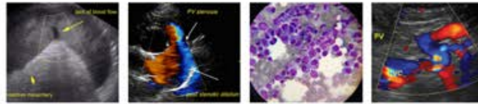


PATIENT

Momma Amaral

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

16 Years

WEIGHT

7 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Mashpee Vet Hospital

REFERRING VET

Dr. Mark Oldham

INVOICE

38446

DATE

6/6/22

PRESENTING CLINICAL SIGNS

Weight loss; vomiting; urinating inappropriately; normal labwork.

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.

Normal size and margination 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 mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint medullary mineral noted in both kidneys. The left kidney measured 3.8 cm. The right kidney measured 3.1 cm. Minor pyelectasia noted in the right kidney.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.28 cm. The right adrenal gland measured 0.36 cm.

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

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, non-homogeneous to microcystic mass was present in the deep mid to right liver, measuring approximately 3.1 cm in diameter. Subjective hepatic vasculature congestion.

The gallbladder was non distended in size with mild gallbladder debris, likely incidental. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

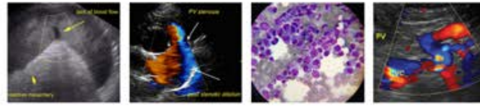
The stomach presented intact yet mildly prominent wall layering. Mild retained chyme was present in the stomach. Ventral gastric body wall measured 0.33 cm.

The small intestine presented intact yet prominent wall layering owing to segmental to generalized propensity for mildly prominent mucosa and muscularis layers. Duodenum wall measured 0.34 cm. Jejunum wall measured 0.30 cm. Ileocolic wall measured 0.42 cm.

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

Pancreas

The pancreas was normal in size and contour with mildly hypoechoic parenchyma with minor pancreatic duct dilation.



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Free Abdomen

Intermittent enlarged mesenteric lymph nodes were present, including gastric, jejunal and colic lymph nodes. Example measured 0.56 cm in diameter. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of mild perilymphatic and peri intetistinal reactive mesentery.

Small pockets of scant free fluid present.

ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable urinary bladder.
- Bilateral chronic renal changes.
- Non-homogeneous to microcystic liver mass – suspect benign cystic biliary adenoma, potential for cystic biliary adenocarcinoma or other.
- Infiltrative enteropathy pattern.
- Associated mildly prominent to hypoechoic mesenteric lymphadenopathy.
- Suspect low-grade chronic active pancreatitis.
- Scant free fluid.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine exhibited intact yet prominent wall layering, suggestive of infiltrative enteropathy. Considerations may include inflammatory infiltrative enteropathy/IBD, while the possibility of neoplastic infiltrative enteropathy with round cells such as lymphoma, which may present in similar sonographic manner, cannot be excluded. Concurrent mild mesenteric lymphatic hyperplasia or reactive lymphadenitis owing to underlying inflammatory bowel, with potential for very early neoplastic lymphadenopathy.

Further assessment may include GI panel to include PLI, TLI, cobalamin and folate. 3-view chest radiographs suggested to rule out occult thoracic pathology and assess cardiopulmonary status. Full thickness intestinal biopsies would be required for definitive diagnosis. Empirical IBD protocol, which may include cobalamin supplementation, as needed gastrointestinal support, and Prednisolone trial at lowest effective dose to control clinical signs, would be reasonable.

The subjective hepatic vasculature congestion and scant peritoneal free fluid are suspected to be owing to sedation, although no reported sedation in the history. If sedation was not used, and assuming normal albumin levels, the etiology of the hepatic vasculature congestion and minor peritoneal effusion would be unclear. Recheck sonogram to assess for progressive intestinal mural changes, lymphadenopathy, or increasing effusion pending clinical response to therapy.

