory symptoms. Dehydrated, pale MM, palpable thyroid nodule, palpable abdominal masses (firm/irregular), emaciated. Rads showed abdominal effusion, cardiomegaly T4 3.8 ug/dl (on 10 mg bid methimazole) ALT 132 U/l Hematocrit 24%

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 (3.51 cm). The cortex is increased in echogenicity, with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is pyelectasia noted at 0.20 cm. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.79 cm). The cortex is increased in echogenicity, with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 “plump” measuring 0.66 cm at the cranial pole and 0.58 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.

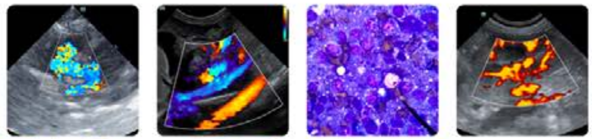
The right adrenal gland is normal in size measuring 0.49 cm at the cranial pole and 0.38 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.75 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 large in size, and normal in 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. There is a poorly defined hyperechoic nodule visualized in the parenchyma measuring 0.99 cm in diameter.



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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The bile duct appears mildly dilated and tortuous, measuring at 0.36 cm. A focal obstruction is not clearly visualized.

Gastrointestinal

The stomach contains mild fluid. 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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.29 cm. Jejunum wall measures 0.29 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. There is a significant amount of hard shadowing fecal material visualized within the colon. The distal colon wall is slightly prominent and irregular, measuring 0.31 cm with intact wall 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

There is a large amount of free abdominal fluid. There are occasional small mesenteric lymph nodes. No large distinct lymph nodes are visualized. The omentum generally has a very mottled, irregular echotexture with slight variations in echogenicity. Some areas appear significantly vascular, possibly consistent with more solid areas(?). There is an overall mottled/mildly nodular appearance to the mesentery and omentum, which is slightly hyperechoic.

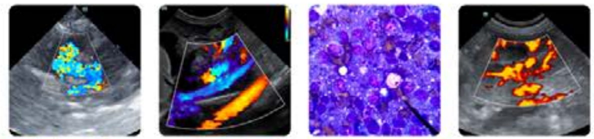
ULTRASONOGRAPHIC FINDINGS

- Hyperechoic kidneys with decreased corticomedullary distinction – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

- Prominent, mottled right and left limbs of the pancreas – Findings are suggestive of chronic pancreatic remodeling. Mild chronic pancreatitis is possible.

- Heterogeneous liver with a hyperechoic nodule – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy. The hyperechoic nodule has somewhat of a benign appearance. Recommend continued monitoring.

- Mildly dilated/tortuous bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).



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- Large volume, mildly echogenic free fluid with a generalized, irregular/patchy/nodular appearance to the omentum/mesentery – Findings could be consistent with peritonitis (sterile versus infectious), scar tissue, a neoplastic process, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No distinct focal mass lesions are observed, although the mesentery has an abnormal patchy/irregular/nodular appearance. Some areas could palpate as firmer. There is a suggestion of generalized inflammation. This could represent an atypical presentation for carcinomatosis, peritonitis, less likely scar tissue, etc. Recommend a fluid analysis and cytology for further evaluation. Additionally, there appears to be hard shadowing stool in the colon, which could be mimicking a mass effect as well.

