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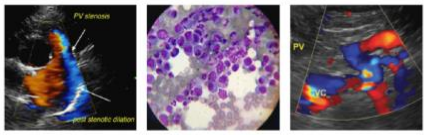
fredgromalak@gmail.com



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

PATIENT

Bella Komro 54934A

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

10 Years

WEIGHT

4.51 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

Bel Air VH

REFERRING VET

Madison VS- Dr. Keller

INVOICE

18865

DATE

11/29/22

PRESENTING CLINICAL SIGNS

History: Bella acutely stopped eating her dry food 3 weeks ago. Owners switched to wet food and Bella ate that for a while, but still decreased appetite. A week ago she stopped eating her wet food as well. She will occasionally still lick her food, but won't eat anything. She is still drinking water but less. Owners note she appears to have lost some weight. Urinating normally. She has been vomiting bile 1-2 times a week since she lost her appetite. Bella has a hx of chronic vomiting up to a couple times a week for the past several years, but usually food not bile. No known ingestion of anything inappropriate. Indoor/outdoor cat.

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. 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 were noted. Aortic trifurcation was normal.

The left kidney was subnormal in size with asymmetrical contour. Multiple cortical infarcts were noted. Moderate loss of corticomedullary border demarcation was noted. The left kidney measured 2.4 cm in length.

Normal size and margination was present in the right kidney. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The right kidney measured 4.1 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.38 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.41 cm.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease. The spleen measured 0.8 cm in width at the level of the hilus.

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 non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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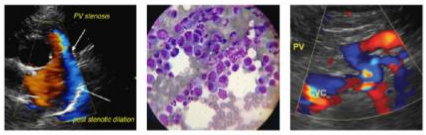

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Gastrointestinal

An ill-defined nonhomogenous gastric mural to intraluminal mass was noted, subjectively occupying the gastric body and fundus, potentially extending into the area of the gastric cardia, measuring approximately 3.6 cm x 3.4 cm. The mass did not appear to be obstructive to pyloric outflow and did not appear to involve the area of the pylorus or upper duodenum. Minor retained pyloric anechoic fluid was present.

The small intestine presented intact wall layering with subjective maintained 1:3 muscularis/mucosa ratio. Segmental propensity for mildly prominent segmental muscularis layer yet without evidence of mural hypertrophy or loss of intestinal wall layering to the level of the ileocolic junction. The duodenum wall measured 0.23 cm. The jejunum wall measured 0.23 cm. The ileocolic wall measured 0.35 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 mildly nonhomogenous parenchyma compared to adjacent omentum with mild pancreatic duct dilation.

Free Abdomen

Intermittent, mildly prominent mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation. An example of lymph node size measured 1.4 cm x 0.6 cm width. All visualized lymph nodes exhibited normal width to length ratio <0.5 cm.

Intermittent small pockets of scant peritoneal free fluid were noted. No omental masses noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gastric mural to intraluminal mass, mild retained pyloric anechoic fluid without evidence of mechanical pyloric outflow obstruction.
- Overtly normal small bowel
- Possible concurrent mild chronic pancreatitis
- Intermittent nonspecific subjectively benign/reactive minor mesenteric lymphadenopathy
- Intermittent scant pocket of peritoneal free fluid

Secondary Findings

- Subnormal left kidney size with left cortical infarcts

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If accessible, and assuming normal clotting status, FNA cytology of the gastric mass could be considered for screening cytology. Assessment for evidence of cranial abdominal or subxiphoid discomfort on palpation in the area of the pancreas +/- spec CPL or full GI panel to assess for concurrent nonstructural intestinal disease and further assessment of the pancreas may be considered. Three view chest radiographs are recommended. No obvious evidence of regional perigastric metastasis.

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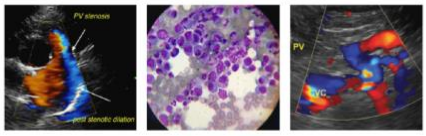

