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Clinical Sonography & Telecytology
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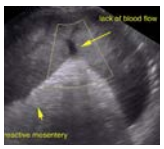
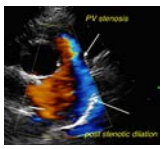
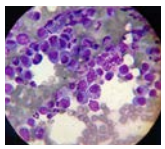
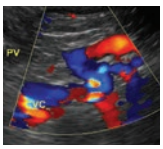





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Sophie Crispell

SPECIES
Feline

BREED
DMH

SEX
Spayed Female

AGE
11 Years

WEIGHT
13.7 Pounds

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

IMAGING PERFORMED BY
Dr. John Bucha

HOSPITAL NAME
Harveys Lake Vet

REFERRING VET
Dr. John Bucha

INVOICE
44741

DATE
8/17/23

PRESENTING CLINICAL SIGNS

Sophie had been bringing up hairballs more than usual. No diarrhea. CBC, Comprehensive Diagnostic Profile, T4, SDMA, Urinalysis, and radiographs were all within normal limits. 8-17-23 Sophie returned to clinic. Vomits every couple days (sometimes kibble, other times bile). Eating normal, normal bowl movements, sleeps more often now. We sedated her today with 100mg Gabapentin and 0.12cc IV butorphanol to do an ultrasound.

Abnormal PE/Chem/CBC/UA Results: CBC, Comprehensive Diagnostic Profile, T4, SDMA, Urinalysis via Cystocentesis (All within normal limits) 2-27-23

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 is irregular and hypoechoic with mildly decreased corticomedullary distinction and non-obstructive nephroliths visualized measuring 0.37 cm and 0.45 cm. The left kidney measured 4.03 cm. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size but irregular in shape, measuring 3.39 cm, with shadowing non-obstructive nephroliths. Overall echogenicity is slightly hypochoic with poor 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.36 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.

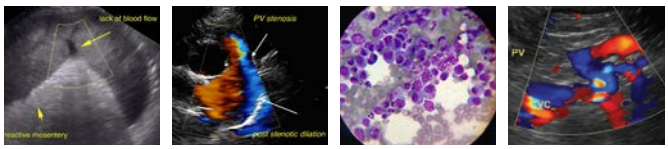
The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

Spleen

The spleen is large with a scalloped edge, measuring 0.97 cm. The spleen echotexture is heterogenous and mottled. 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 normal in echogenicity with rounded margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.



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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/ingesta and a prominent wall measuring 0.38 cm. 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 mild to moderate 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. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. There are some areas of small bowel that have moderate fluid distention. One area has a small amount of shadowing intraluminal material with no evidence of a focal obstruction.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. The distal colon appears prominent, with a colonic wall measuring 0.24 cm. Sections of colon are visualized with formed fecal material and gas shadowing distally.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild/moderate pancreatitis.

Free Abdomen

There is scant free abdominal fluid. There is a significant lymphadenopathy present with irregular, hypoechoic mesenteric lymph nodes measuring 1.0 cm and 0.98 cm in diameter. Additionally, a splenic lymph node is measured at 0.43 cm. The omentum is diffusely hyperechoic.

Other

There is a large cystic lesion visualized caudal to the left kidney measuring 2.55 cm x 2.51 cm.

ULTRASONOGRAPHIC FINDINGS

- Irregular kidneys with mildly decreased corticomedullary distinction and non-obstrutive nephroliths – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.

- Large, irregular, mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

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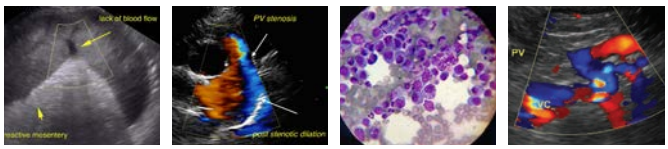

