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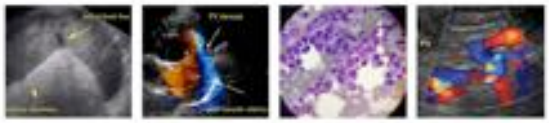


IMAGING PERFORMED BY
pawssonography@gmail.com 530-786-8340

PATIENT

Peatrie Ingels

SPECIES

Feline

BREED

Domestic Longhair

SEX

Spayed Female

AGE

11 years

WEIGHT

2.6 kg

INTERPRETED BY

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Round Hill AH

REFERRING VET

Dr. Kelly

INVOICE

30873

DATE

6/6/22

PRESENTING CLINICAL SIGNS

History: Peatrie" Paul Ingels 11 year old female spayed feline, domestic long hair 2.62 kg Owner brought in 6-1-2022 for weight loss over past couple months and recent extreme decline in appetite. Not passing feces. Likes to eat plastic. Radiographs did not indicate an obvious mass but did show "dough-like" feces decorated with small bits of foreign material, possibly plastic. FPL was abnormal. Low total protein and albumin, suspect due to GI loss. Weakly regenerative anemia. Started eating small amounts of food at end of day. Acted very hungry when offered. 6-2-2022 Barium study showed a fair amount of feces in the colon and soft feces in the distal small intestines, along with food. Showed owner how to give subcutaneous fluids for over the weekend. 60cc Bid. Supplement with Nutri-Cal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is well distended. The wall is smooth and regular. No abnormalities are present with the trigone or proximal urethra. A trivial amount of free floating sediment is present, however, there is no evidence of cystoliths, polyps or a mass. Ascites is noted at the apex of the urinary bladder.

Kidneys

The **left** kidney measures 3.42 cm (3.80-4.40 cm), mildly decreased in size. The capsule is smooth. A mild loss of the normal definition of the cortico-medullary junction is present. Mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

The **right** kidney measures 3.42 cm (3.80-4.40 cm). Findings are similar to the left kidney.

Adrenal Glands

The **left** adrenal gland is not visualized.

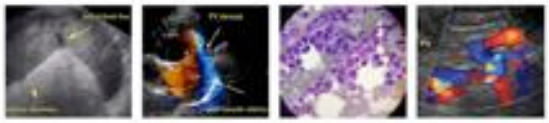
The **right** adrenal gland measures 0.36 cm at the cranial pole, 0.35 cm at the caudal pole and 0.77 cm in length. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Spleen

The spleen is mildly decreased in size 6.4 mm (normal = 10 mm), echotexture, and echogenicity. however, the contours are scalloped. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified. Mild hypovolemia is suspected.

Liver

There are no obvious signs of hepatomegaly. The liver's borders are smooth, but mildly rounded. A diffuse, mildly coarse or granular echotexture is observed. No focal lesions are visualized. The walls of the portal veins are hyperechoic and more prominent than usual. The hepatic arteries appear very mildly dilated.



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The gallbladder (GB) wall is within normal limits in thickness and echogenicity. A very small amount of echogenic material is present within the GB. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction. Effusion is present surrounding the GB.

Gastrointestinal

The gastric wall is within normal limits in thickness and the wall layers are well defined. No obvious abnormalities are observed with its peristalsis.

The duodenum is within normal limits 0.22 cm, however, fogging of the mucosa is present.

The small intestinal wall thickness and definition of the wall layers is preserved. Stippling and fogging of the mucosa of multiple loops of small intestines are present. Ingesta and fluid are present in a large number of the small intestines.

The mass shows a segment of jejunum at the high end of the normal reference range (0.25 cm). It then leads into a heterogeneous mass, 2.39 cm in diameter x 3.47 cm in length. Intestinal wall involving the mass measures 0.77 cm. A marked to complete loss of the normal definition of the wall layers is noted. Multiple loops of bowel and omentum are adhered to the mass. It is well vascularized, likely due to the vasculature of the mesentery.

Gas and ingesta are present in the transverse colon.

"Ineffective" peristalsis is noted throughout the entire GI tract, i.e., a "to and fro" motion is observed, consistent with a mild to moderate ileus. An abnormally dilated loop of jejunum with severe ileus is present cranial to the urinary bladder.

The colonic wall is not thickened and mural detail is considered normal. Gas and a small amount of fecal matter are present in the colon

Pancreas

No overt abnormalities are observed with the architecture, contours, echogenicity or echotexture of the right limb.

The left limb is mildly hypoechoic. The pancreatic lymph node is prominent and the surrounding mesentery is moderately hyperechoic. A small amount of anechoic fluid with floating echogenic material is present in the surrounding area. These signs are suggestive of active pancreatitis, whether primary or secondary to the inflammation in the surrounding area.

