

**DATE PRESENTING CLINICAL SIGNS**

4/5/22 Presented on 3/17 for routine exam and was noted to have 2.9lb weight loss without changing diet or activity, senior bloodwork was performed and showed mild anemia.

**PATIENT**

Lucy Mink Current Medications: None listed.  
Lab Results: 03/17- CBC- RBC (L) 6.64, Hgb (L) 9.2; reticulocytes (H) 113; Chem 27- TP (L) 6.1, T4 2.2, UA to follow, fecal negative.

**SPECIES**

Feline Date of Previous IntraPet Ultrasound: No previous.  
Sedation: Not required to complete full diagnostic ultrasound.  
Stat Report: Not requested.

**BREED**

Siberian

**SEX**

Spayed Female

**AGE**

4/2/10

**WEIGHT**

7 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Andi Parkinson RDMS

**HOSPITAL NAME**

Perry Hall AH

**REFERRING VET**

Dr. Baer

**INVOICE**

36719

**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 (3.12 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 (3.49 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 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 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 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 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. Visualized peristalsis appears appropriate. There is a focal area of small bowel with focal wall thickening and complete loss of layering. In this area, the bowel measures at 0.88 cm in thickness.

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 small amount of free abdominal fluid. There is a significant lymphadenopathy present with mesenteric lymph nodes measuring 1.97 cm x 0.92 cm and 1.78 cm x 0.54 cm. The omentum is of increased echogenicity around the abnormal bowel and the lymph nodes.

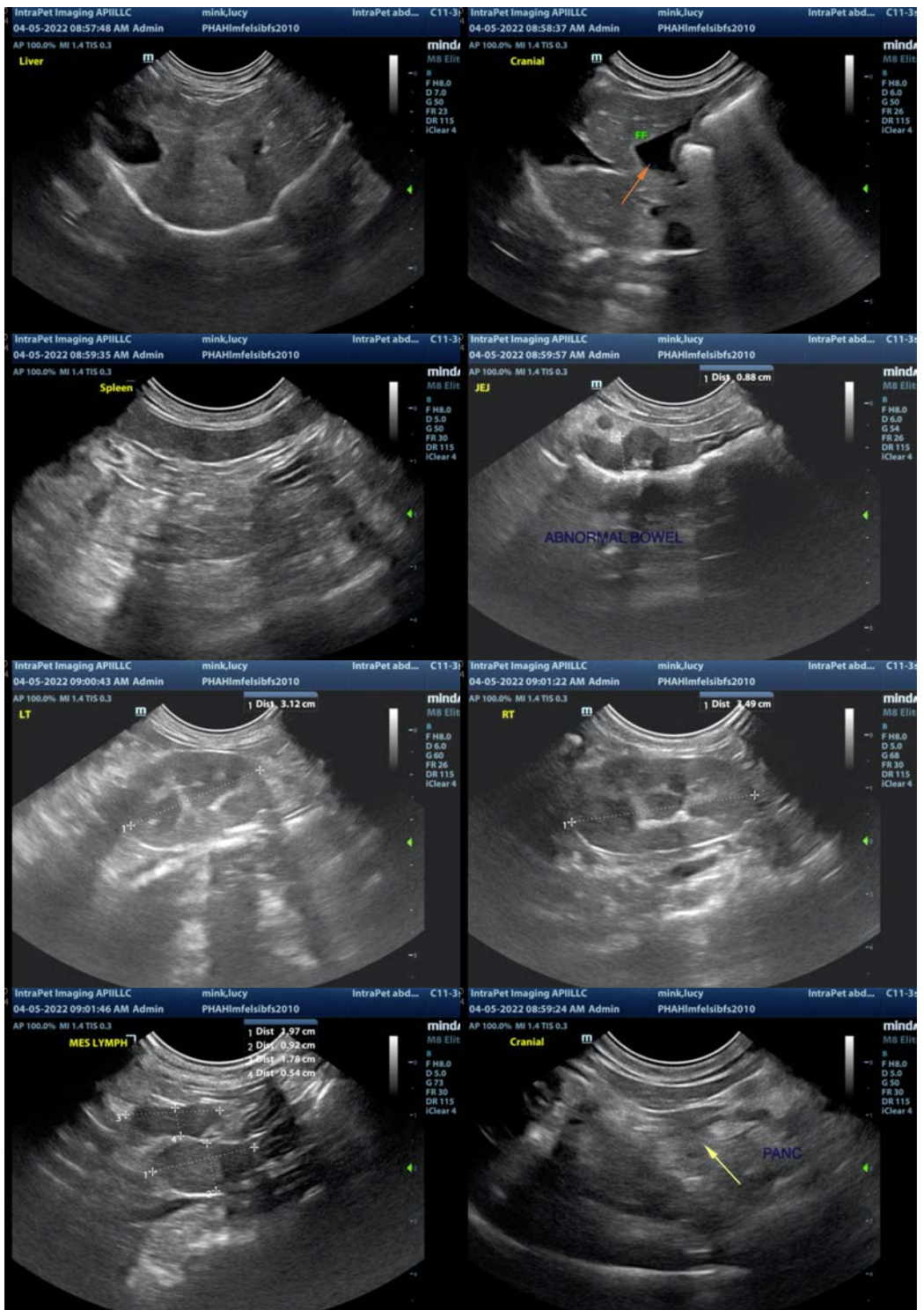
## **ULTRASONOGRAPHIC FINDINGS**

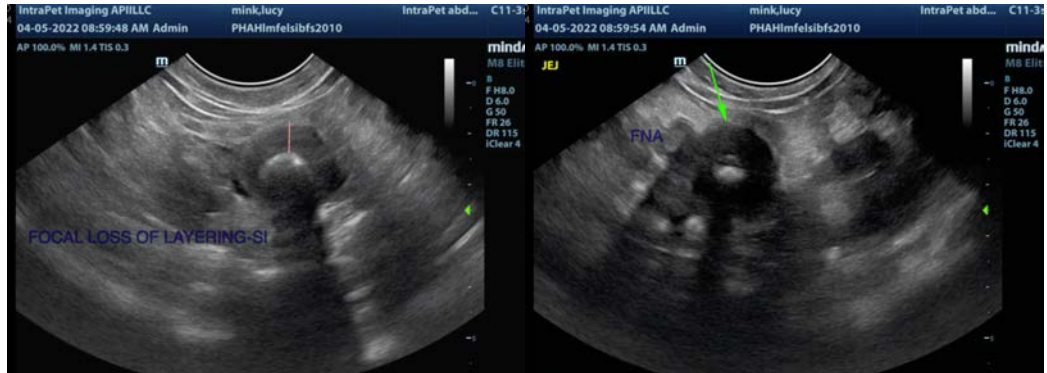
- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Focal area of small intestine with complete loss of layering and wall thickening – Findings are most consistent with a small bowel mass. Differentials include round cell neoplasia, carcinoma, leiomyoma, leiomyosarcoma, etc.
- Small volume free abdominal fluid
- Moderate mesenteric lymphadenopathy – The moderate 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.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There is an area of bowel with severe wall thickening and a complete loss of layering. This area is most consistent with a focal bowel mass. Recommend fine needle aspirate of the intestinal wall and the enlarged mesenteric lymph nodes. If a cytologic diagnosis cannot be obtained based on these aspirates, you could consider sampling the free abdominal fluid or obtaining surgical biopsies.

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





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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