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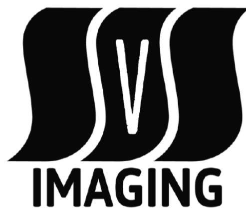

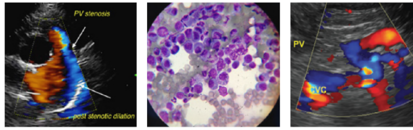

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Rusty Charnitsky

SPECIES

Feilne

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

16.5 Pounds

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging Michigan

REFERRING VET

Wixom Family Pet Practice

INVOICE

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DATE

1/31/22

PRESENTING CLINICAL SIGNS

History since mid November of intermediate vomiting, weight loss. BW at that time showed increase WBCs. Started B12 oral supplement. Went to ER yesterday for increased vomiting and not eating. Treated outpatient. Owner thinks he is uncomfortable.
Abnormal PE/Chem/CBC/UA Results: WBC 13.4, HCT 37.8, BUN 9.9, Crea 0.5, Calcium 8.6, Alb 2.3, unremarkable liver enzymes, Amylase 887, Lipase 30.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Minor non-dependent, non-mineralized sediment to mucus present. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. A focal, moderately sized caudolateral cortical infarct was present in the left kidney. The left kidney measured 4.4 cm. The right kidney measured 4.8 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.47 cm in width. The right adrenal gland measured 0.34 cm in width.

Spleen

The spleen exhibited subjective mild generalized enlargement (1.1-1.2 cm in width at the level of the hilus) and a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. No masses or nodules noted. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

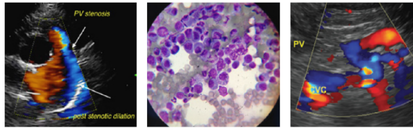
Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was normal in size, yet subjectively partial to completely divided into two compartments. Proximal common bile duct exhibited mild tortuous dilation without evidence of mucus or calculi, and not appearing to extend to the level of the duodenal papilla. The proximal common bile duct measured 0.40 cm in width.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate progressively shadowing ingesta most consistent with post prandial presentation without signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with maintained 1:3 muscularis/mucosa ratio to the level of the ileum. Duodenum wall measured 0.30 cm. Jejunum wall measured 0.25 cm. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The ileum exhibited intact



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yet subjective mild prominent wall layering to the level of the ileocolic junction. Ileocolic junction wall measured 0.43 cm.

The cecum and proximal colon exhibited hypoechoic mural hypertrophy and loss of discernable wall layering with mild associated cecocolic ileus to non-formed stool. The area of hypoechoic mural hypertrophy measured approximately 3-4 cm in length with proximal colon wall width up to 0.8 cm in width. The remainder of the colon was sonographically unremarkable. Associated regional peri Ileocecocolic reactive to inflamed mesentery and intermittent hypoechoic to mildly prominent colic lymph nodes noted. Example of colic lymph node measured 0.5 cm diameter.

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic inflammation. No overt evidence of neoplasia.

Free Abdomen

A small pocket of scant free fluid was noted around the out apical urinary bladder.

ULTRASONOGRAPHIC FINDINGS

- Cecocolic mural mass
- Concurrent ileitis pattern exhibiting intact yet mildly prominent ileal to ileocolic wall layering
- Associated regional peri ileocolic reactive mesentery and mild colic lymphadenopathy
- Subjective non-specific mild splenomegaly
- Probable concurrent low-grade pancreatitis

SECONDARY FINDINGS

- Mild chronic renal changes with left kidney cortical infarct
- Probable bilobed gallbladder with mild non-obstructive common bile duct dilation – bilobed gallbladder is a normal variant in a cat.
- Mild urinary bladder sediment/mucus

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The common bile duct dilation may suggest age related changes or secondary to underlying cholangitis / cholangiohepatitis especially if previous or current liver enzymes elevations have been noted.

