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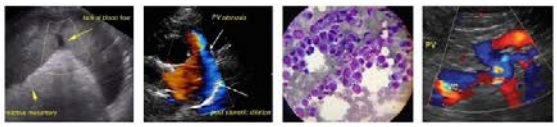


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Tobe Bullem

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 Years

WEIGHT

4.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Governors Road AH

REFERRING VET

Dr. Farooq

INVOICE

43210

DATE

6/15/23

PRESENTING CLINICAL SIGNS

BAR, 210 HR, 30 RR, heart/lungs normal, pink/moist mm, CRT<2sec, normal hydration/abdominal palpation, no obvious organomegaly/abnormality or pain upon palpation, normal E/E/N/oral cavity, normal LN/coat/gait etc. m2-3 dental tartar/plaque buildup. Limited oral exam since grumbly/nervous. Temp: 37.8 Blood Glucose: 20.6mmol/L Current Medications Insulin

Abnormal PE/Chem/CBC/UA Results: CBC: Platlets 650 Chemistry: Glucose 18.25, Urea (BUN) 14.2, Lipase 1518 Urinalysis: 3+ Glucosuria, 2+ hematuria, RBC 6/HPF, WBC <1/HPF please see attached rads.

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 (4.53 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 (4.47 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

The left adrenal gland is normal in size measuring 0.53 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.

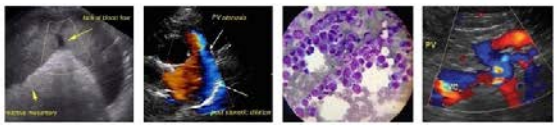
The right adrenal gland is normal in size measuring 0.36 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.86 cm), 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 large and irregular. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. There appears to be an ill-defined hyperechoic mass effect in the right cranial abdomen, which is suspected to be arising from the liver, measuring >3.73 cm x 3.92 cm. A pancreatic mass lesion cannot be excluded as a possibility but seems unlikely. Additionally, there is a hypoechoic lesion measuring 0.93 cm in the cranial abdomen. I suspect this is within the hyperechoic mass effect, but a hypoechoic pancreatic lesion (nodule, abscess, etc.) cannot be ruled out.



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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 moderate fluid and ingesta. 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. There is a moderate amount of focal soft and hard shadowing material visualized within the gastric lumen. This could represent ingested foreign material, hair, etc.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with mild to moderate fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.30 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. Much of the small intestine appears normal with no significant fluid dilation, but there are some areas that have intraluminal shadowing material with no evidence of a definitive obstructive pattern.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. There is a large amount of gas obscuring further evaluation of the distal colon. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery, particularly in the left limb. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis. There is a hyperechoic mass effect in the right cranial abdomen that I suspect is hepatic origin, but a pancreatic lesion cannot be ruled out.

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 hyperechoic in the cranial abdomen around the pancreas and the hyperechoic mass effect.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled left limb of the pancreas with a prominent pancreatic duct and mild surrounding inflammation – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Ill-defined hyperechioic mass effect in the right cranial abdomen – The appearance of this lesion is most consistent with a large hyperechoic hepatic mass lesion. Other differentials would include a pancreatic mass (adenoma, carcinoma, etc.).
- Focal shadowing material visualized within the gastric lumen – Correlate with feeding history and abdominal radiographs. This could represent ingested foreign material, hair, etc.
- Areas of fluid and shadowing material visualized within the small intestine – This could be consistent with ingesta and gas. A definitive obstruction is not observed, but this could represent ingested foreign material passing.