Other

Lymph nodes

Enlarged **mesenteric LN** with irregular contours, 1.86 cm in diameter, with hypo and anechoic cyst-like lesions.

A second mesenteric LN is mildly enlarged (1.38 cm in diameter x 1.58 cm in length). It is round with smooth borders with anechoic lacunae, suggestive of cysts.

Pancreatic LN is mildly prominent

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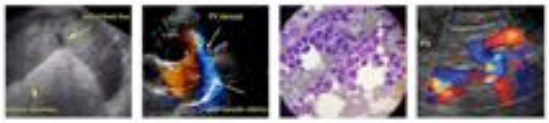

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Abdominal effusion

Anechoic ascites is visualized between intestinal loops and liver lobes and ventral to the urinary bladder

Heart

A brief video clip of the heart was submitted. Pericardial and pleural effusion are not identified. There is no evidence of a mass in any of the cardiac chambers, however, a mass may be overlooked in the absence of pericardial effusion. No obvious abnormalities with chamber size or contractility (measurements not performed).

ULTRASONOGRAPHIC FINDINGS

- **Gastrointestinal (GI) tract**: The GI mass involving jejunum, ileum and omentum, as well as adhesions of other loops of bowel is suggestive of an adenocarcinoma, however, alimentary lymphoma cannot be excluded. Underlying inflammatory bowel disease may be playing a role in some of the changes observed.
- **Lymphadenomegaly**: The multiple mesenteric lymph nodes that are mildly enlarged and cystic likely represent infiltration of neoplastic cells, however, some of the smaller or prominent lymph nodes may be due to reactive hyperplasia, with emerging neoplasia.
- **Liver**: A reactive hepatopathy is suspected. There are no obvious signs of metastatic disease or cholangitis/cholangiohepatitis.
- **Pancreas**: Overt enlargement and hypoechogenicity of the pancreas are not observed, however, the surrounding mesentery is hyperechoic. These signs are suggestive of inflammation. Active pancreatitis cannot be excluded, whether primary or secondary to the inflammation in the surrounding area.
- **Spleen**: Mildly scalloped contours may be suggestive of infiltrative disease, such as lymphoma or other round cell tumour. Reactive hyperplasia and splenitis are also possible causes. Mild hypovolemia is suspected.
- **Ascites**: may occur in association with adenocarcinomas, vasculitis, hypoalbuminemia, as well as extravasation.
- **Kidneys**: The mild renal changes are suggestive of age related degeneration.
- **Urinary bladder**: The free floating sediment within the lumen of the urinary bladder is most likely composed of mucus, crystalline material and exfoliated cells. The debris is likely clinically insignificant given the lack of inflammatory changes to the bladder wall, however, findings should be correlated with clinical signs and a urinalysis.

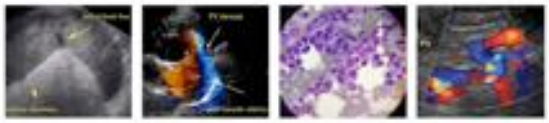
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirates of the mass, spleen, ascites may be performed to obtain a diagnosis and determine a treatment plan, e.g., whether surgery or chemotherapy, or a combination of surgery and chemotherapy, are ideal.

Analgesia (buprenorphine and gabapentin) is strongly recommended

Canned food mixed into a slurry may decrease the risk of a mechanical obstruction.