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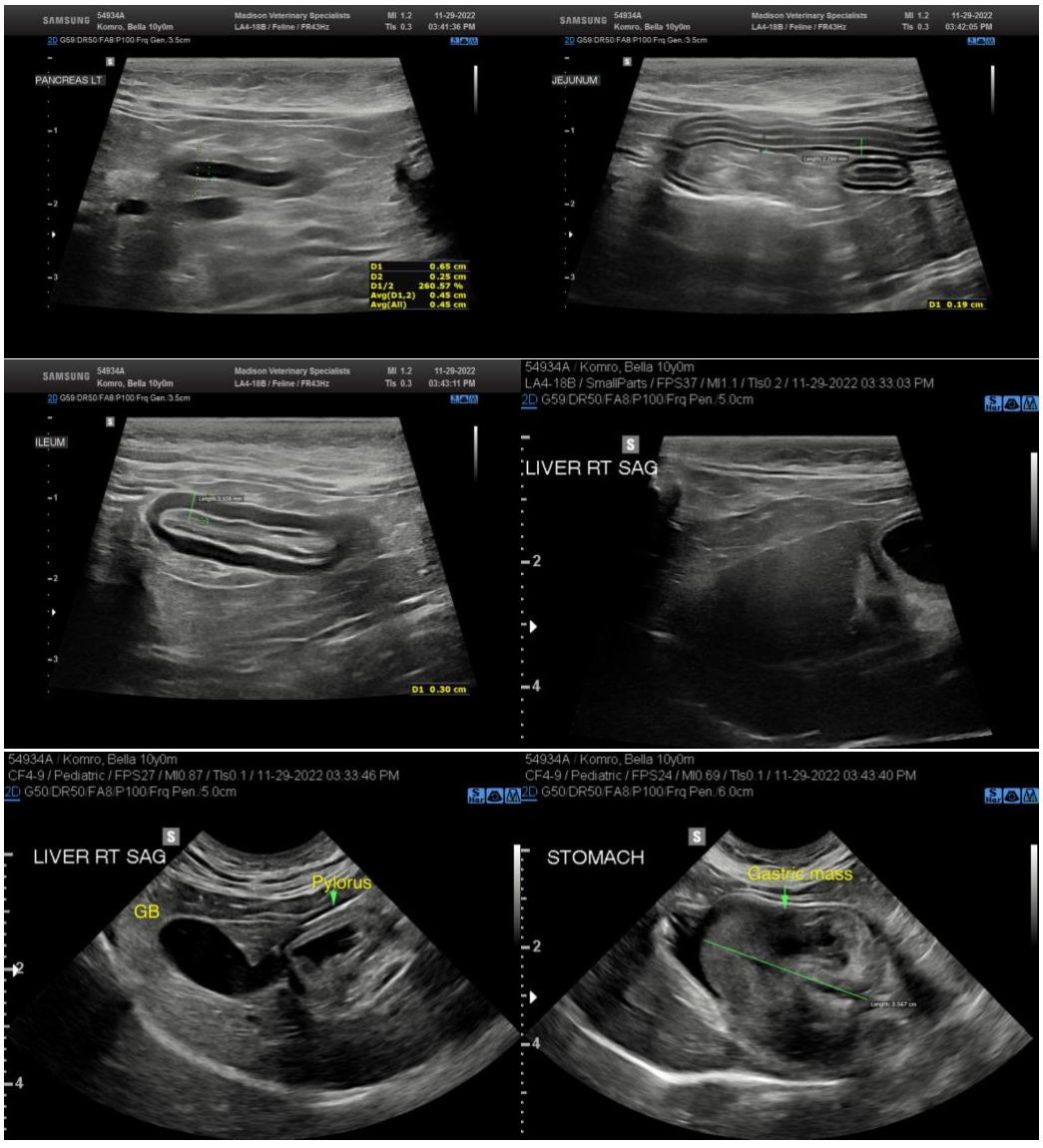
Ideally, given this presentation, abdominal CT is recommended for further clarification of the gastric mass, assessment for nonobvious metastatic disease +/- surgical planning if surgery is a potential option in this case.

Empirically, as needed gastrointestinal support pending additional diagnostics is recommended.



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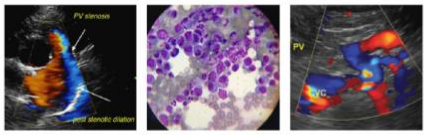

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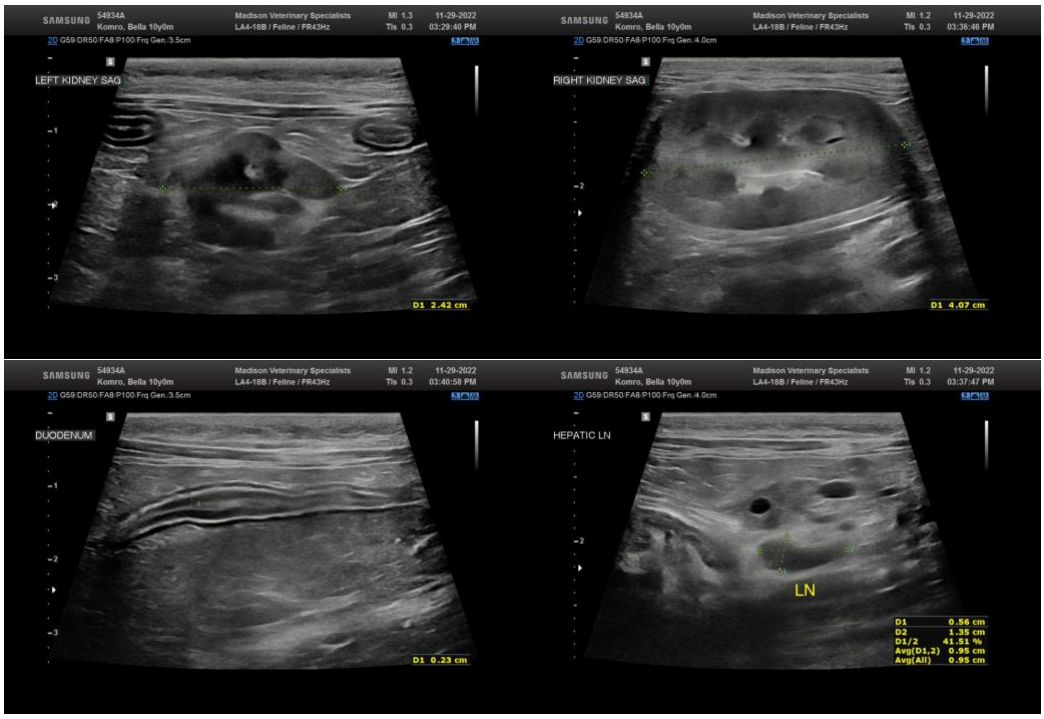

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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