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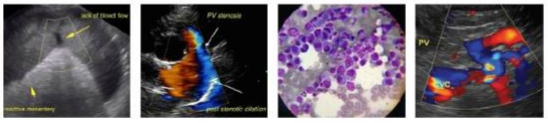

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Bruce Ollie

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

7.4 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

VCA Feline AH

REFERRING VET

Dr. Vincent Fleming

INVOICE

16266

DATE

6/23/22

PRESENTING CLINICAL SIGNS

History: sedated with butorphanol Chemistry profile - BUN 36 Creat 2.4 Ca 11.2 K 5.8 else unremarkable; CBC - Unremarkable; Urinalysis - USG 1.019 else unremarkable; Thyroid hormones - T4 1.7 ASSESSMENTS Hyperkalemia - mild, Hypercalcemia - mild, Weight loss Unremarkable labs aside from mild hyperkalemia r/o renal, tumor lysis, other, mild hypercalcemia r/o renal, neoplasia, idiopathic, other. PLANS Hyperkalemia - mild, Hypercalcemia - mild, Weight loss, Thickened small intestine - muscularis, HOCM - mild, Heart murmur, grade 2 of 6 Combined recheck echo/AUS scheduled 6/23/22.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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.

The right kidney was mildly subnormal in size compared to the right kidney. 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. Nonspecific yet nonobstructive minor proximal left ureter dilation. No evidence of calculi noted. The left kidney measured 2.9 cm in length. The right kidney measured 3.35 cm in length.

Adrenal Glands

An indistinct nonhomogeneous to mixed echogenic mass lesion was present in the area of the left adrenal gland, measuring 1.8 cm x 1.2 cm.

The right adrenal gland was indistinctly visualized yet without overt pathology, subjectively measuring 0.36 cm width.

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. The spleen measured 0.47 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.

Gastrointestinal

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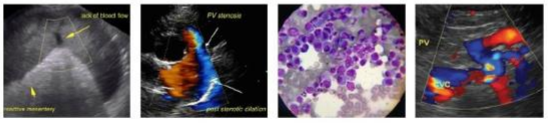

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.25 cm.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered to inverted muscularis / mucosa owing to generalized moderate to marked yet variable muscularis hypertrophy. The jejunum wall measured up to 0.38 cm. The duodenum wall measured 0.33 cm. The ileocolic wall measured 0.50 cm.

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

Pancreas

The left pancreatic limb exhibited normal size with minor areas of capsule asymmetry, subtle hypoechoic to heterogeneous parenchyma compared to adjacent omentum.

Free Abdomen

Intermittent focally enlarged jejunocolic lymph nodes were present. 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 measured 2.45 cm x 0.71 cm.

Small pockets of scant peritoneal free fluid were present. Generalized mild reactive mesentery noted.

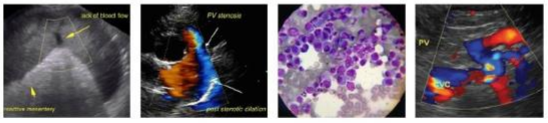
ULTRASONOGRAPHIC FINDINGS

- Enteropathy, exhibiting altered to inverted wall layer ratio- consistent with infiltrative enteropathy
- Associated intermittent to multiple prominent to hypoechoic mesenteric lymph nodes and minor peritoneal free fluid- hyperplasia or reactive lymphadenitis suspected.
- Indistinct nonhomogeneous mass lesion in the area of the left adrenal gland
- Possible concurrent low-grade pancreatitis
- Bilateral moderate chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the small intestinal presentation may include inflammatory infiltrative enteropathy, i.e., IBD/eosinophilic enteritis or neoplastic infiltrative enteropathy with round cells, such as lymphoma or mast cell neoplasia, both of which may present in similar sonographic manner. Potentially, ultrasound guided FNA of the thickened intestinal wall could be considered for screening cytology, as well as mesenteric lymph node. Full thickness intestinal and lymphatic biopsies are likely required for a definitive diagnosis. IBD protocol with assessment of clinical response and monitoring of body weight would be reasonable. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

