

**DATE**

2/22/22

PRESENTING CLINICAL SIGNS

Presented for sneezing and decreased mobility. On exam mild weight loss, full colon, mid abdominal mass. Plication of SI seen on lateral rad with caudal shift of gastric axis. Bloodwork showed mild elevation of T4. Current Medications: 2/18- Gabapentin 25mg SID, Chlorpheniramine 2mg BID.

PATIENT

Sheeba Edwards

Lab Results: CBC/Chem- unremarkable. T4 3.3, UA- USG 1.030, Prot 1+.

Radiographs: Plication of SI seen on lateral rad with caudal shift of gastric axis.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Rachel Brillhart, RDMS.

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

3/8/06

WEIGHT**INTERPRETED BY**

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

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 (2.98 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. Small, non-obstructive nephroliths were noted. There is no evidence of pyelectasia or hydroureter. There is an irregular, hypoechoic lesion visualized in the cortex of the kidney measuring 0.72 cm. This lesion is most consistent with an acute infarct, but a developing mass lesion cannot be excluded as a possibility. Renal vasculature is normal.

The right kidney has a normal shape and size (3.12 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. Non-obstructive nephroliths were noted. The largest of which measured 0.46 cm. There is no evidence of pyelectasia, 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 0.31 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.

HOSPITAL NAME

Hickory VH

REFERRING VET

Dr. Lyle

Spleen

The spleen is subjectively borderline large in size measuring 0.96 cm in height at the level of the hilus. The spleen echotexture is heterogenous and mottled, 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.

INVOICE

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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. There is a large cystic lesion visualized in the left-side of the liver and measured 3.81 x 2.84 cm. Additionally, there is a hyperechoic, nodule visualized between the left hepatic cyst and gallbladder measuring 1.11 x 0.94 cm. 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 proximal common bile duct is prominent and tortuous, but no obvious obstruction is visualized and there is no bile duct dilation at the level of the duodenal papilla.

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. The jejunum measured 0.27 cm. 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. 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. The pancreatic duct measured 0.23 cm. 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 did not reveal any evidence of effusion. A mesenteric lymph node is visualized and measured 0.41 cm. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Decreased corticomedullary distinction in both kidneys with non-obstructive nephroliths and a hypoechoic lesion visualized in the cortex of the left kidney. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. I recommend to continue monitor the lesion in the left kidney for progression of size, prominence, etc.
- Irregular, mottled spleen. The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Large, left-sided hepatic cysts with hyperechoic nodule. The findings could be consistent with a benign or neoplastic lesion. I recommend to continue to monitor. Sampling will be difficult as it is between the gallbladder and the large hepatic cysts.
- 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:

- Hypoechoic prominent pancreas. The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

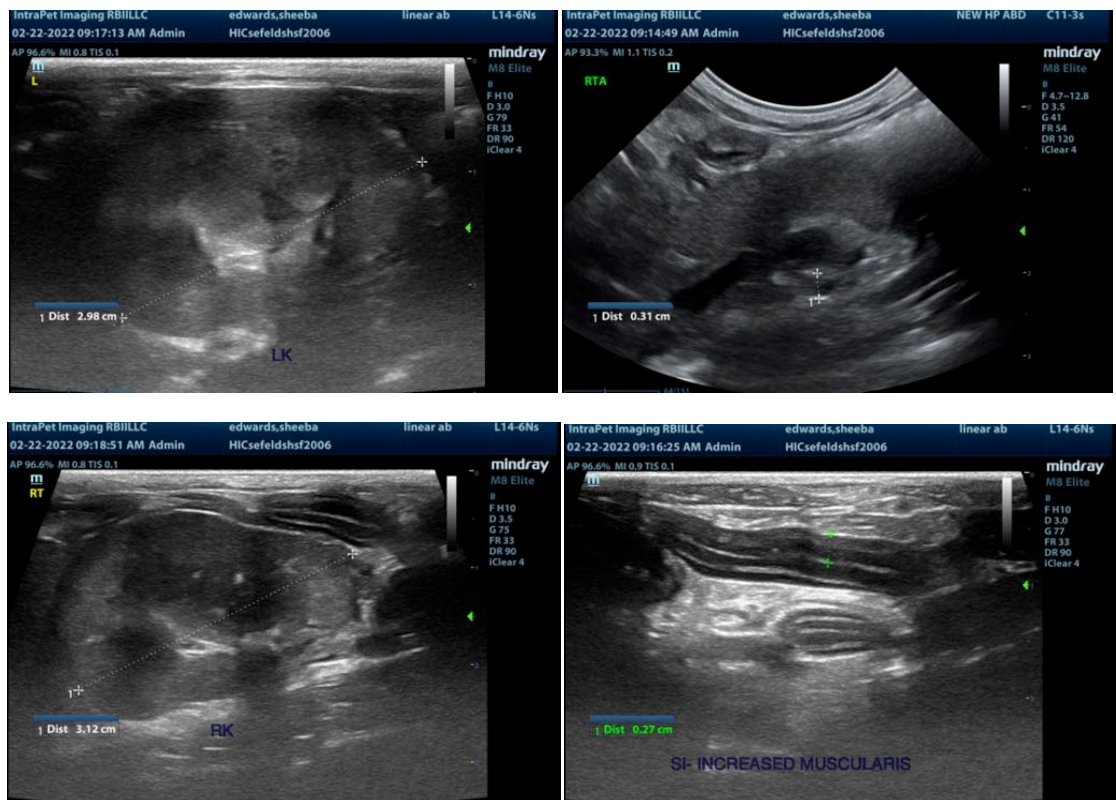
No significant bowel plication was observed and it is possible that the mass effect visualized was the large hepatic cyst? Additionally the spleen is somewhat irregular with no focal lesions. Consider a FNA. The hyperechoic nodule in the liver is in a difficult area to sample. Consider following this lesion with ultrasound. If growth is noted I recommend a CT scan for evaluation of possible surgical removal.