Potential etiologies for the cecocolic mass may include significant inflammatory, granulomatous (dry form FIP) or neoplastic etiologies with neoplasia such as adenocarcinoma, lymphoma, MCT or other favored. Potential for early involvement or extension into the area of the ileocolic junction and distal ileum possible.

Assuming normal clotting status, ultrasound guided FNA of the mass as well as screening splenic FNA using 25-gauge needle for further staging could be considered. 3-view cheset radiographs recommended if not done.

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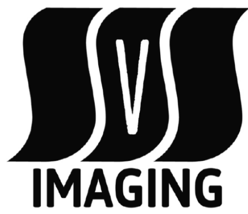

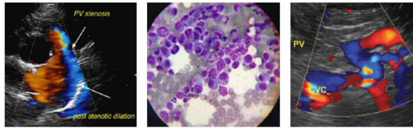

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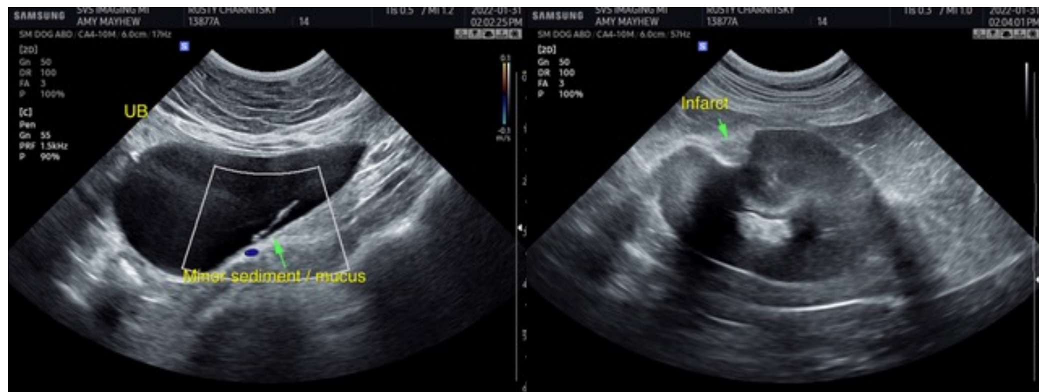