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- Prominent, hypoechoic, irregular pancreas with surrounding hyperechoic mesentery – The pancreatic changes are most consistent with moderate pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Mild to moderate fluid distention of the stomach and small intestine with subjectively thickened gastrointestinal walls – Findings could be consistent with diffuse ileus and an enteropathy. Diffuse thickening can be seen with inflammatory or infiltrative disease. Shadowing intraluminal material is visualized in some areas, which appears non-obstructive, but an obstruction cannot be definitively ruled out.
- Irregular, moderately enlarged mesenteric lymph nodes – The moderate mesenteric lymphadenopathy could be 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.
- Large cystic structure visualized caudal to the left kidney – This cannot be associated with any other structures. Findings are most consistent with an omental cyst/cystic lymph node.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is the general impression of severe diffuse inflammatory changes in the abdomen with enlarged, irregular, hypoechoic lymph nodes and irregular hypoechoic pancreas with a large, mottled, irregular spleen. These findings are concerning for possible infiltrative disease/round cell neoplasia. Consider a fine needle aspirate of the spleen and mesenteric lymph nodes.

Additionally, the liver is large and heterogeneous. If a cytologic diagnosis cannot be made off of the aspirates previously mentioned, a fine needle aspirate of the liver could be considered.

There are significant changes visualized associated with both kidneys, including non-obstructive mineralizations, irregularity, and decreased corticomedullary distinction. This could be consistent with chronic renal disease or infiltrative disease to the kidneys.

The significance of the cystic structure caudal to the left kidney is uncertain, but this could represent a benign omental cyst/cystic lymph node. This can be seen with chronic lymphadenitis and they can sometimes contain infected fluid. Drainage with fluid analysis/cytology +/- aerobic and anaerobic cultures could be considered.

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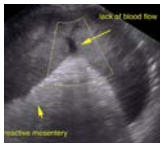
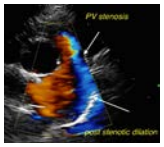
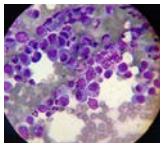
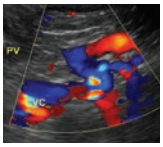

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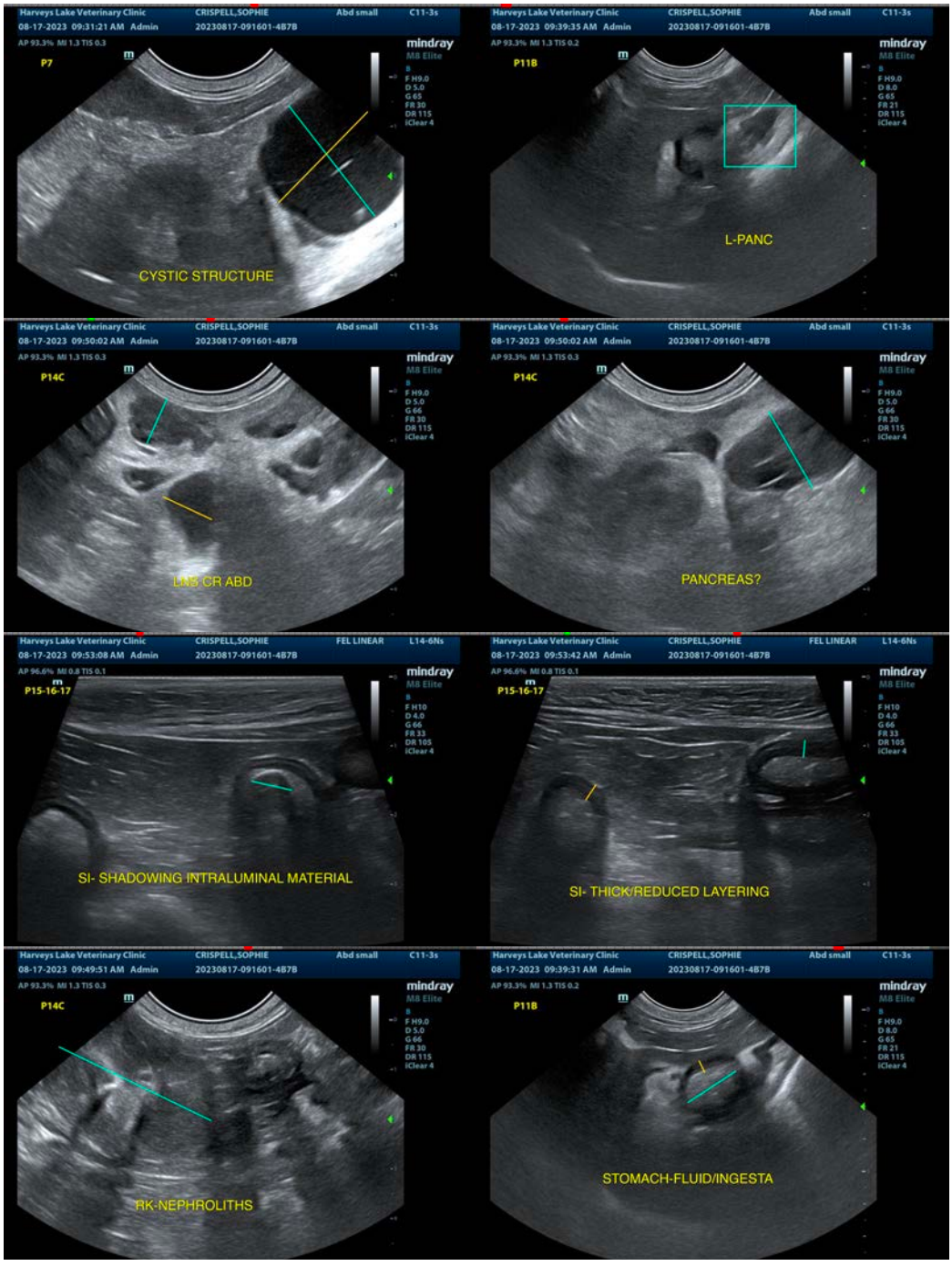

