SonoPath
Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™
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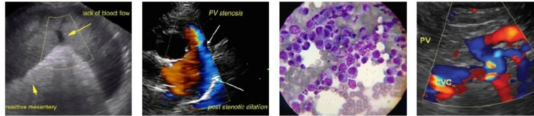

PAWS
Portable Animal Western Sonography, Inc.

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Tristan Hall

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years 9 Months

WEIGHT

9.5 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

VCA Feline AH

REFERRING VET

Dr. Vincent Fleming

INVOICE

35998

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PRESENTING CLINICAL SIGNS

CBC - Unremarkable; Chemistry profile - Unremarkable; Thyroid hormones - T4 3.0; Urinalysis - USG 1.059 protein 1+ else unremarkable ASSESSMENTS Borderline T4, Vomiting, Weight loss

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 (3.62 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 (3.98 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 0.35 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 0.48 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.

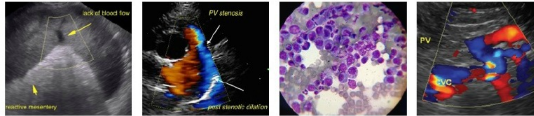
Liver

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 gall bladder 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



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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. Duodenum wall measured 0.25 cm. Jejunum wall measured 0.27 cm. Visualized peristalsis appears appropriate. There is a large focal bowel mass observed measuring >3.42 cm x 2.39 cm. This is most consistent with a primarily mucosal mass with wall thickness measuring 1.58 cm, and severe narrowing of the lumen. Adjacent bowel is persistently thickened, measuring 0.47 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.

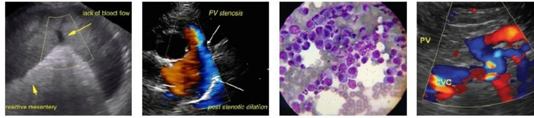
Free Abdomen
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a significant mesenteric lymphadenopathy with a mesenteric lymph node visualized measuring 0.75 cm x 1.29 cm and another measuring 0.56 cm. The omentum is of increased echogenicity around the bowel mass.

ULTRASONOGRAPHIC FINDINGS

- Large area of focally thickened/abnormal bowel – most consistent with a focal bowel mass. This could be a benign or neoplastic lesion.
- Diffusely thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).
- Mottled, prominent pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Moderate mesenteric lymphadenopathy – The moderate mesenteric lymphadenopathy could be concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick borne disease-such as bartonella, fungal infections, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large abdominal mass visualized, which appears to be arising from the small intestine. Recommend a fine needle aspirate of this bowel mass (see images). If you're unable to get a



