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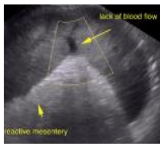
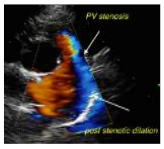
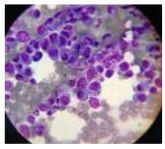
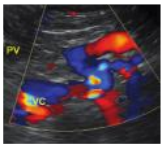





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Mickey Lawrence

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9/2003

WEIGHT

6.68 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging Michigan

REFERRING VET

Cat Care of Rochester Hills

INVOICE

15142

DATE

5/12/22

PRESENTING CLINICAL SIGNS

History: Vomiting, decreased appetite, weight loss

Abnormal PE/Chem/CBC/UA Results:Treating UTI (urine culture came back negative), chronic pancreatitis (However recent fPL was 2.7 wnl), controlled hyperthyroid, chronic renal insufficiency

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. Most of 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. There is a focal section of bladder wall which appears thickened and slightly mineralized, creating a possible mass effect, measuring 0.78 cm x 0.64 cm. The findings could be consistent with focal inflammation or a neoplastic process.

The left 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. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal. Pinpoint nonobstructive nephroliths were present.

The right kidney has a normal shape and size (3.36 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. 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 0.32 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.

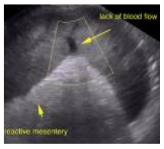
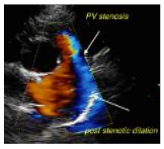
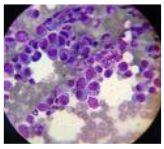
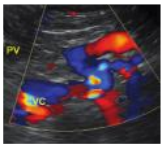
The right adrenal gland is normal in size measuring 0.37 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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 large in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. There are numerous lesions within the hepatic parenchyma. There are ill-defined subtle hypoechoic nodules throughout the parenchyma in addition to a focal discreet hypoechoic nodule, measuring 0.47 cm. There are numerous cystic lesions of variable size, the largest is a slightly mixed echogenicity mass effect towards the ventral aspect of the liver, measuring 3.35 cm x 3.28 cm. This mass lesion is largely cystic, comprised of a cyst, measuring approximately 2.3 cm x 2.86 cm. Additionally, there is a smaller cystic lesion, measuring 1.57 cm and a very small cyst, measuring 0.64 cm at the periphery.

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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 primarily anechoic. The bile duct appears tortuous and mildly dilated, measuring at 0.45 cm.

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. The jejunum measured 0.23 mm in diameter. 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 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, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Focal irregularity in the urinary bladder wall. This could represent an inflammatory or neoplastic process. History states a negative culture was performed. I recommend reevaluation of this lesion with a more distended urinary bladder. If it is persistent, then consider a traumatic catheterization for cytology.
- Large hyperechoic liver with hypoechoic nodules and a large cystic mass lesion.
- Subjectively thickened small intestine with prominent muscularis layer. 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

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

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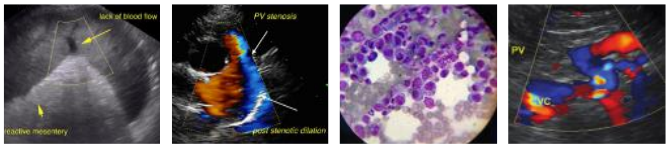

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- Tortuous prominent bile duct. Dilation of the common bile duct could be consistent with a functional obstruction (i.e., primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith,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

- Mildly reduced corticomedullary distinction. The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a focal area of thickening within the urinary bladder wall, which is concerning. There is minimal distention of the urinary bladder on today's exam, which makes evaluation challenging. I recommend finishing the treatment for the urinary tract infection mentioned in the history and reevaluation of the urinary bladder with more urine distention. If this lesions persists, I recommend a traumatic catheterization with cytology to look for evidence of a transitional cell carcinoma.

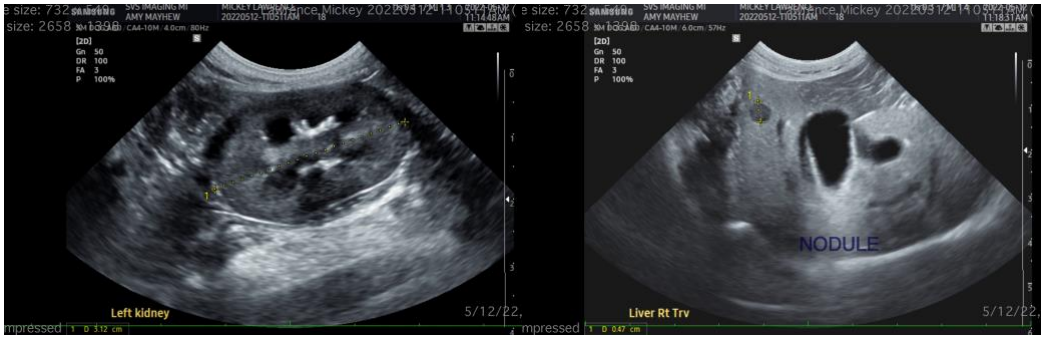
The changes observed in the kidneys are consistent with chronic age-related renal disease. I recommend blood pressure, urinalysis and culture.