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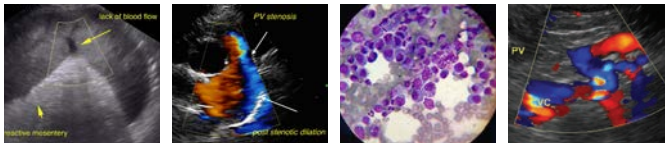

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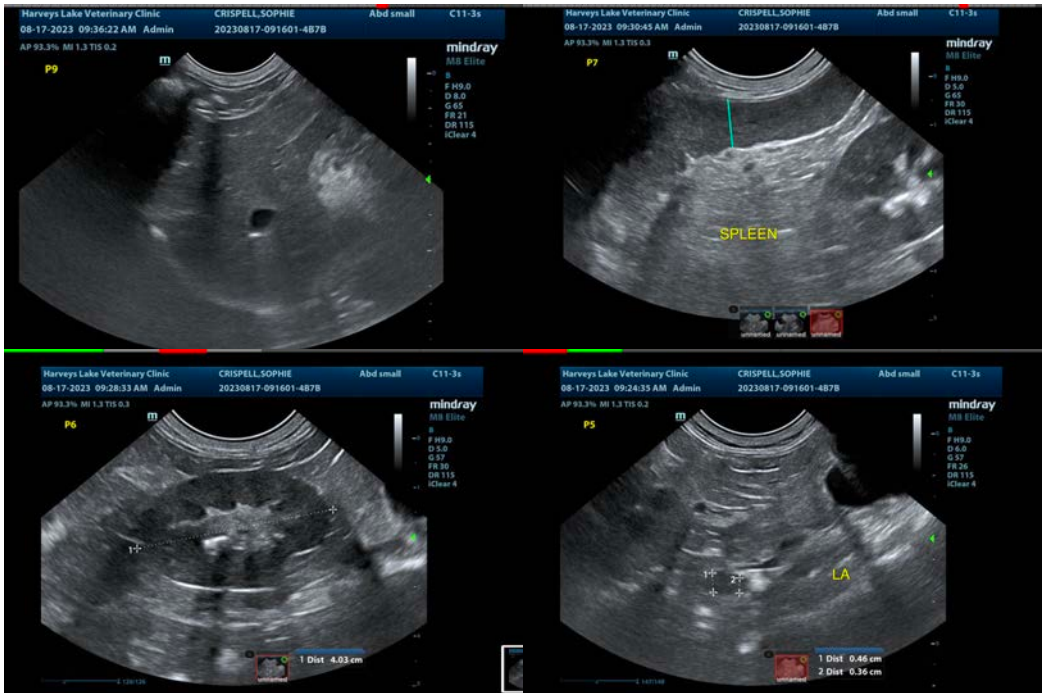

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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