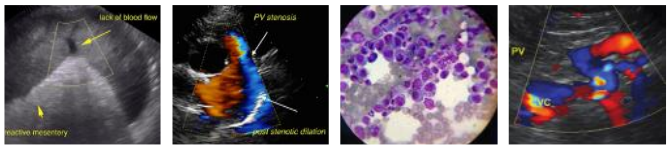
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Stacy Merson

SPECIES
Feline

BREED
DSH

SEX
FS

AGE
16yr

WEIGHT
2.71kg

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

IMAGING PERFORMED BY
Bennett

HOSPITAL NAME
Wilvet South

REFERRING VET
Bennett

INVOICE
13620ag

DATE
04/28/2023

PRESENTING CLINICAL SIGNS

Presented 4/27 PM for straining to defecate and vomiting. Known history of hyperthyroidism.

Abnormal PE/Chem/CBC/UA Results: CBC: NSF. HCT 33%, Neutrophilia 10.94k, Eos 0.1k, rest WNL. Rads: FINDINGS: The cardiac silhouette is mildly increased in width. The pulmonary vasculature appears normal. The bronchial structures are diffusely, mildly thickened. The trachea appears normal. There is no evidence of thoracic lymphadenopathy, and no pleural space abnormalities are seen. The liver is enlarged with a masslike caudal contour, consistent with the clinical history. Suture material is associated with the abdomen and consistent with a prior abdominal surgery. The abdominal viscera is otherwise unremarkable. A mild decrease in density is present in the skeletal structures and is attributed to age-related osteopenia. Small mineral foci are superimposed with the cranial aspects of the stifle joints, most consistent with meniscal mineralization, which is typically incidental. Periarticular bone formation is associated with the elbows. CONCLUSIONS: 1. Mild generalized cardiomegaly may be secondary to hypertrophic cardiomyopathy or other cardiac disease. No evidence of congestive heart failure. 2. The diffuse, mild bronchial pattern is supportive of lower airway disease of inflammatory, infectious, or parasitic etiology. No evidence of pulmonary metastasis. 3. Elbow degenerative joint disease. RECOMMENDATIONS: If removal of the liver mass is considered, CT may be considered for treatment planning. PT = 21 sec (wnl) FNA cystic liver mass for cytology - pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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.

Borderline subnormal size was 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 moderate to marked loss of corticomedullary symmetry and definition. Pinpoint dystrophic medullary mineral and mild bilateral pyelectasia were present. The left kidney measured 3.1 cm in length. The right kidney measured 3.1 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

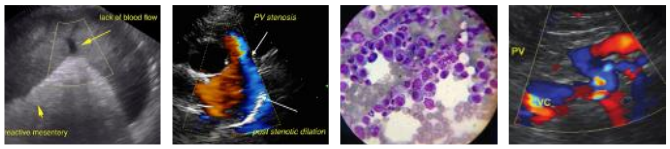
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.35 cm width. The right adrenal gland was not definitively visualized.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. 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/Gallbladder

The liver exhibited mild generalized enlargement with asymmetrical contour. The hepatomegaly primarily owing to a moderately sized fluid filled lesion in the caudal liver parenchyma measuring ~ 4.4 cm in diameter. Anechoic fluid and concurrent non-dependent echogenic cellular debris or sediment



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was noted in the lesion. An isoechoic rim potentially around the periphery of the lesion was present. Generalized parenchymal remodeling with concurrent separate smaller intraparenchymal cystic lesions containing variable anechoic to echogenic fluid were present. A focal cystic nodule was present in the mid liver. An example of a smaller intraparenchymal cystic lesion measured 2.0 cm in diameter. 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 with mild echogenic to particulate debris. The common bile duct was not definitively visualized.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild retained echogenic fluid with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained segmental non-shadowing ingesta/chyme with no signs of ileus, obstruction or foreign material.