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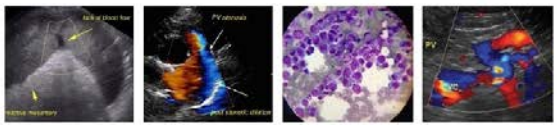

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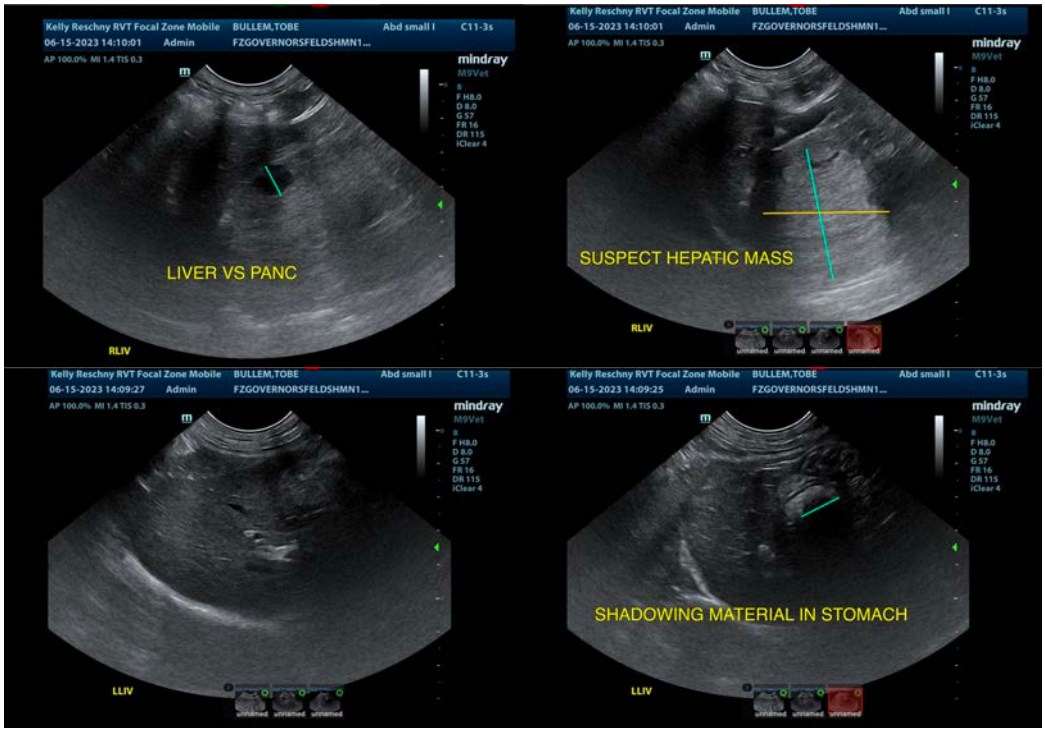
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

It is not clear what the cause for today's ultrasound is. This patient appears to be diabetic, but it is not clear if this is a new diabetic, patient has GI signs, etc. Based on the ultrasonographic findings, I'd be concerned for mild pancreatitis. Additionally, there is a hyperechoic ill-defined mass effect in the cranial abdomen, which I suspect is hepatic in origin, but I cannot rule out a pancreatic lesion. There appears to be hypoechoic shadowing material visualized within the gastric lumen. If this patient wasn't fasted, this could be ingested, etc. If this patient is sick, not eating, vomiting, etc., this could represent ingested foreign material, hair, etc.

Additionally, there is some shadowing material visualized within the small bowel, which could be consistent with ingesta, passing foreign material, etc. If there is concern that this patient has pancreatitis or a foreign body, consider medical management with fluids, pain medications, nausea medications, etc., and IV fluids, with serial imaging (radiographs +/- ultrasound) to look for progression/improvement. If the patient is not improving, consider repeat imaging. Additionally, you could consider a contrast CT ccan to further evaluate the hyperechoic mass effect in the right cranial abdomen. A fine needle aspirate could be considered of this area.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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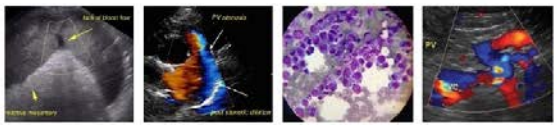