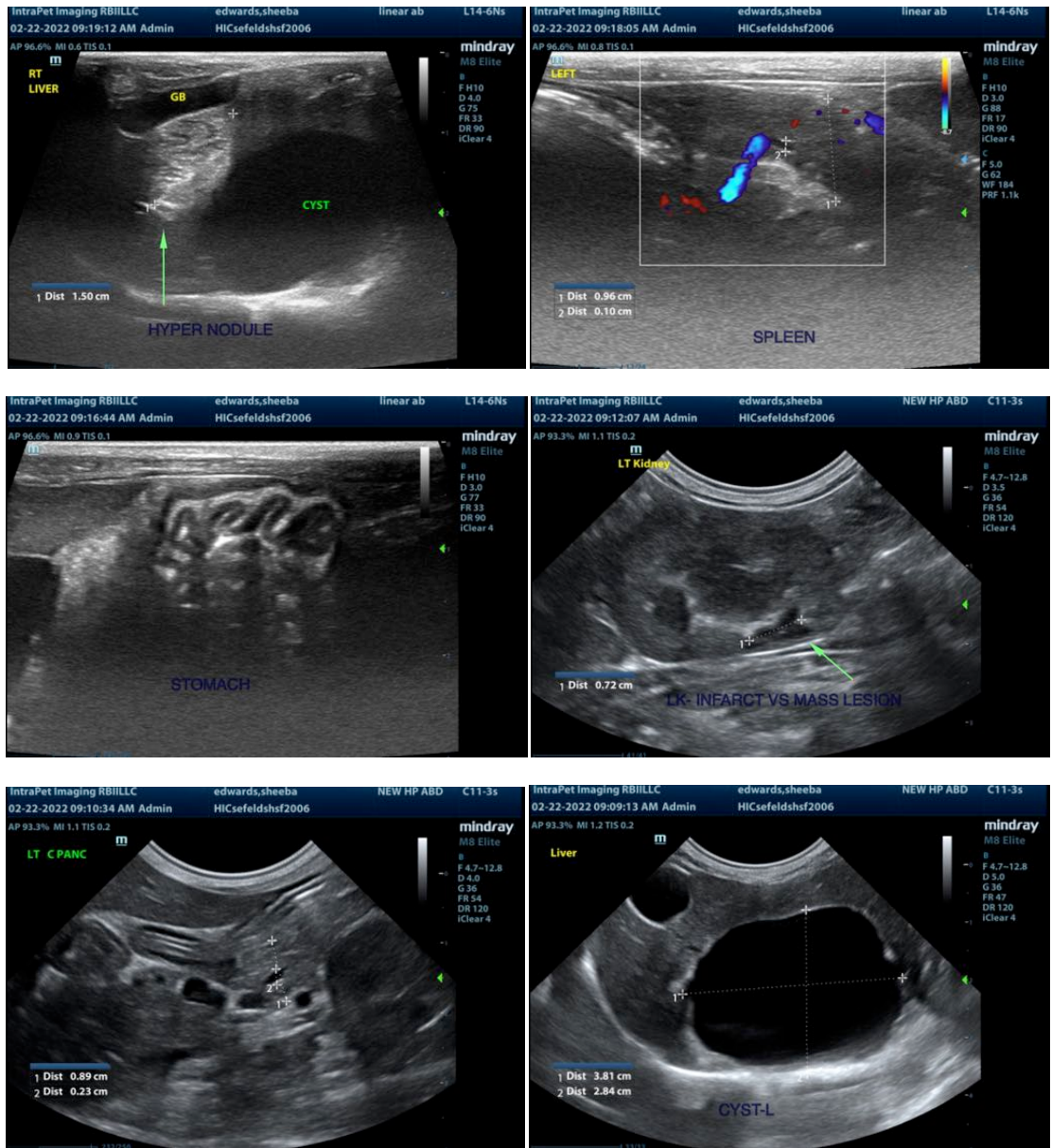
Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

The changes observed in the kidneys are most consistent with progressive chronic age related disease. There is an irregular, hypoechoic lesion in the cortex of the left kidney. This could be consistent with a previous infarct, but I recommend to continue monitoring.

- Recommend blood pressure evaluation.
- Recommend urinalysis and culture.

The muscularis layer of the small intestine is somewhat prominent. This can be a normal finding in older cats. If there is significant weight loss or GI signs then consider a GI panel to Texas A&M to further evaluate for this issue.





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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