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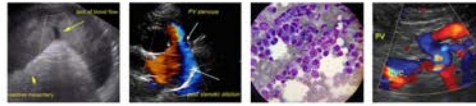
4paus.com 781-635-5677



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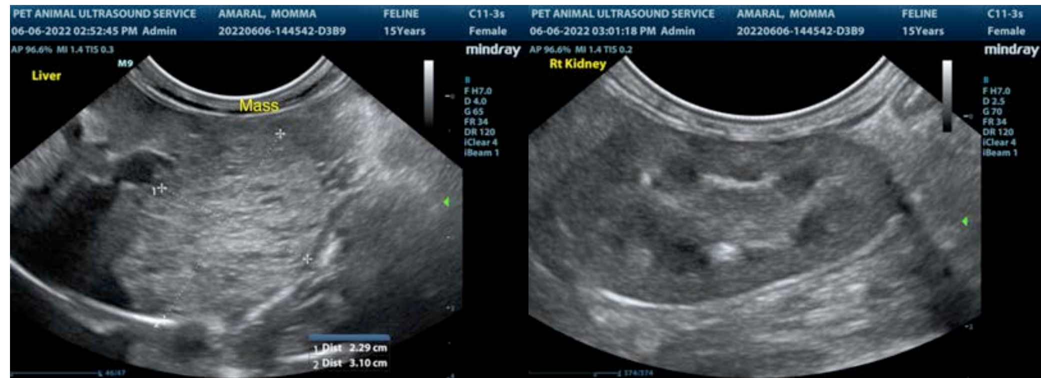

