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Clinical Sonography & Telecytology
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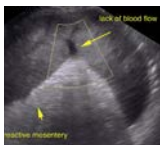
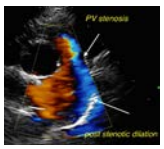
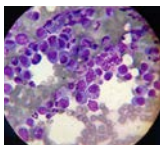
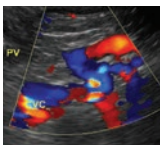

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1-800-838-4268 info@sonopath.com

PATIENT

Ginny Lightfoot

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

17 Years

WEIGHT

10.52 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Haley Harasimowicz

HOSPITAL NAME

Waterbury Vet Hospital

REFERRING VET

Dr. Emily Crawford

INVOICE

39729

DATE

7/21/22

PRESENTING CLINICAL SIGNS

Cat presents for 24 hours of acute onset inappetence, repeated vomiting of bile. Does not normally vomit. Indoor only, no new food or known dietary indiscretion. History of dilute urine (vy early renal insufficiency?) and high normal thyroid level on labwork done 3/22 elsewhere, had planned to recheck this summer.

Abnormal PE/Chem/CBC/UA Results: PE today: 2 # wt loss since last exam in March (at another clinic). Cat is afebrile, hyd wnl, very quiet intermittent heart murmur, normal rate and rhythm. Abd feels doughy, no apparent masses, not painful. Mkd AD ear infection. Labwork today: mild SDMA elevation 17, no azotemia, abnormal fPL, CBC wnl, T4 wnl. UA: USG of 1.013, no protein quiet sediment, No cytsalline debris noted Cat is hospitalized for supportive care. Abd rads: (read by radiologist) Mild hepatomegaly is accompanied by rounded caudoventral margins; the smooth convex shape of the ventral liver margin may represent the GB contour (patient anorexia). Renal sizes are slightly asymmetric (R>L) and small normal; renal shapes are normal. The stomach is empty except for a small amount of intraluminal gas; the gastric wall is uniformly thickened (~ 0.9-1.0 cm). The small and large intestines are uniformly empty. Peritoneal and retroperitoneal serosal detail are normal.

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 (3.5 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 (4.1 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 0.26 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.

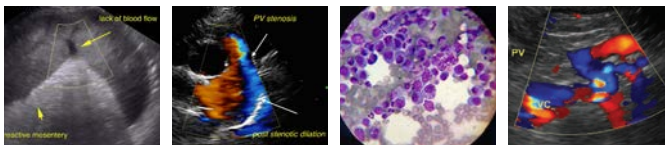
The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.71 cm in width at the level of the hilus), 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



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normal. There is a very large cystic lesion visualized within the hepatic parenchyma measuring approximately 4.49 cm in diameter. Findings are most consistent with a benign hepatic cyst.

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 0.37cm 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 relatively uniform diameter with minimal 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 measured 0.22 cm. Jejunum wall measured 0.21 cm. 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 a focal heterogeneous mass effect in the region of the pancreas measuring approximately 1.55 cm in diameter. This lesion appears partially cystic with what appears to be non-vascular echogenic fluid (hypoechoic tissue cannot 100% be excluded). Findings are suspicious for a cystic pancreatic mass. Additionally, an abscess or an overlying cystic lymph node could be possible.

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

- Prominent, mottled pancreas with focal cystic mass effect – this could represent a pancreatic cyst, abscess, tumor, or possibly even an overlying cystic lymph node. Recommend fine needle aspirate.
- Large cystic lesion in the liver – most consistent with a benign hepatic cyst.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a cystic lesion visualized medial to the spleen in the region of the pancreas. This lesion does not color flow, and appears most consistent with a cystic lesion with echogenic fluid within. This could be seen associated with a pancreatic cyst, abscess, or mass effect. Consider a fine needle aspirate of this lesion. Additionally, consider drainage of the fluid with cytology and fluid analysis. Recommend a GI panel for Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to reevaluate the PLI level and to look for evidence of concurrent small intestinal disease. Recommend aggressive treatment for pancreatitis while awaiting cytology results. If drainage cannot be attained, or a cytologic sample cannot be obtained, you could consider aggressive treatment with close monitoring, but if this lesion does not resolve, surgical intervention may be necessary.

