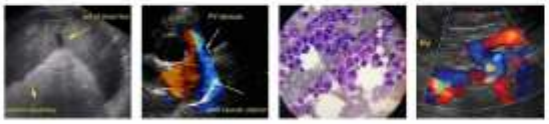


PATIENT

Sammy Eville

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

16.5 years

WEIGHT

9 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Penn Valley Veterinary Associates

REFERRING VET

Dr. Nancy Reese

INVOICE

12974

DATE

1/6/22

PRESENTING CLINICAL SIGNS

sedated with dexdormitor- Sammy is a 16.5 year old (DOB 7/1/05) male neutered DSH belonging to Cathy Eville. Sammy has had a history of IRIS stage 1-2 CKD and had an ultrasound done by your group in November of 2019 for comparison. Sammy has been doing well with his CKD- his most recent BUN and Creat were: 35 (14-36) and 1.7 (0.6-2.4 mg/dl) respectively. He has also had a stable normocytic normochromic nonregenerative anemia (HCT 22%-23% (29-48% normal)) for 2 years now. He gets mariopitant and mirtazapine transdermally when his appetite is down. He has had some intermittent loose stool and recently had some slow weight loss. He gets blood panels (and usually U/A) every 3 months or so. In October, his intestinal loops felt somewhat thickened and his mild weight loss was noted. He had been in the 11.3# range for a long time and now has slowly been decreasing to 10.3 in 12/2021. On his October blood work, he had a basophilia (900 (0-150 uL)) which was confirmed by the pathologist review. Given the increased basophils and the thickened GI loops on palpation and his mild weight loss and hyporexia at the time, I opted to do a trial prednisone course- 5 mg q24 decreasing the 2.5 mg q 24. We also started him on Cobalamin orally to possibly help with the appetite/GI signs. Given Sammy's reactive nature (he will be sedated for his U/S) and his advanced years, we decided not to refer him for GI scope/bx or even U/S at that time. Clinically he did improve and his basophilia resolved at his next CBC in 12/2021. His weight stabilized at 10.3#. The owner does have another cat with GI lymphoma on pred/leukeran (who your group also did an U/S when she had an intussusception on top of her LSA!), so she was interested in now having an U/S on Sammy to see how things looked-- if consistent with IBD/LSA or other, and a comparison to his previous U/S in 2019. My impression is that she might not pursue a biopsy on Sammy (which is why I opted to put him on pred earlier...). Sammy is on a raw diet with probiotics.

Urinary System

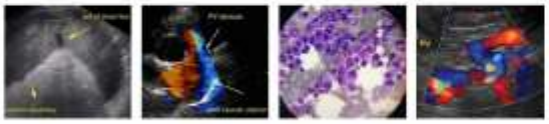
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal renal size with asymmetrical margination were present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Mildly progressive left kidney pyelectasia without evidence of left ureter distention was present. The degree of pelvis dilation measured 0.88 cm width. The left kidney measured 4.1 cm in length. The right kidney measured 4.5 cm in length. Both kidneys were static in size compared to the previous ultrasound.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.23 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.39 cm width.



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Spleen

The spleen exhibited generalized enlargement with mild asymmetrical medial capsule contour. The spleen primarily maintained a finely textured homogeneous parenchyma. A solitary, mildly expansive medial parenchymal nodule Impinging upon the focal medial capsule vs. potential impinging splenic lymph node adjacent to the hilus was present. The nodule measured 0.49 cm. The overall spleen measured 1.3 cm in width.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. A solitary, moderately sized, nonhomogeneous to cystic mass was present in the deep liver, measuring approximately 4.5 cm in diameter. Concurrent cystic intraparenchymal nodule was also present. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material. The gastric body wall width measured 0.25 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The duodenum wall width measured 0.26 cm. The jejunum wall width measured 0.26 cm.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

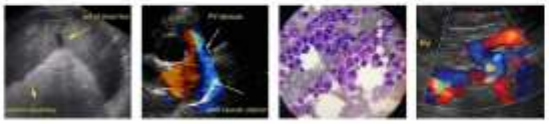
Regional, nonspecific, nonuniform to indistinctly nodular area of midabdominal mesentery was present. Small volume subjectively acellular peritoneal free fluid was present.

Several jejunal to jejunocolic lymph nodes were present in the midabdominal. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 0.85 cm diameter.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral moderate chronic renal changes with mildly progressive left kidney pyelectasia to mild hydronephrosis



