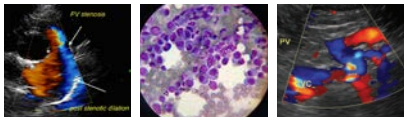
IMAGING PERFORMED BY

IntraPet.com



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DATE

2/16/23

PATIENT

Sosa Gagliardi

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

5/28/13

WEIGHT

11.55 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Banfield Towson

REFERRING VET

Dr. Chadha

INVOICE

45156

PRESENTING CLINICAL SIGNS

Lethargy and weight loss. O states P has lost about 3 pounds in a short time span. O expresses concerns about the previous vet who saw him and was not worried about drastic weight loss.

Current Medications: None.
Lab Results: NSF.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Declined.
Stat Report: STAT requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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 (4.37 cm). Overall echogenicity is normal with adequate 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.

The right kidney has a normal shape and size (4.16 cm). Overall echogenicity is normal with adequate 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

There is a large mixed echogenic mass effect cranial to the left kidney in the region of the left adrenal gland. This lesion is somewhat hypoechoic with mixed echogenicity and surrounding inflammation and scant fluid. This is concerning for a left adrenal mass lesion, and there is concern for possible vascular invasion.

A normal right adrenal gland is not visualized. A mass effect is visualized in the region of the right adrenal, but this likely represents extension of the left adrenal mass into this lesion. The possibility of this being a right adrenal mass does exist, but it appears more consistent with a left adrenal mass.

Spleen

The spleen is large, hypoechoic, and scalloped, measuring 1.0 cm in width at the level of the hilus 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 gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and 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 <0.7cm 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. Jejunum wall measures 0.27 cm. Mucosal fogging is evident in some regions with reduced detail of wall layering. 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. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is a scant amount of free abdominal fluid. A severe mesenteric lymphadenopathy is noted with a mass of lymph nodes visualized at the mesenteric root measuring 5.11 cm x 2.52 cm. Diffuse hypoechoic, large, rounded lymph nodes are noted measuring 1.3, 0.8, 0.7, 0.91 cm, etc. The omentum is diffusely hyperechoic.

Thorax

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

There is ringdown artifact visualized at the level of the diaphragm, indicating likely pulmonary parenchymal disease. Recommend 3-view thoracic radiographs.

There is a moderate to large amount of mildly echogenic fluid visualized in the right cranial thorax, consistent with pleural effusion.

ULTRASONOGRAPHIC FINDINGS

- Large, irregular, hypoechoic and heterogeneous mass effect visualized medial to both kidneys, most consistent with a large left adrenal mass with possible vascular invasion – Differentials include pheochromocytoma, carcinoma, less likely adenoma, etc.

- Large, hypoechoic spleen with scalloped edges – The primary differential would be round cell neoplasia, although congestion, sedation, and other differentials are possible.

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

- Diffusely thickened small intestine with mildly reduced detail of wall layering – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.

- Severe mesenteric lymphadenopathy – The severe mesenteric lymphadenopathy is most concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease (tick born disease-such as bartonella, fungal

infections, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.

- Right-sided pleural effusion with ringdown artifact visualized – Consider sampling for fluid analysis, cytology, and for therapeutic benefits, as well as 3-view thoracic radiographs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a severe diffuse lymphadenopathy present within the abdomen. Recommend a fine needle aspirate of a mesenteric lymph node. Additionally, the spleen appears somewhat hypoechoic and enlarged. This could be consistent with round cell neoplasia. Consider a fine needle aspirate.

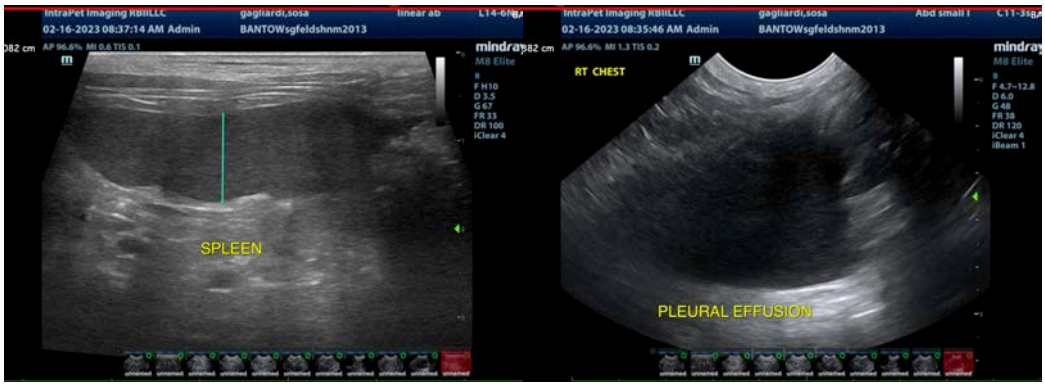
The pancreas is somewhat prominent. This could be consistent with pancreatic inflammation, remodeling, or infiltrative disease.