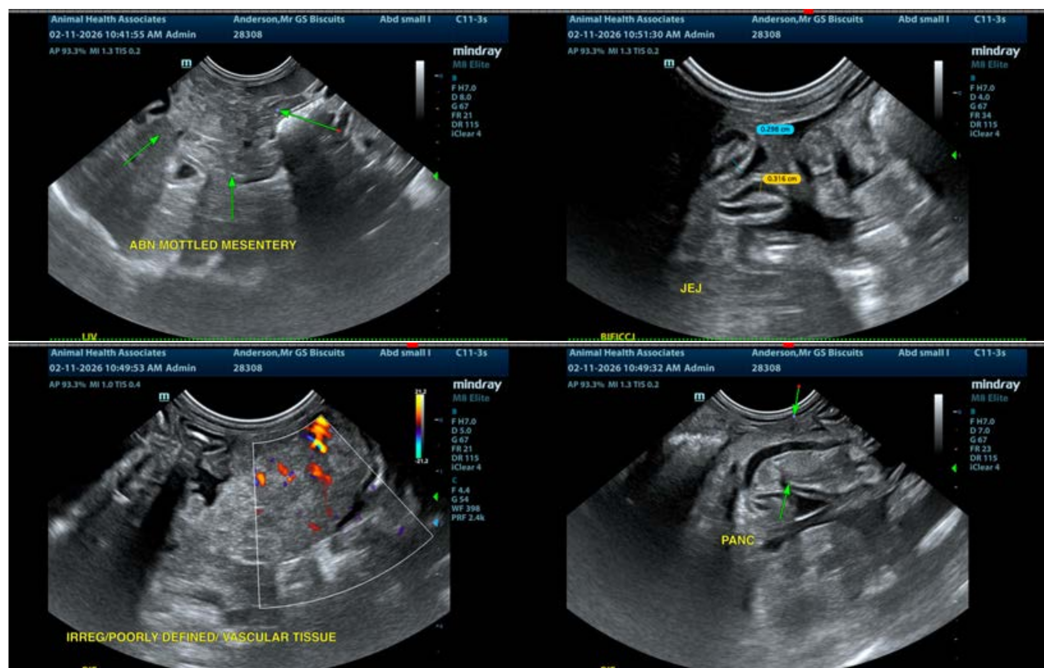
Both limbs of the pancreas are visible and somewhat prominent, although generally have a more uniform appearance than the mesentery itself, suggestive of mild chronic pancreatic remodeling, although mild pancreatitis cannot be ruled out.

Both kidneys have changes consistent with chronic renal disease. Correlate with current lab work, urinalysis and a blood pressure evaluation.

The liver is diffusely heterogeneous. The significance of this is uncertain. Given the ALT elevation reported, a fine needle aspirate could be considered (provided coagulation parameters are normal).

The gallbladder appears normal, but the bile duct is slightly dilated and tortuous. Recommend continued monitoring. A focal obstruction is not visualized at this time.

If symptoms are persistent and cytologic evaluation of the free abdominal fluid, aspirates of the abnormal mesenteric tissue and the liver are not helpful, there is a possibility that surgical biopsies would need to be considered. Prior to this recommend cardiac evaluation and 3-view thoracic radiographs.



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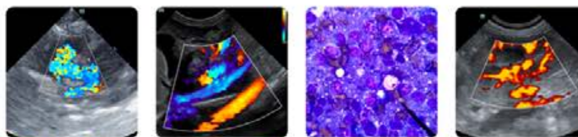

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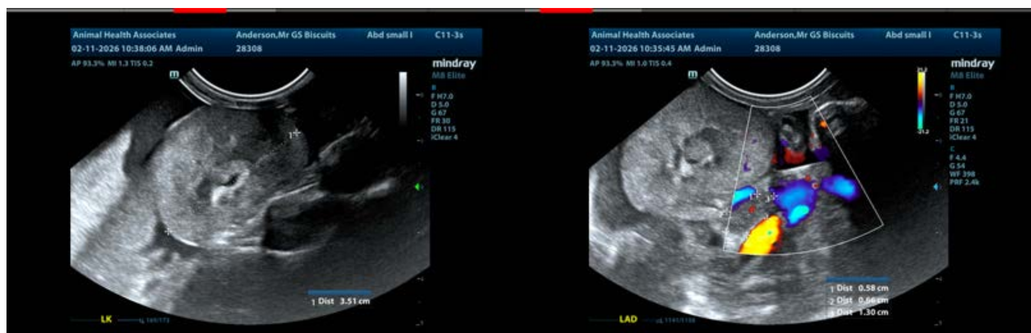

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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