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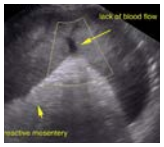
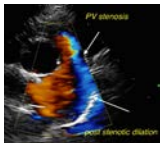
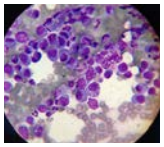
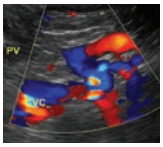

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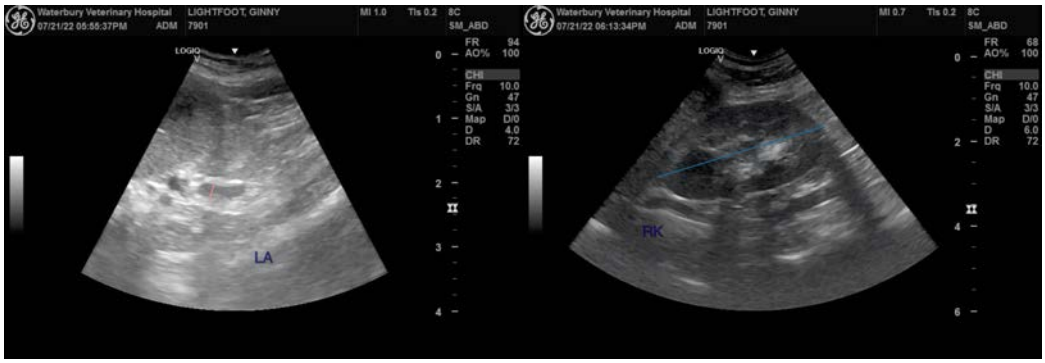
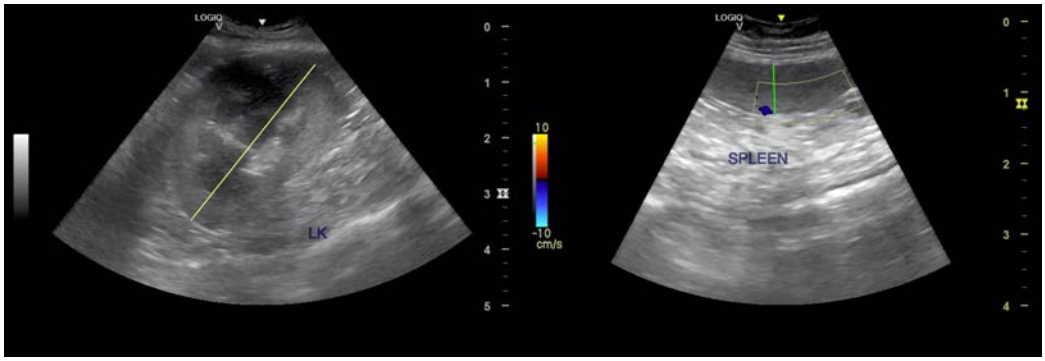
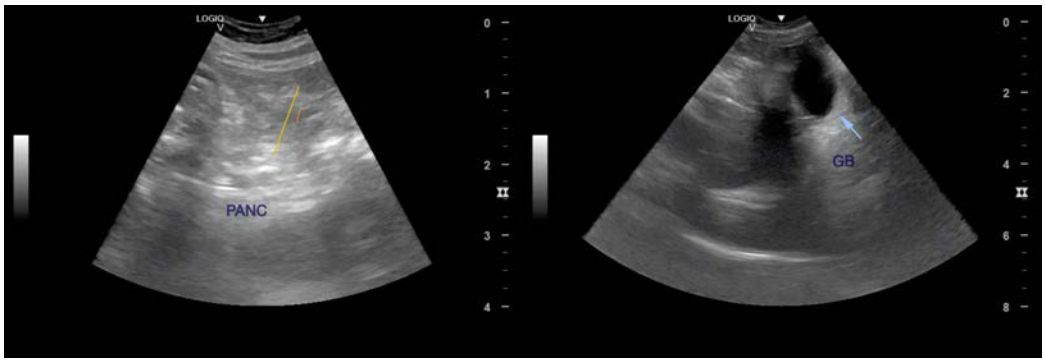
Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