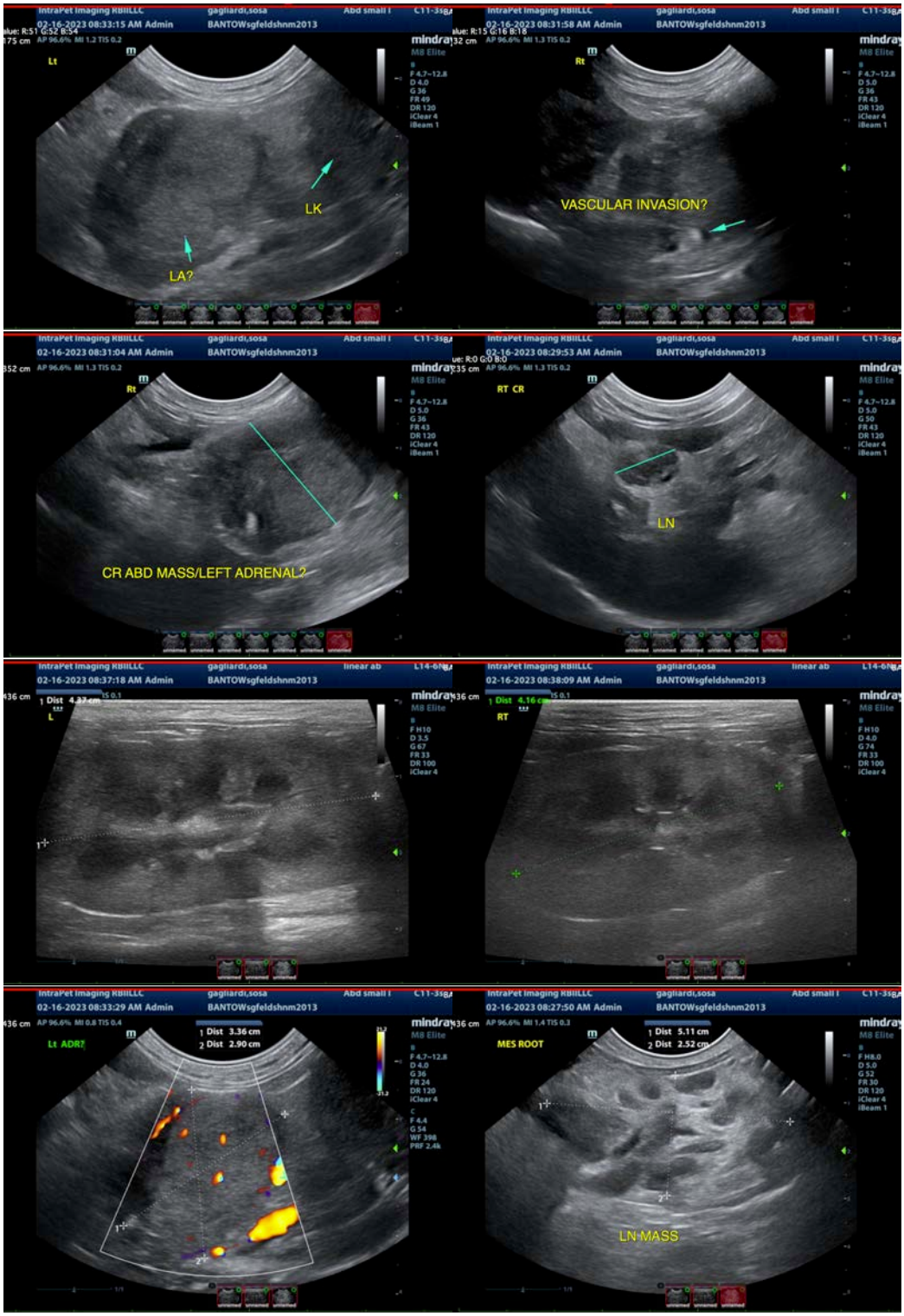
There is a large mass effect visualized medial to both kidneys. This mass appears inflamed and is surrounded by a scant amount of free abdominal fluid. There is impingement on the local vessels and concern for vascular invasion. This mass lesion is most consistent with a left adrenal mass, although a right adrenal mass or other lesion is possible. Recommend a blood pressure evaluation and consider a contrast CT scan if further steps are being pursued. Additionally, a fine needle aspirate of this lesion could be considered as long as this patient is normo-tensive and a small gauge needle is used.

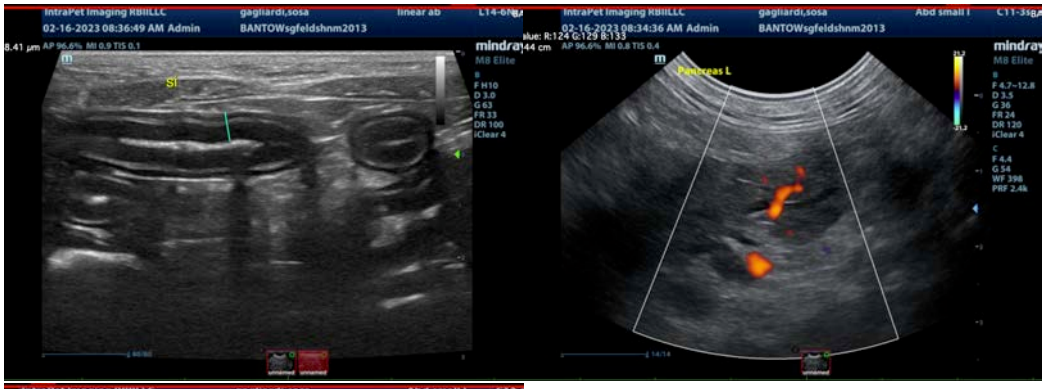
The small bowel appears thickened with reduced detail of wall layering. These findings are most concerning for severe inflammation or neoplastic change.

There is a moderate to large amount of echogenic free fluid visualized within the thorax. Correlate this with the clinical signs of the patient and 3-view thoracic radiographs, as a thoracocentesis may be needed for stabilization and diagnostic purposes.

Unfortunately, the diffuse nature of this disease process and the distribution cranial and caudal to the diaphragm is highly concerning and carries a guarded to poor prognosis.




LK
LA?
VASCULAR INVASION?
CR ABD MASS/LEFT ADRENAL?
RT CR
LN
Lt ADR?
MES ROOT
LN MASS



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.

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