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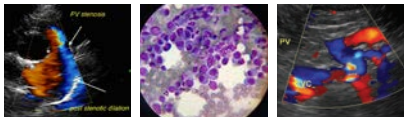

SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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**DATE**

8/3/22

**PATIENT**

Guenhwyvar Johnson

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

7/25/13

**WEIGHT**

12.54 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Stephanie Warga RDCS, RVT

**HOSPITAL NAME**

Frederick Road VH

**REFERRING VET**

Dr. Beyer

**INVOICE**

40072

## PRESENTING CLINICAL SIGNS

ADR: Vomiting and anorexia, reclusive, lethargic. Suspect weight loss
Uncomfortable on abdominal palpation. Suspect cranial abdominal mass.
Presented to ER last week after not being to a vet in 8 years. Not UTD on vax. BW from ER was prediabetic.
Recheck BW pending from Frederick Road 8/2/22

Current Medications: FROM ER visit: SQF 200ml, Cerenia 0.6ml SQ
Convenia 0.6ml SQ, TGH Elura
Lab Results: CBC: HCT 46.3%, WBC 7.6 (neutropenia, monocytosis), PLT 17K with aggregates.
Chem17/lytes: Glu 377, Cl 111, Na 146, remainder wnl. UA: Protein 30+, Glu 1000+, no ketones, WBC 9/hpf, RBC 6/hpf, cocci present. Fructosamine: 311 (191-349)
Radiographs: stomach small/empty, small intestines uniform, no obstructive pattern, no abnormalities of liver, spleen, kidneys or bladder
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested/Approved.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (4.01 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 0.45 cm at the caudal pole. Mineralization is evident. 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 0.39 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 borderline enlarged in size and is hypoechoic, 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 normal. No focal nodules or cystic lesions are observed.

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 is mildly dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The proximal duodenum appears abnormal in that it is thickened with an irregular wall with decreased wall layering. Adjacent to these abnormal sections of duodenum is a large hypoechoic, ill-defined, cavitated mass effect that is most consistent with a focal pancreatic lesion with secondary peritonitis, or with a bowel wall lesion (abscess, perforation, neoplasia, etc.). Bowel in this area measures at 0.5 cm. The distal small intestine and jejunum appear relatively normal.

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 left limb of the pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. Prominent pancreatic duct noted. There is no evidence of regional mesenteric inflammation or fluid. There is a large, hypoechoic, cavitated mass effect in the region of the duodenum with focal severe peritonitis. Findings are most concerning with a pancreatic lesion (abscess, mass, etc.), or a bowel wall lesion.

### *Free Abdomen*
There is a small amount of free abdominal fluid, particularly around the cranial abdominal mass effect. There is a mild diffuse mesenteric lymphadenopathy with lymph nodes measuring 0.36, 0.28, and 0.41 cm. The omentum is hyperechoic, particularly in the cranial abdomen.

## ULTRASONOGRAPHIC FINDINGS

- Large, irregular, cavitated, hypoechoic mass effect adjacent to the duodenum (measures 3.1 cm x 3.13 cm) – most concerning for focal peritonitis and possible abscessation, possibly secondary to pancreatic disease or bowel wall pathology.

- “Plump”, hypoechoic spleen – No focal lesions are visualized associated with the spleen, but it appears prominent and hypoechoic. Consider a fine needle aspirate.

- Echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

- Shadowing material within the gastric lumen – Correlate with feeding history and abdominal radiographs. If the patient was adequately fasted, consider the possibility of gastric foreign material.

- Severe focal duodenal wall thickening with loss of layering – findings could be associated with focal

enteritis secondary to pancreatic inflammation or a primary bowel pathology secondary to perforation, neoplasia, etc.