Additionally, there is a large hepatic cyst present. These are typically benign lesions, but if they get very large, they can start to cause discomfort, etc. It is difficult to say if this is causing any symptoms, but this has likely been present for a long time. You can consider drainage. However, in my experience, these tend to refill relatively rapidly. Alternately, you could consider a contrast CT scan to further evaluate the cyst and the mass effect, and possible surgical intervention.

The visualized portions of stomach appear relatively normal with normal gastric wall.







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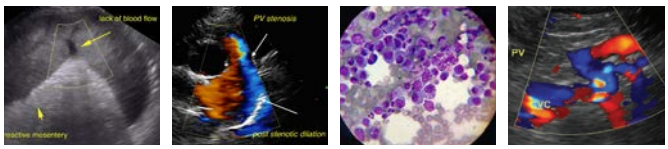

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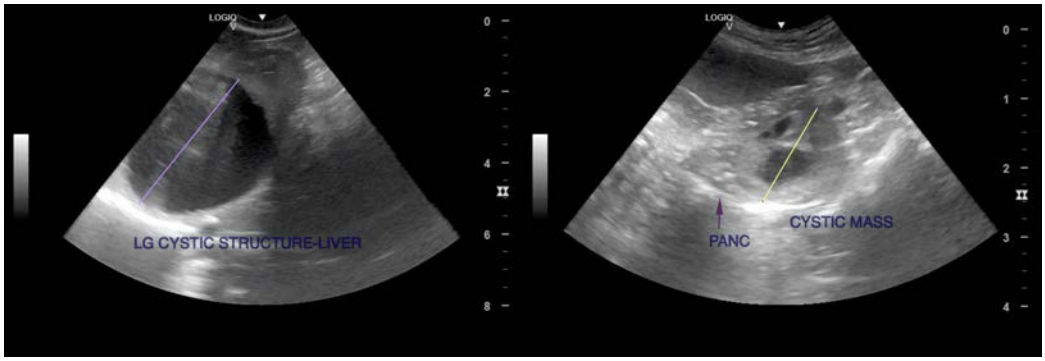

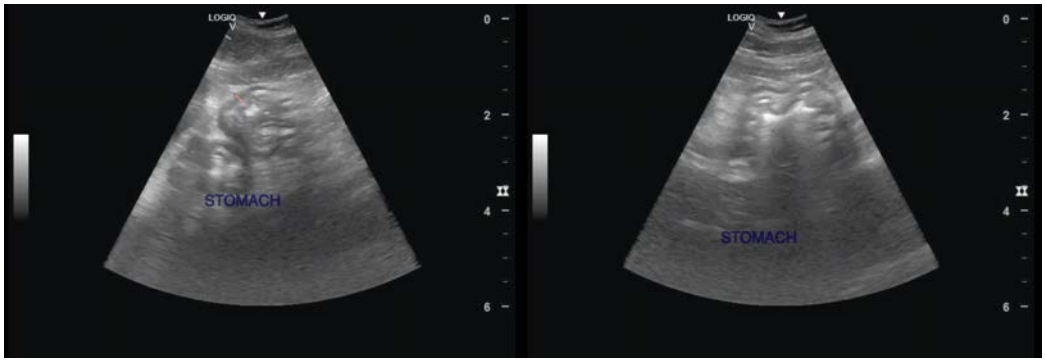

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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