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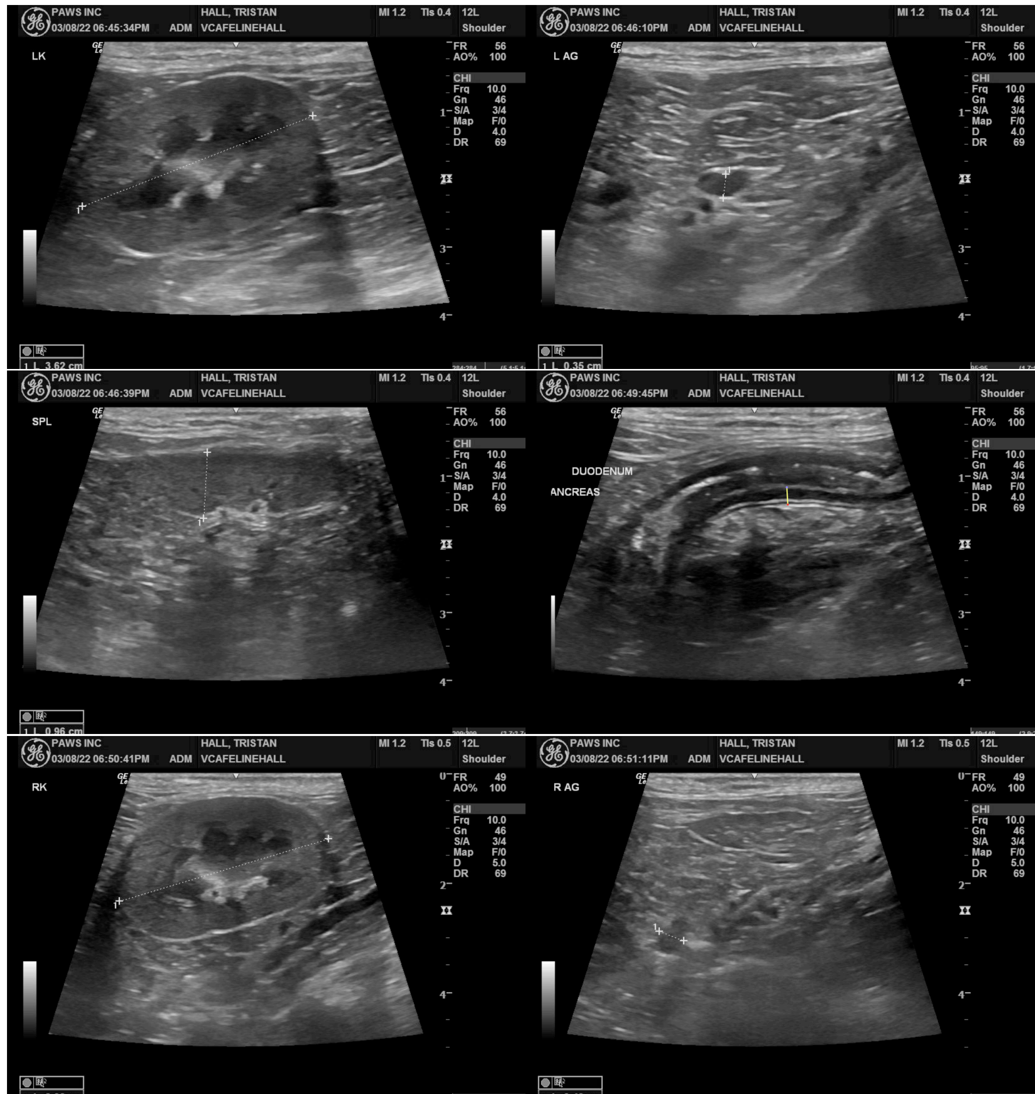
diagnosis this way, you could consider a fine needle aspirate of an enlargement lymph node, or lastly surgical evaluation to both resect the lesion and obtain samples for histopathology. Prior to considering surgery, recommend 3-view thoracic radiographs.



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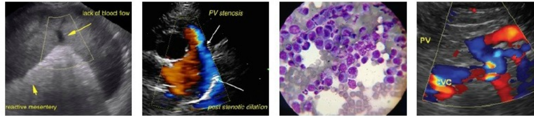

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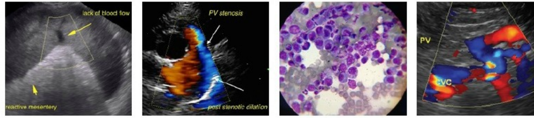

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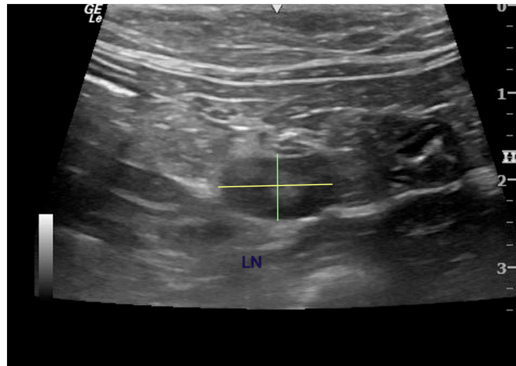

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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