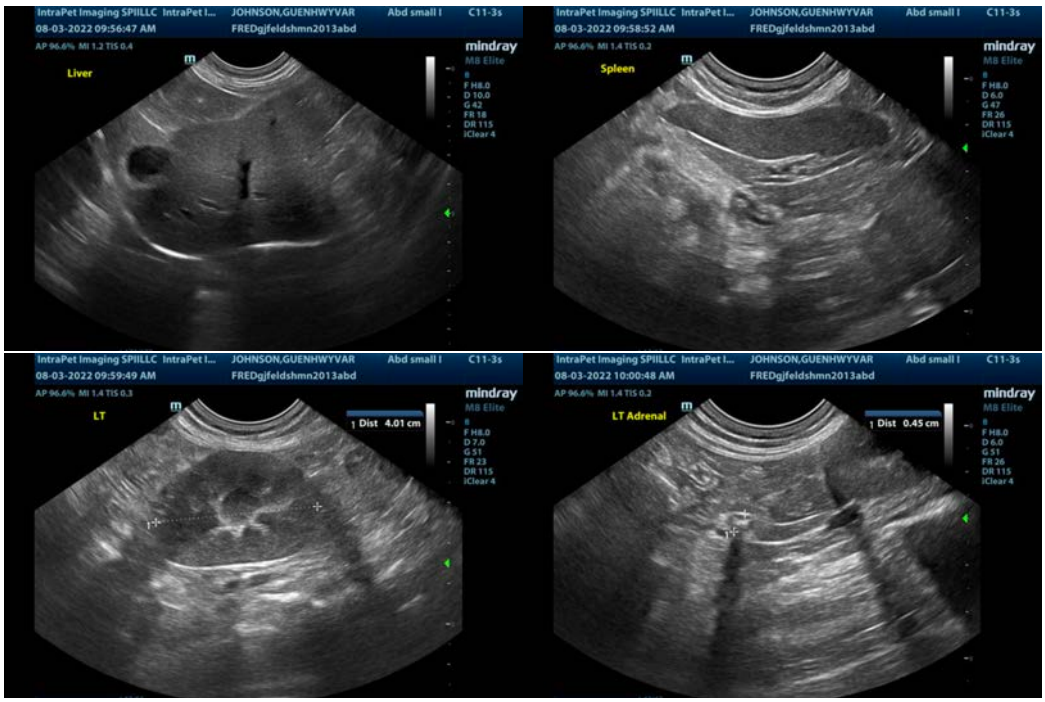
- Small volume free abdominal fluid and severely hyperechoic mesentery – consistent with focal peritonitis (sterile versus septic).