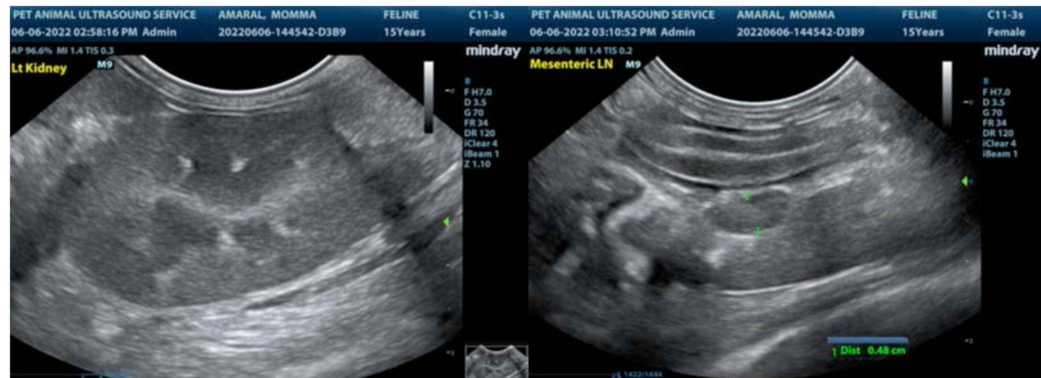

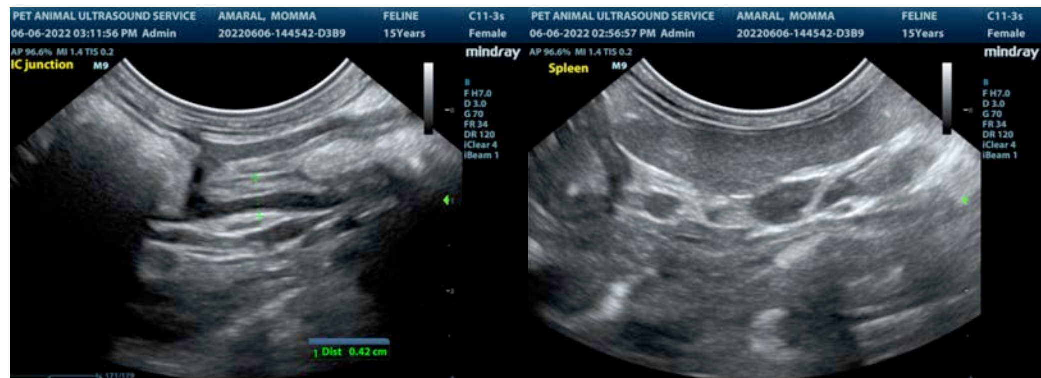

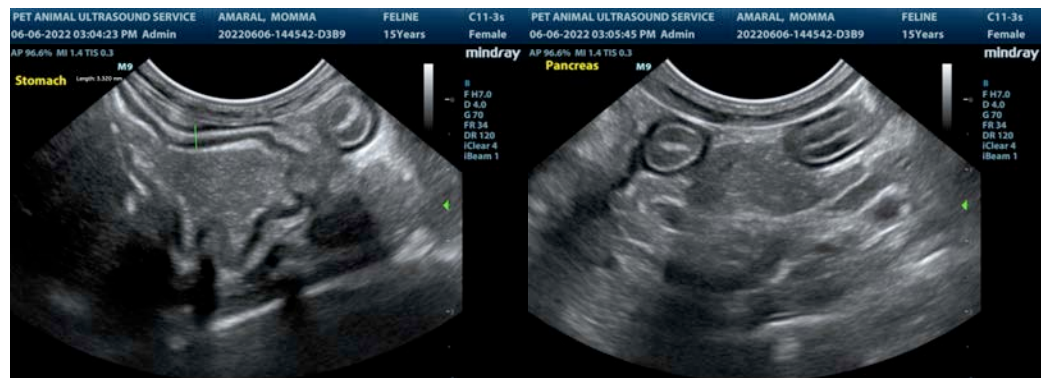

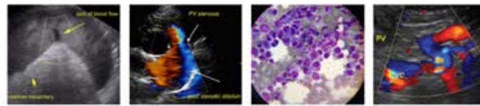

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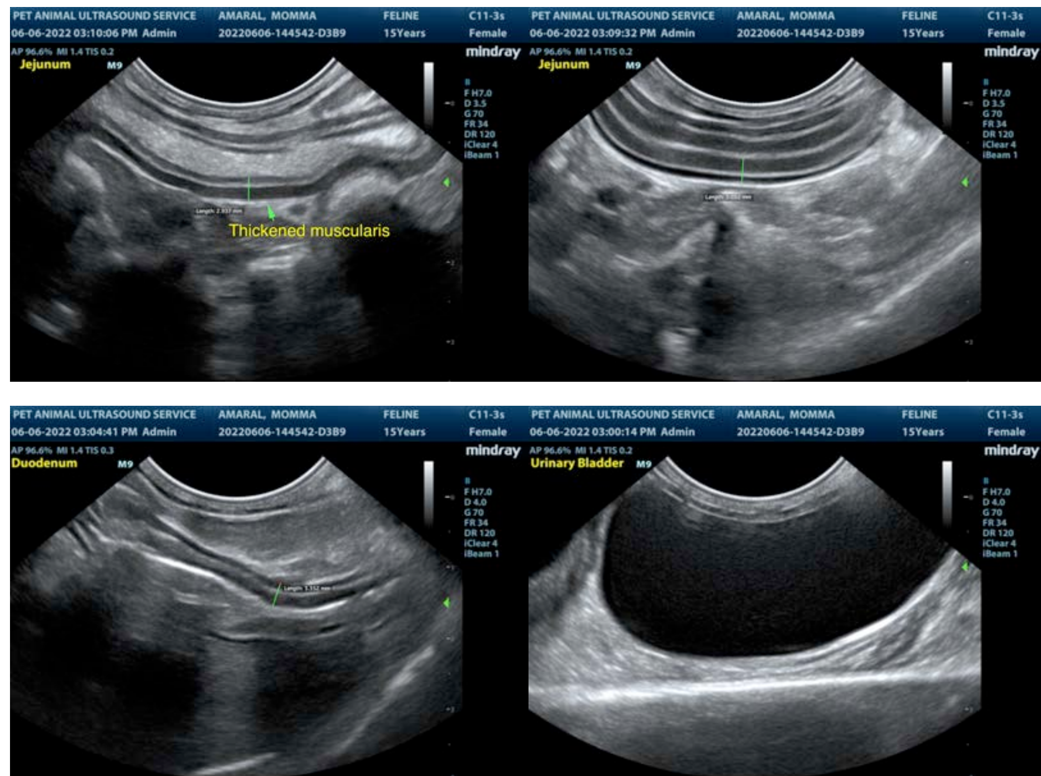

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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