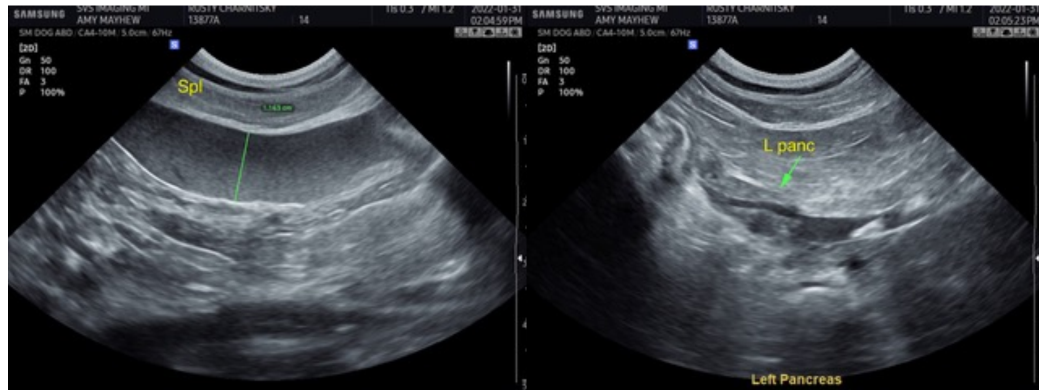

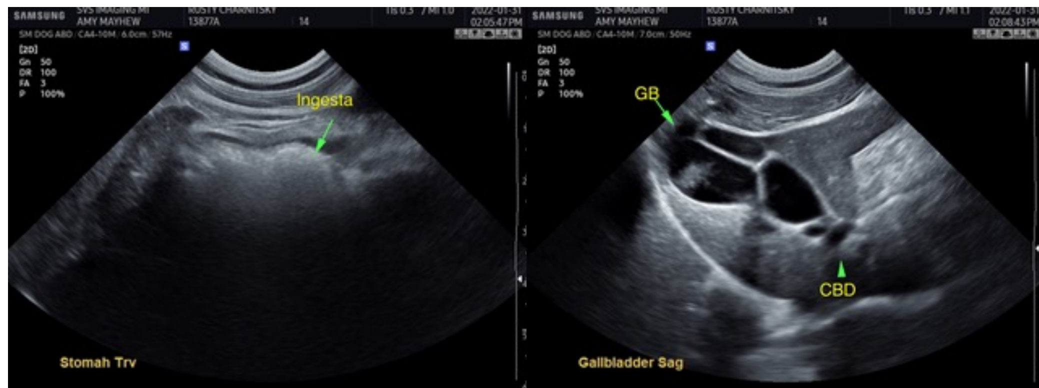

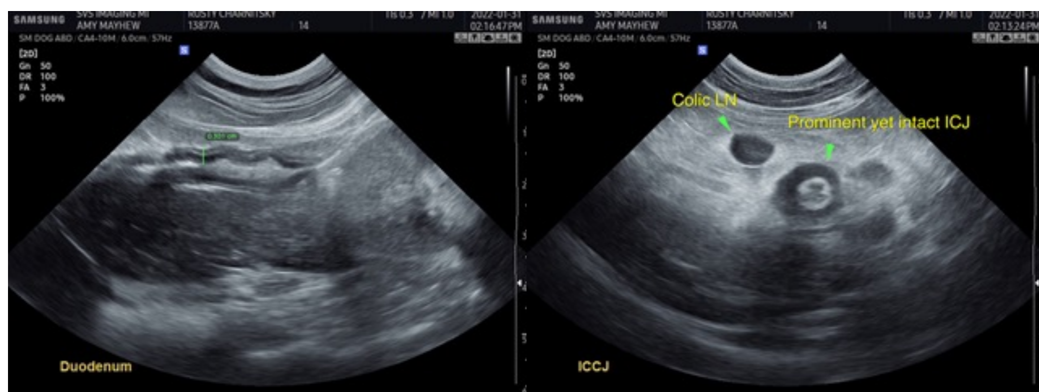

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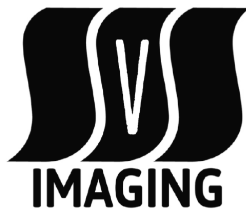

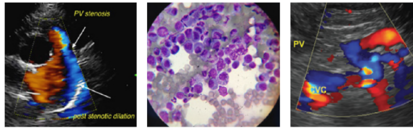

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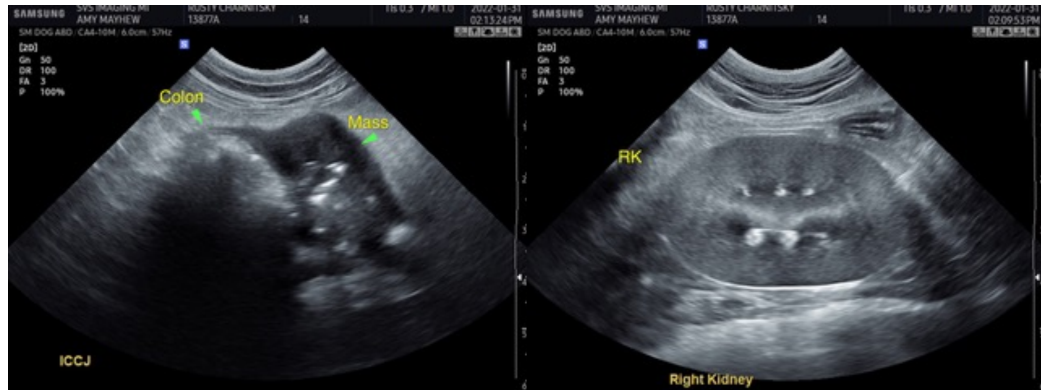

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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