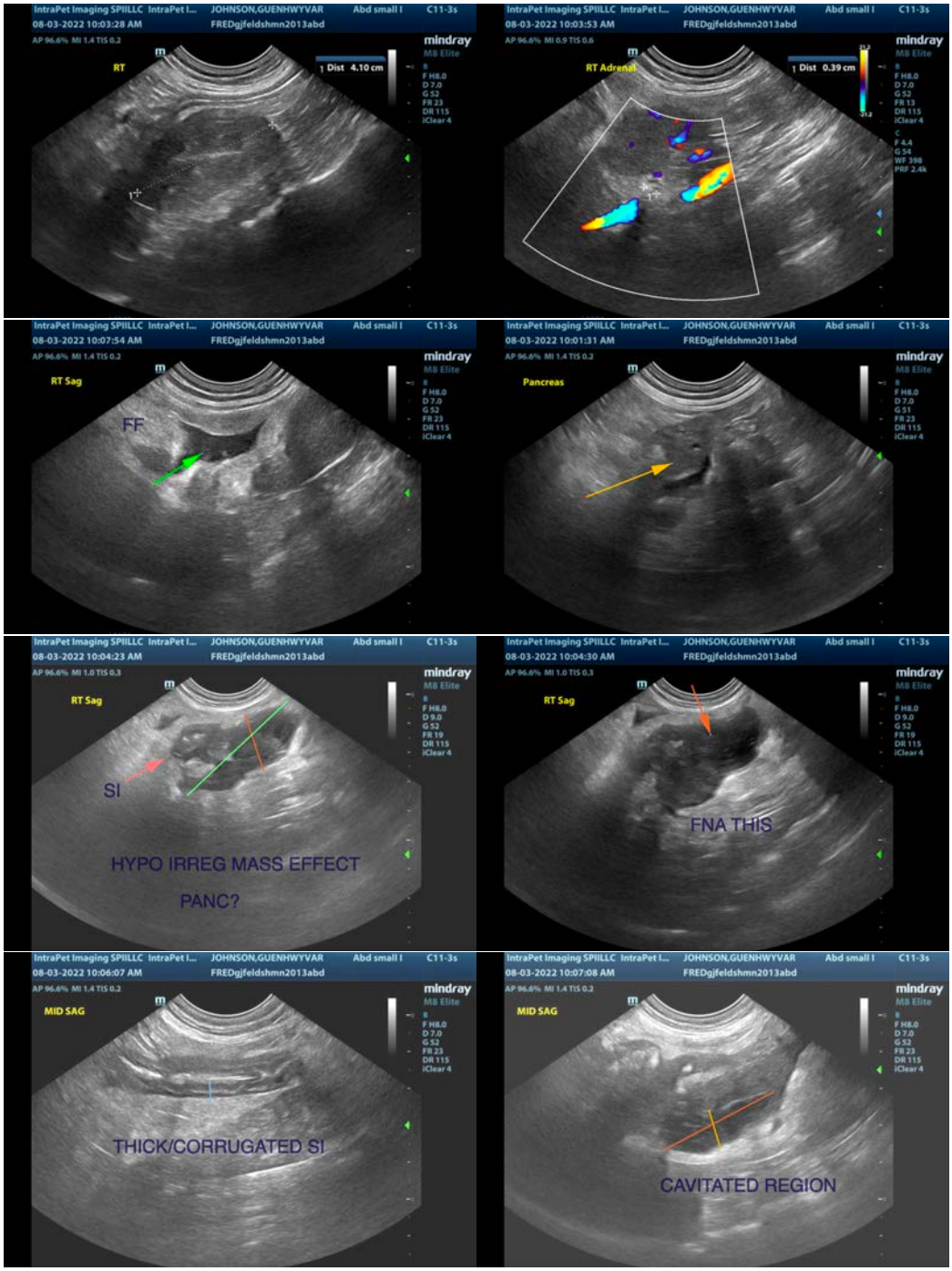
- Mild mesenteric lymphadenopathy

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large, hypoechoic, cavitated mass effect in the cranial abdomen in the region of the duodenum. The cavitated nature and degree of inflammation is concerning for possible abscessation. It is difficult to determine if this lesion is originating from the bowel, or if it is originating from the pancreas and causing secondary bowel wall changes. Recommend a fine needle aspirate of the hypoechoic mass lesion and possible sampling of the cavitated regions for fluid analysis and cytology. If this lesion is septic, exploratory may be necessary in order to evaluate for the possibility of a bowel wall perforation. Critical care is recommended with possible plasma and critical support.

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

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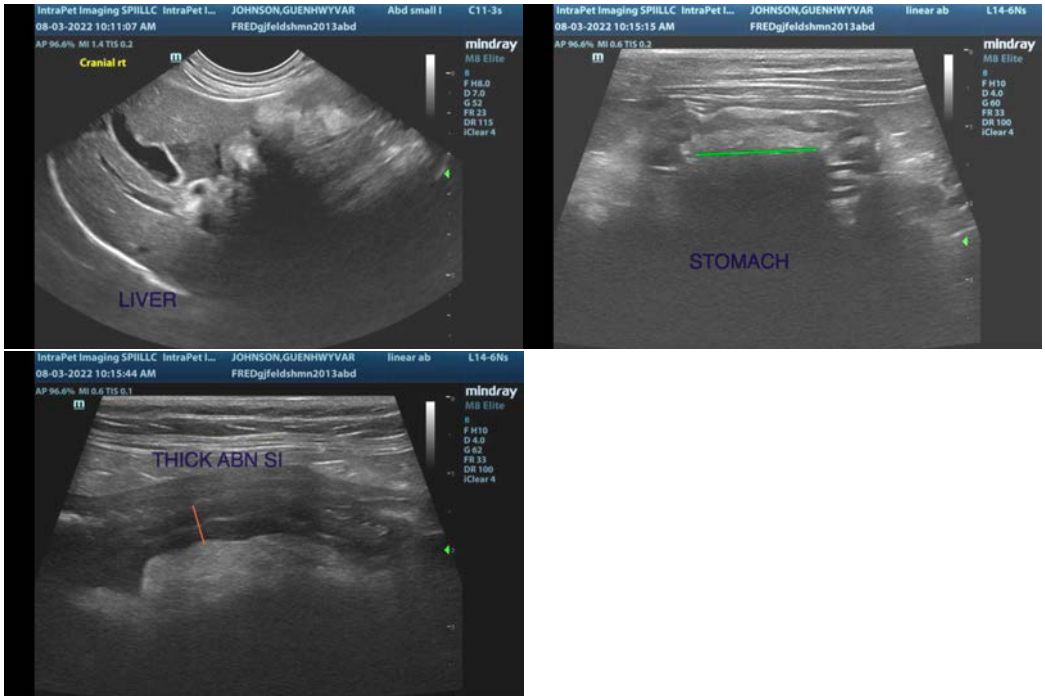


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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