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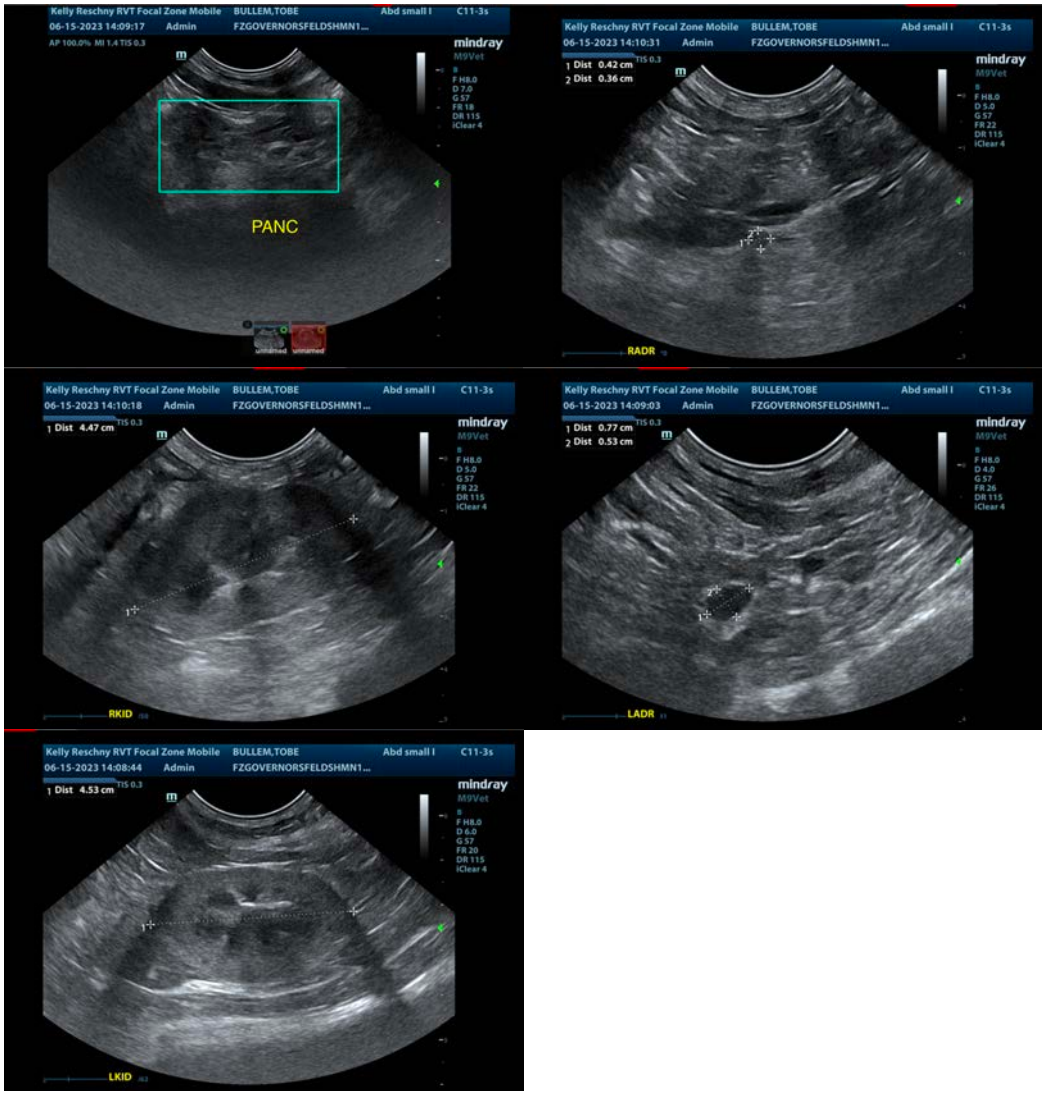

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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