Small, frequent meals



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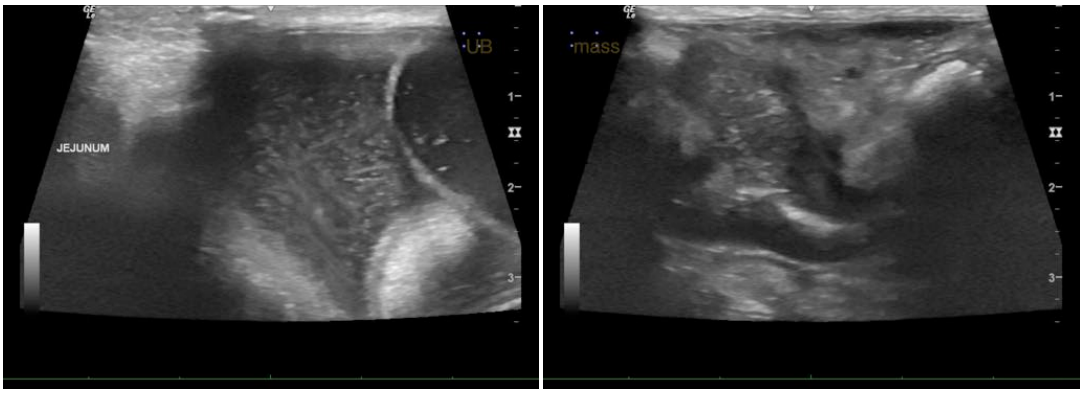
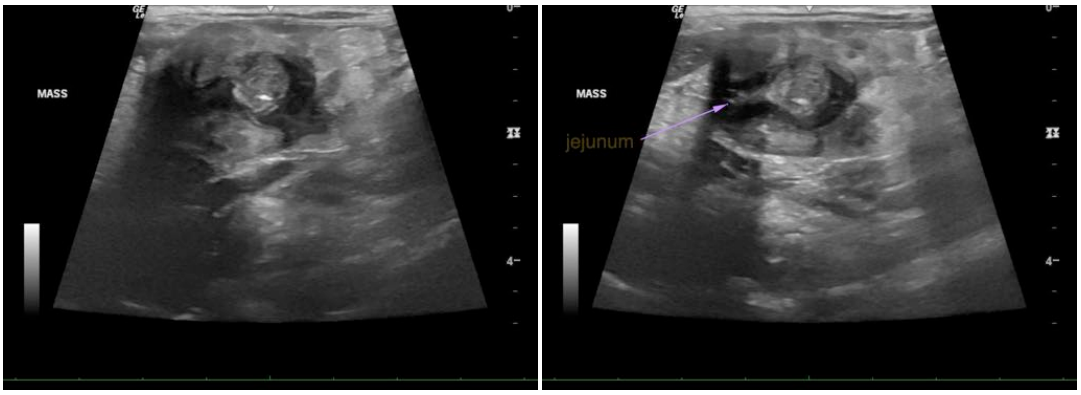
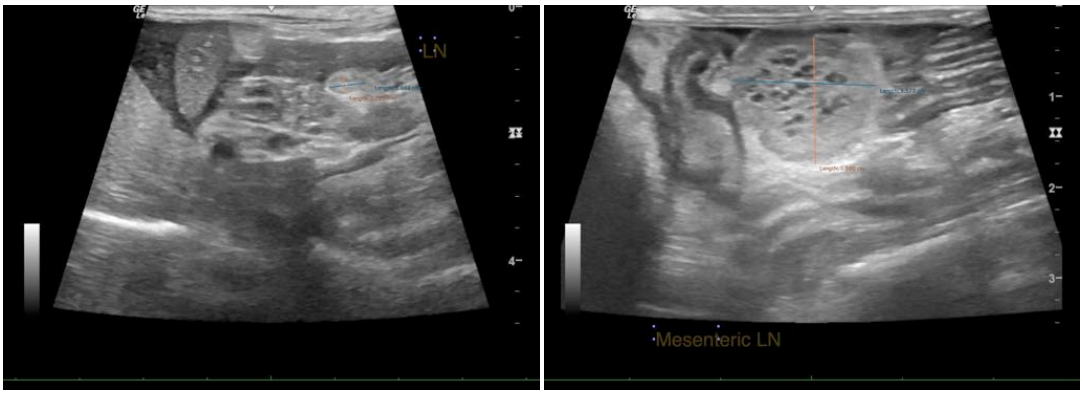
Supplementation with cobalamin

Due to Peatrie's history of pica, obtaining a history regarding signs of GERD from the client is suggested. Treatment with an anti-acid or proton pump inhibitor may be required depending on the patient's history.

If signs of GERD, 10-14 day trial with famotidine or omeprazole (0.7-1 mg/kg PO **q12h**)







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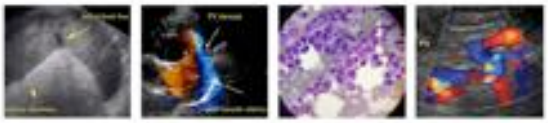

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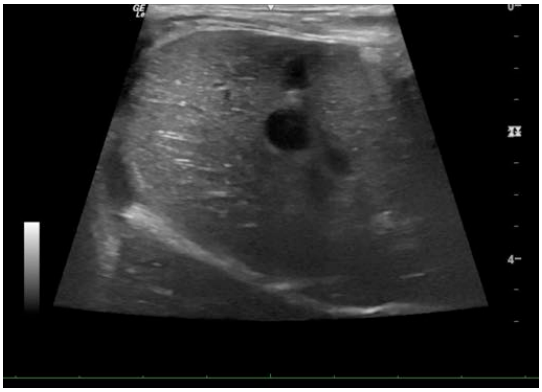