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

Pancreas

The left pancreatic limb was normal in size with minor capsule asymmetry and isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Hepatomegaly with large fluid filled intraparenchymal lesion, concurrent separate smaller hepatic cystic lesions/cystic nodules, variably sized hepatic cysts-cystic biliary adenomas, abscess/necrosis, neoplasia all potentials.
- Bilateral chronic degenerative kidneys with mild pyelectasia.
- Possible mild chronic pancreatitis-left limb.
- Structurally unremarkable GI tract with mild gastric hypomotility and non-shadowing segmental small bowel ingesta.
- Formed feces in colon.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, hepatic FNA and centesis of hepatic fluid filled lesion for screening cytology +/- C/S could be considered for further assessment if clinically indicated. Surgical resectability of the hepatic lesion is considered questionable with potential involvement of more than one liver lobe. Abdominal CT would likely be ideal for further clarification.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

As needed GI support and possible conservative empirical therapy for chronic pancreatitis would be reasonable.

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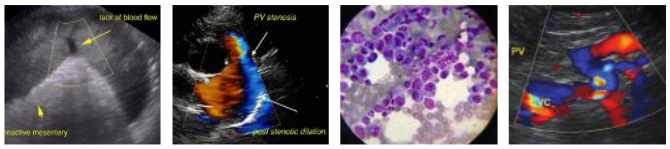

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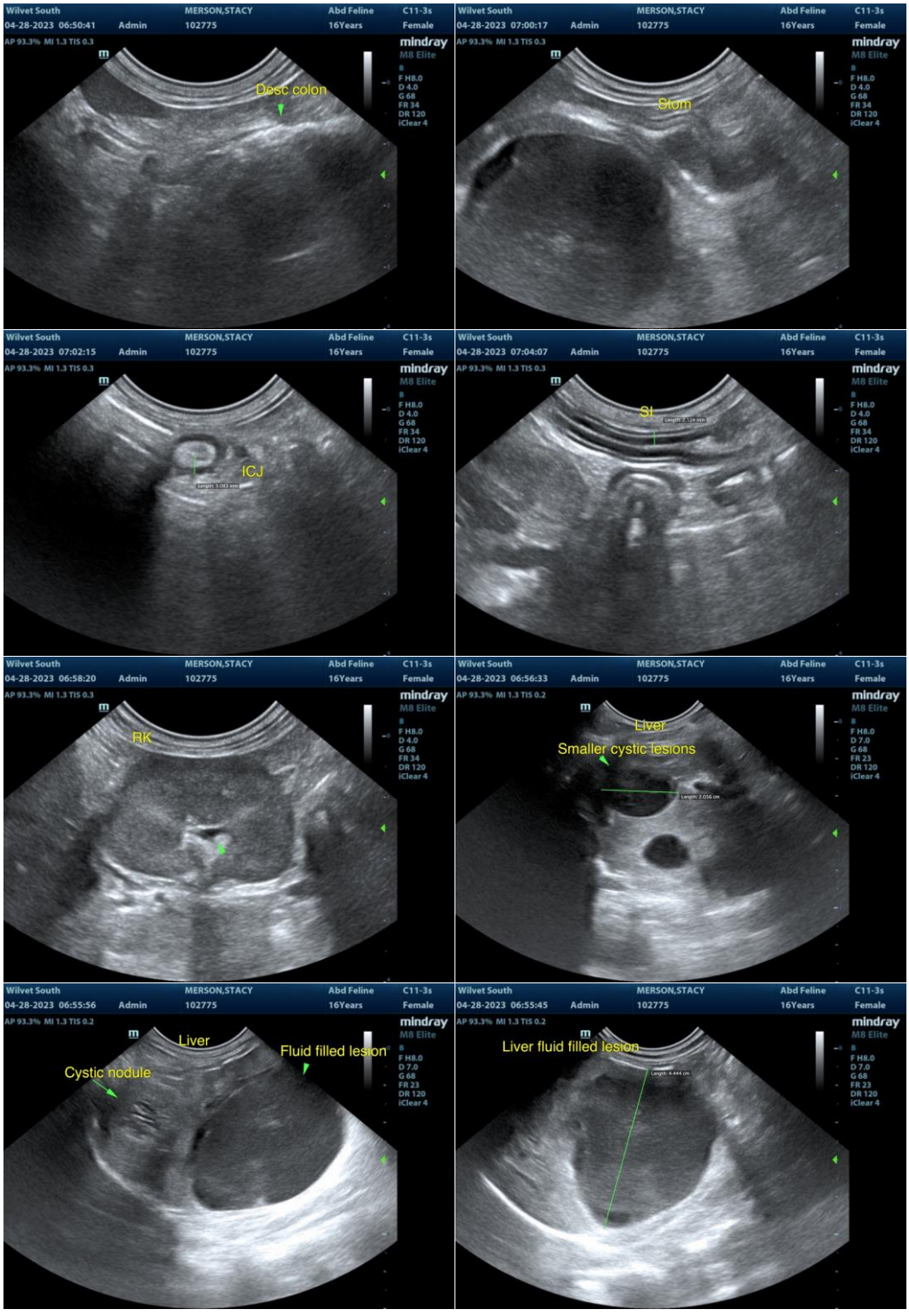

