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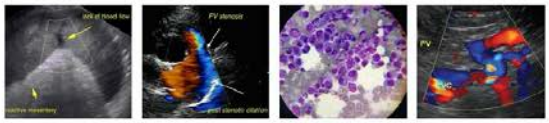


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Lucky Charms Wallace

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years

WEIGHT

8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Advanced Pet Care of Nevada

REFERRING VET

Dr. Alexis Hazelwood

INVOICE

24592

DATE

8/11/21

PRESENTING CLINICAL SIGNS

Lucky Charms started showing mild lethargy and decreased appetite in April, following tooth root abscess in February. Showed mild azotemia on labwork. Dental pursued in May. Azotemia stable after. Starting in June, he stopped eating/ate very little, has lost a large amount of weight and was vomiting. He was presented to ER clinic on July 7 th for anorexia, dehydration, and vomiting.. Ultrasound was recommended at the time. P is no longer vomiting recently per O, but is not eating still. They believe he is drinking, but he is rather private. Physical Exam Findings/Reason for Ultrasound: Weight loss, anorexia, previously vomiting, suspected/potential gastric mass (per ER seen on rads or food) vs worsening renal disease vs neoplasia vs other Persistent azotemia.

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 an irregular, rounded, somewhat lobulated shape, and is small in size measuring 2.04 cm. Overall echogenicity is increased with almost absent corticomedullary distinction. There is no evidence of perinephric inflammation or effusion. There is mineralization in the area of the renal pelvis, with no evidence of an obvious obstruction. There is mild pyelectasia present at 0.38 cm. Renal vasculature appears normal.

The right kidney is very irregular and lobulated, almost mass-like in shape, and is larger than the right kidney, measuring 3.4 cm. Overall echogenicity is increased with almost absent corticomedullary distinction. Non-obstructive nephroliths are evident, and there is pyelectasia measuring 0.35 cm. There is no evidence of perinephric inflammation or effusion. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is large in size measuring 0.94 cm in length, 0.31 cm at the cranial pole, and 0.51 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It uniformly hypoechoic and has a somewhat enlarged caudal pole as compared to the cranial pole. There is no evidence of a discreet mass effect.

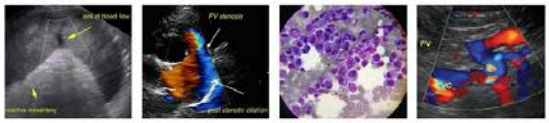
Due to the irregularity and shape of the right kidney and the diffuse mesenteric lymphadenopathy, it is dififcult to identify the right adrenal gland. There is a hyperechoic nodule visualized in the right cranial abdomen measuring 0.77 cm, which could be consistent with a right adrenal nodule. Alternately, it could be an abnormal lymph node or hepatic nodule.

Spleen

The spleen is subjectively large in size (0.79 cm at the hilus). The spleen echotexture is heterogenous and mottled, 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 in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is a 1.75 cm, somewhat cystic/cavitated mass effect visualized within the hepatic parenchyma.



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The gallbladder lumen is moderately distended. The wall of the gall bladder is prominent and relatively isoechoic, measuring 0.17 cm. The surface is slightly irregular, but luminal contents are primarily anechoic. There is the suggestion of dilation of the bile duct, but it is difficult to clearly visualize.

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 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. Jejunum wall measured 0.26 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 hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. Prominent pancreatic duct is noted measuring 0.2 cm. 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 diffuse moderate lymphadenopathy present. A large number of prominent mesenteric lymph nodes are noted, randing in size from 0.35-0.9 cm. 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.

PRIMARY FINDINGS

- Very irregularly shaped kidneys bilaterally with loss of corticomedullary distinction and pyelectasia in addition to non-obstructive nephroliths – these changes are dramatic and could be consistent with infiltrative neoplasia, acute renal failure with infarcts, FIP, etc. Consider fine needle aspirate.
- Diffuse 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.
- Borderline enlarged left adrenal gland and difficult to visualize right adrenal gland (possible adrenal mass/enlarged adrenal) – Bilaterally irregular adrenals can be concerning for infiltrative disease, neoplasia, or benign hyperplastic change.
- Heterogeneous liver with cavitated, cystic, hyperechoic mass effect – this could be consistent with a benign or cancerous mass.

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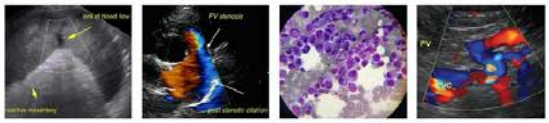

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SECONDARY FINDINGS

- Mottled, prominent spleen – this spleen subjectively appears plump and slightly mottled. It does not measure outside of the normal range. Possible differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to obtain a definitive diagnosis.
- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The renal changes are severe and are concerning for a possible neoplastic process such as round cell neoplasia or carcinoma. There is no discreet mass effect, so I cannot rule out the possibility of FIP, pyelonephritis, etc. Recommend fine needle aspirate of the kidneys and urinalysis and culture and blood pressure.