The mass effect in the area of the left adrenal gland is suspicious for primary left adrenal pathology. Screening blood pressure to assess for evidence of hypertension is recommended. CONNS syndrome is



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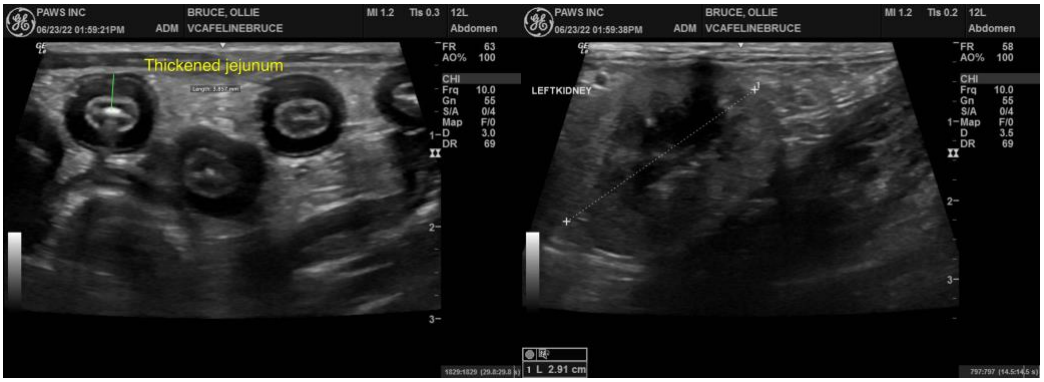
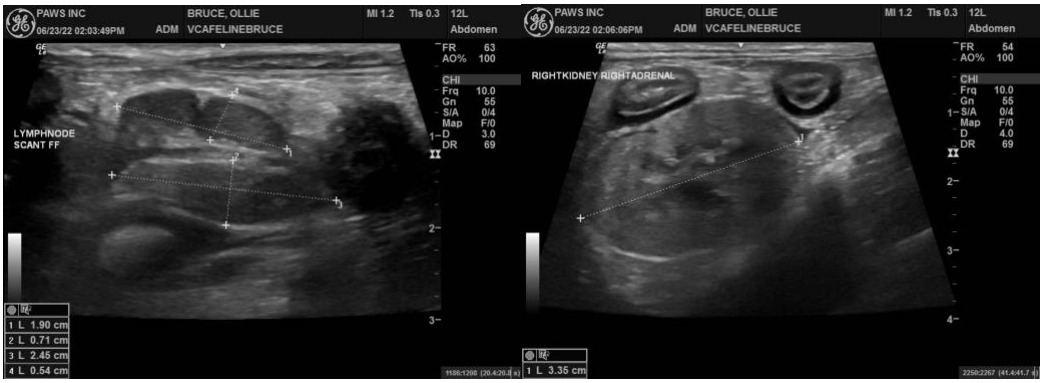
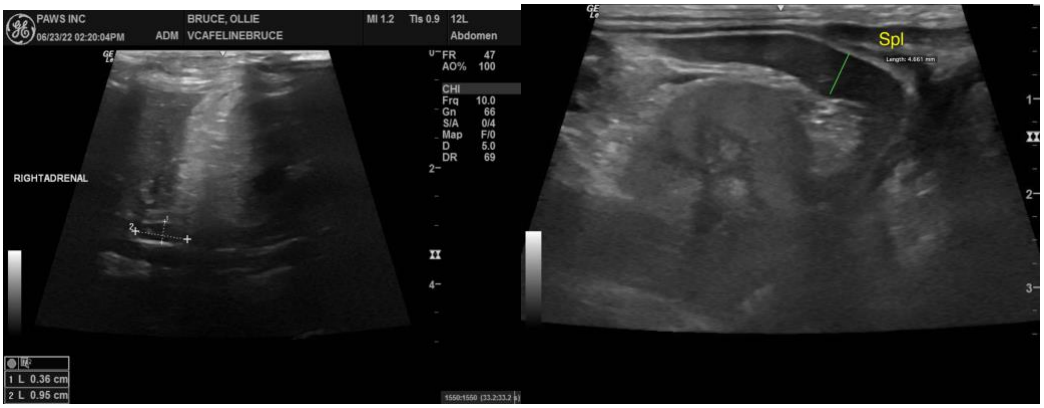
considered unlikely, given the hyperkalemia. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