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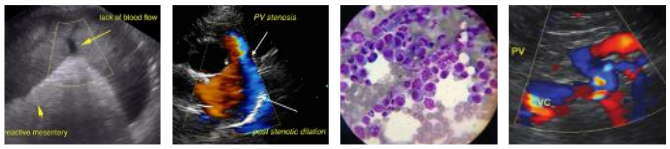

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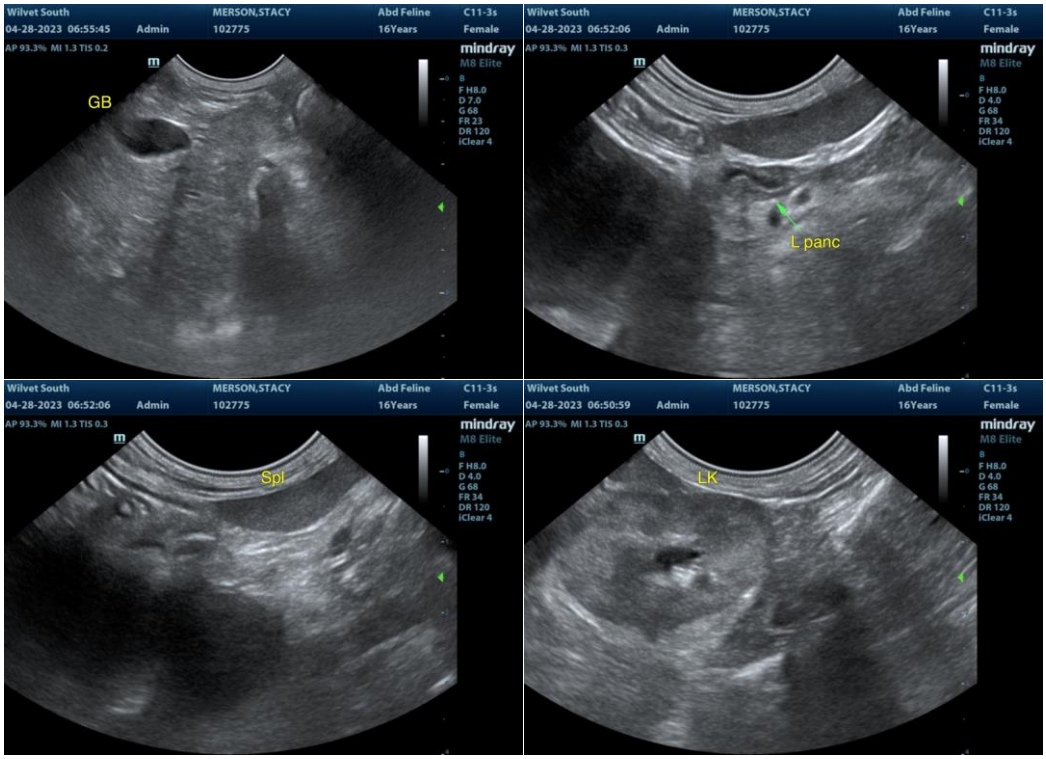

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com