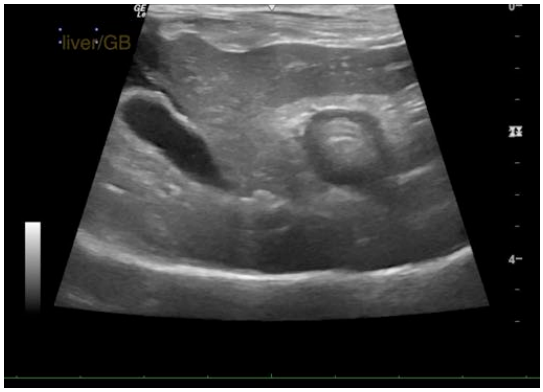

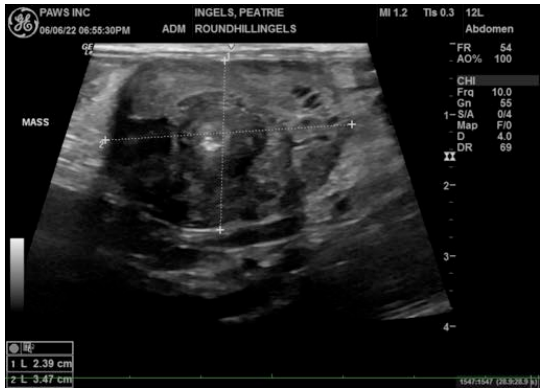

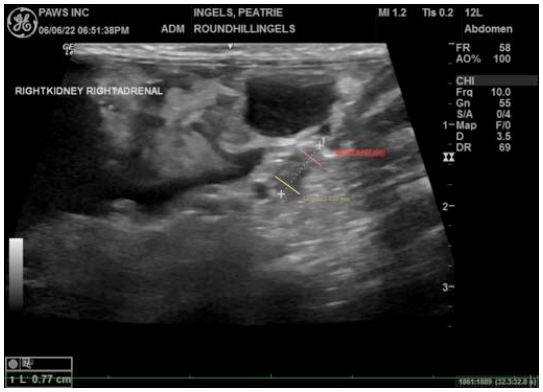

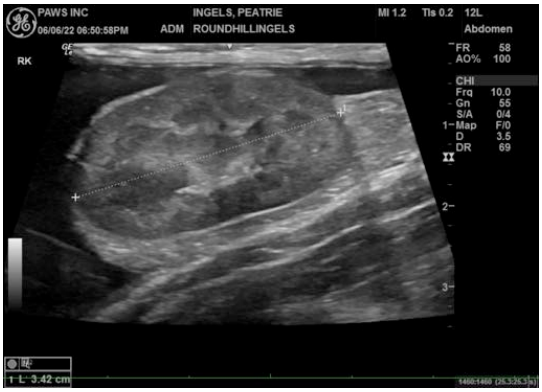

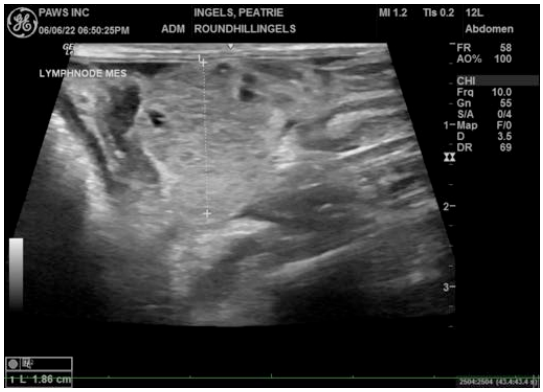

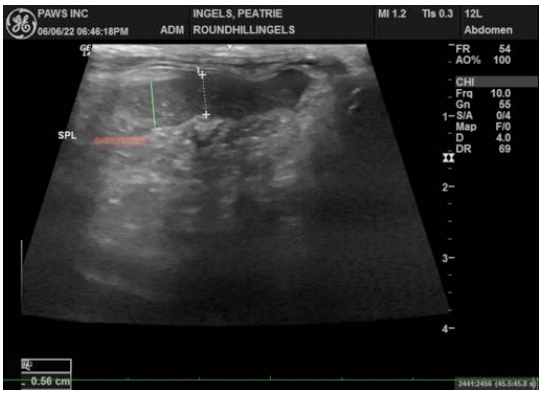

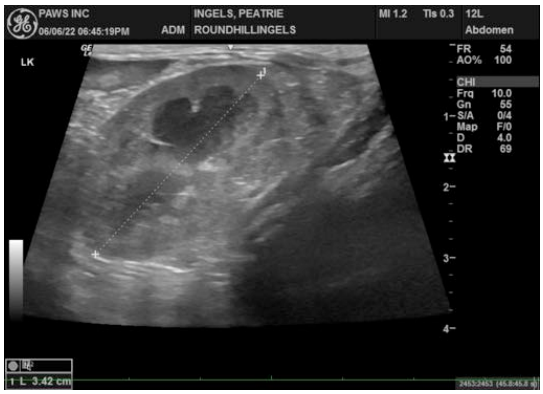

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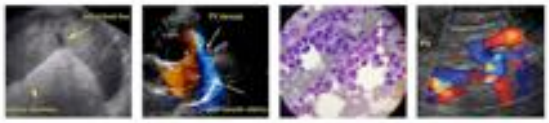

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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