The liver is large and hyperechoic and has numerous hypoechoic nodules, as well as cystic lesions and a mass lesion, which is largely cystic. Consider a fine needle aspirate of the liver and of a hypoechoic lesion if reachable. Sampling of the cystic mass lesion will be challenging, as it is primarily a fluid filled cyst. If cytology is not helpful, I suspect a contract CT scan would need to be performed to evaluate possible surgical options.

I recommend continued monitoring of the gallbladder and bile duct for progressive dilation. I suspect this is an incidental finding.

There is mild small intestinal thickening, some of which could be consistent with age-related change. If signs of primary gastrointestinal disease are present, you could consider a GI panel (to Texas A & M) for a qualitative fPLI, TLI, cobalamin and folate, to further evaluate the pancreas and small intestine.

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



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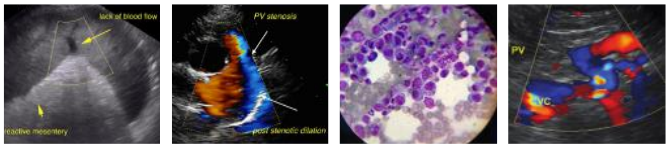

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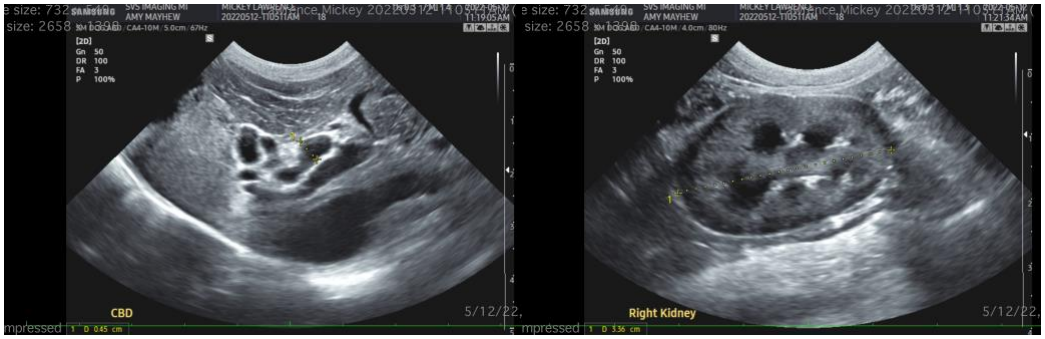

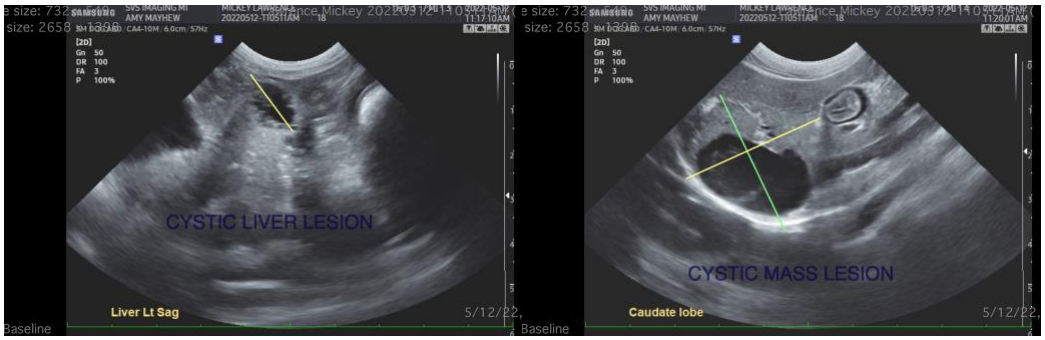

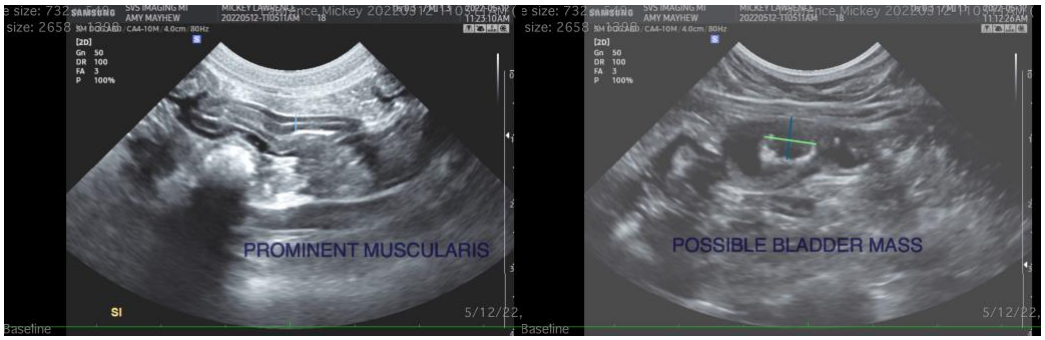

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com