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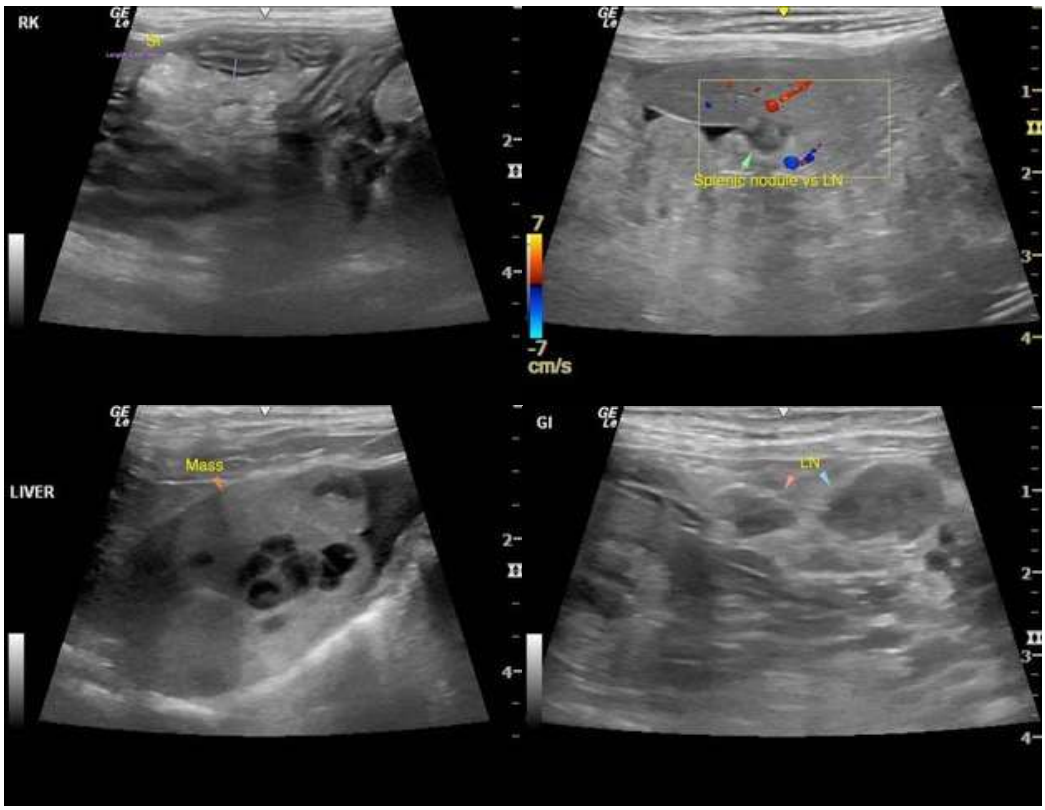
- Nonspecific splenomegaly with potential mildly expansive medial parenchymal nodule vs impinging focal splenic lymph node
- Cystic liver mass with concurrent cystic intraparenchymal nodule- nonspecific, cystic biliary adenoma, cystic biliary adenocarcinoma, cystic hyperplasia, or other possible
- Overtly normal gastrointestinal tract
- Nonspecific midabdominal nonuniform to indistinctly nodular mesentery
- Small volume peritoneal free fluid and nonspecific intermittent jejunocolic lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal albumin levels, the peritoneal free fluid may be owing to Dexdomitor sedation, although potential non-sedation etiology for the effusion such as lymphatic obstruction cannot be definitively excluded. If clinically indicated, effusion analysis, cytology +/- C/S could be considered.

Potentially, previous or current Prednisolone use may be masking intestinal mural changes. Given the presence of jejunocolic lymphadenopathy, which may indicate hyperplasia or minor reactive lymphadenitis, potential for structurally insignificant inflammatory bowel may be possible.

Assuming normal clotting status, ultrasound-guided FNA of the hepatic mass +/- jejunocolic lymph node and spleen, using a 25-gauge needle, could be considered for screening cytology.



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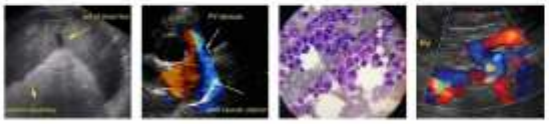

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

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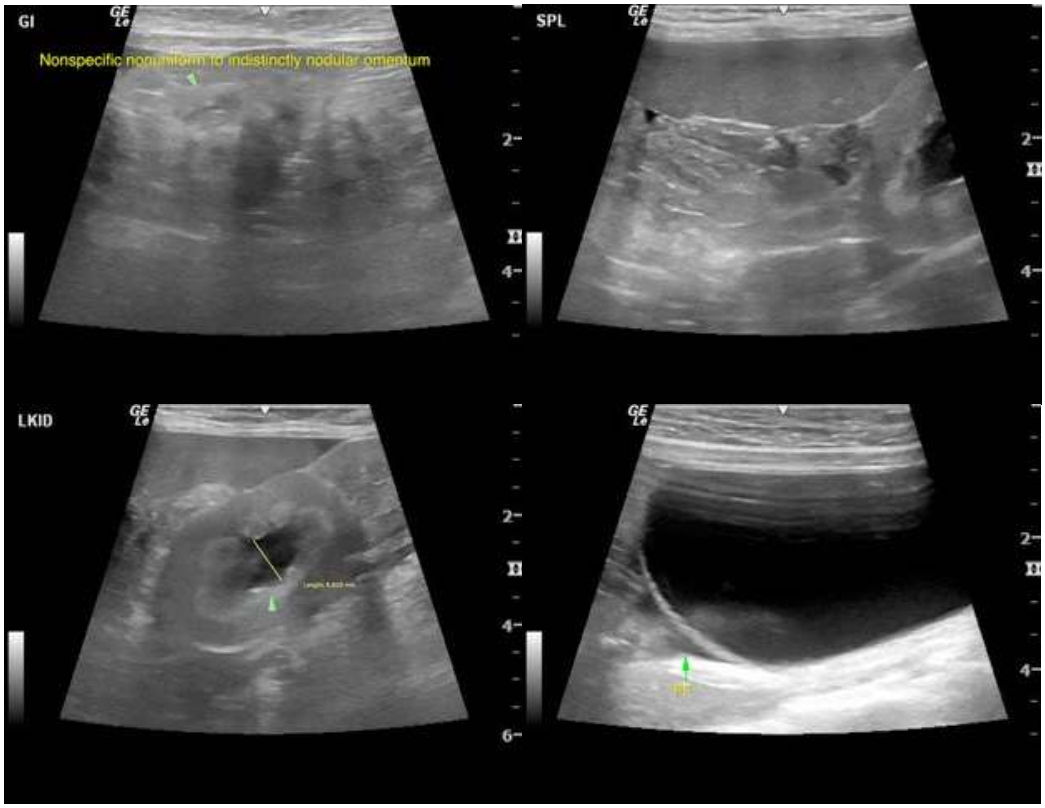

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com