Additionally, there is a diffuse mesenteric lymphadenopathy. Consider fine needle aspirate of a mesenteric lymph node and spleen. The adrenal changes are difficult to assess, as there are so many nodules in the area of the kidneys (enlarged mesenteric lymph nodes) that it is difficult to discern what is adrenal and what is lymph nodes. Reevaluation of the right adrenal could be considered in the future, or CT scan to better delineate this structure.

This patient should have current bloodwork if not already done, urinalysis, culture, blood pressure evaluation, and if possible a fine needle aspirate of the kidneys, lymph nodes, +/- liver and spleen and 3-view thoracic radiographs.

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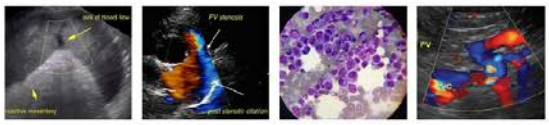

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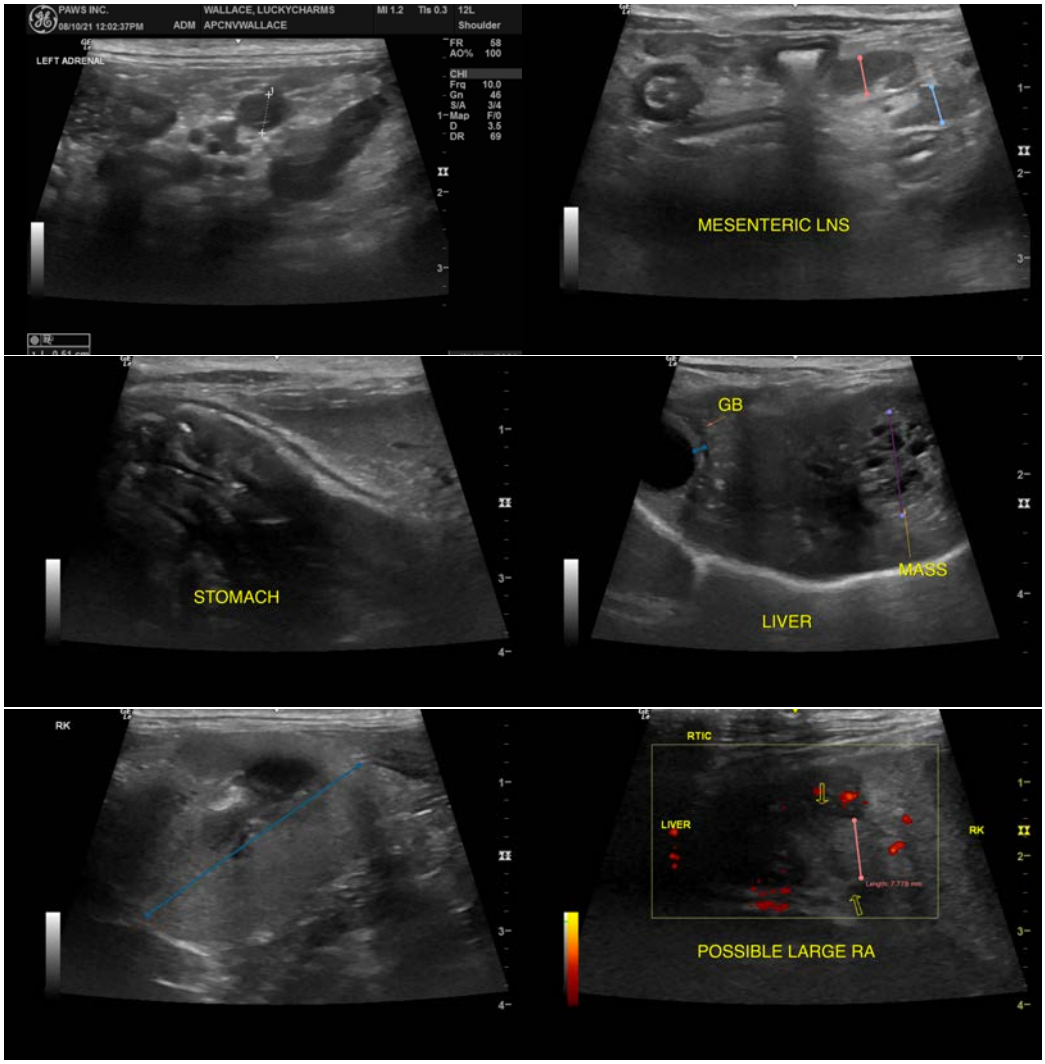

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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