Three-view chest radiographs are suggested, if not done, to rule out occult pathology which may be a contributing factor to the weight loss.







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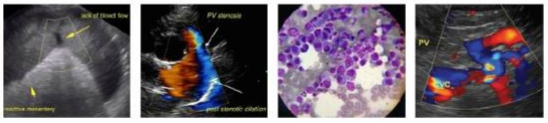

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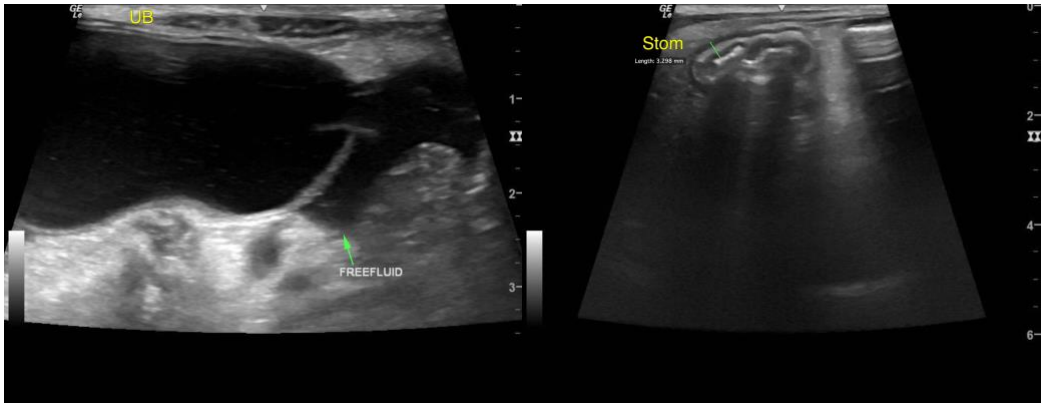

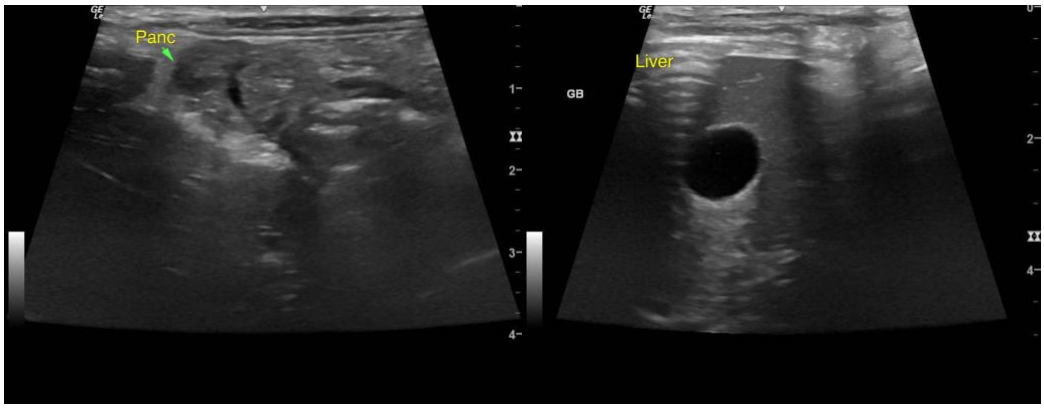

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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