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Clinical Sonography & Telecytology
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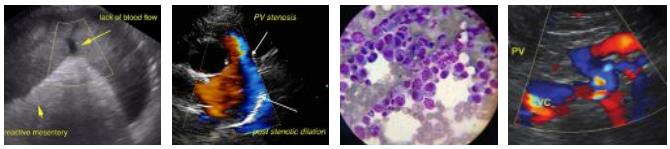

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Dog Plummer

SPECIES
Feline

BREED
DSH

SEX
FS

AGE
15yr

WEIGHT
6.65kg

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

IMAGING PERFORMED BY
Patti Mayfield DVM

HOSPITAL NAME
Feline Fine Cat Clinic

REFERRING VET
Dr. Kadasi

INVOICE
11406ag

DATE
08/18/2022

PRESENTING CLINICAL SIGNS

Acute onset recurrent vomiting and diarrhea, hoping to rule out abdominal mass / obvious neoplasia. Adopted by O as senior cat unknown prior hx about 1 year ago, no diagnostics done yet.

Abnormal PE/Chem/CBC/UA Results: Pertinent Physical Exam Abnormalities: -- Exam today revealed very tense cranial abdomen with discomfort, appears nauseous on exam. Moderate dental disease. Moderate muscle wasting over spine and ribs. Pertinent Diagnostic Result Abnormalities (i.e., blood work, urine analysis, fecal tests, radiographs, etc): -- AXR shows area of fuzzy opacity in cranial abdomen - r/o pancreatitis, hepatomegaly, splenomegaly, +/- masses of any of these organs. -- O holding on lab work until AUS findings - if mass/obvious cancer, no further diagnostics. If not obvious answer on AUS, O would like blood pressure and full labs (CBC chem T4 UA FPL PROBNP) done.

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 focal dependent to mild non-dependent hyperechoic sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The left kidney was subnormal in size with asymmetrical margination including multiple cortical infarcts. Normal size and margination were present in the kidneys. Moderate to marked loss of corticomedullary demarcation with reduce medullary volume was present. The left kidney measured 2.7 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 cortex 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. Minor nonobstructive medullary mineral was present. The right kidney measured 4.5 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 0.50 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.5 cm width at the caudal pole.

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 0.91 cm in width at the level of the hilus.

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 regional indistinct area of hypoechoic parenchyma to ill-defined nodule was present in the ventral liver measuring ~ 1.4 cm in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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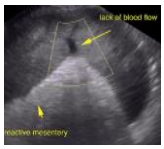

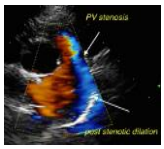

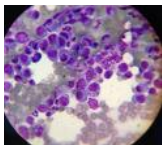
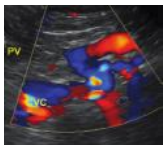

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The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild non-shadowing ingesta with no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.23 cm in width.

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 measured 0.21 in width. The jejunum wall measured 0.22 cm in width.

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

Pancreas

The parenchyma of the pancreas was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present. Regional mild hyperechoic mesentery noted around the ileocolic junction.

ULTRASONOGRAPHIC FINDINGS

- Focal dependent urinary bladder mineral with non-dependent sediment-cellular debris/protein, lipid, mucus or crystalline debris possible
- Subnormal left kidney size with marked degenerative changes and cortical infarcts
- Right kidney mild chronic changes and medullary mineral
- Chronic pancreatitis pattern
- Hepatic parenchymal remodeling with ill defined regional hypoechoic parenchyma vs nodule-nonspecific

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

Considerations for the hepatic parenchyma remodeling include benign changes i.e. hyperplasia, hematopoiesis or inflammation with neoplastic criteria thought less likely.

The GI signs may be secondary to dietary intolerance, occult parasitism, structurally insignificant inflammatory gastroenteropathy or chronic pancreatitis. No overt evidence of GI neoplastic criteria was noted. This potential for pancreatitis may be considered if evidence of cranial abdominal or subxiphoid discomfort on palpation. Correlation with a spec fPL or a GI panel to include PLI/TLI/Cobalamin/Folate and full chemistry panel/ CBC is recommended.

Assuming normal clotting status and using a 25g needle a hepatic FNA is recommended for screening cytology if evidence of abnormal liver enzymes.

As needed GI support and conservative therapy for chronic pancreatitis with assessment of clinical response would be reasonable.

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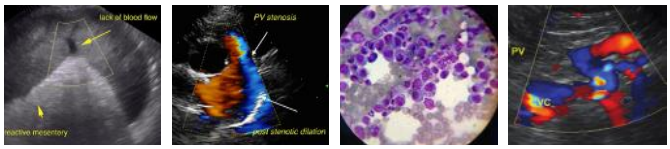

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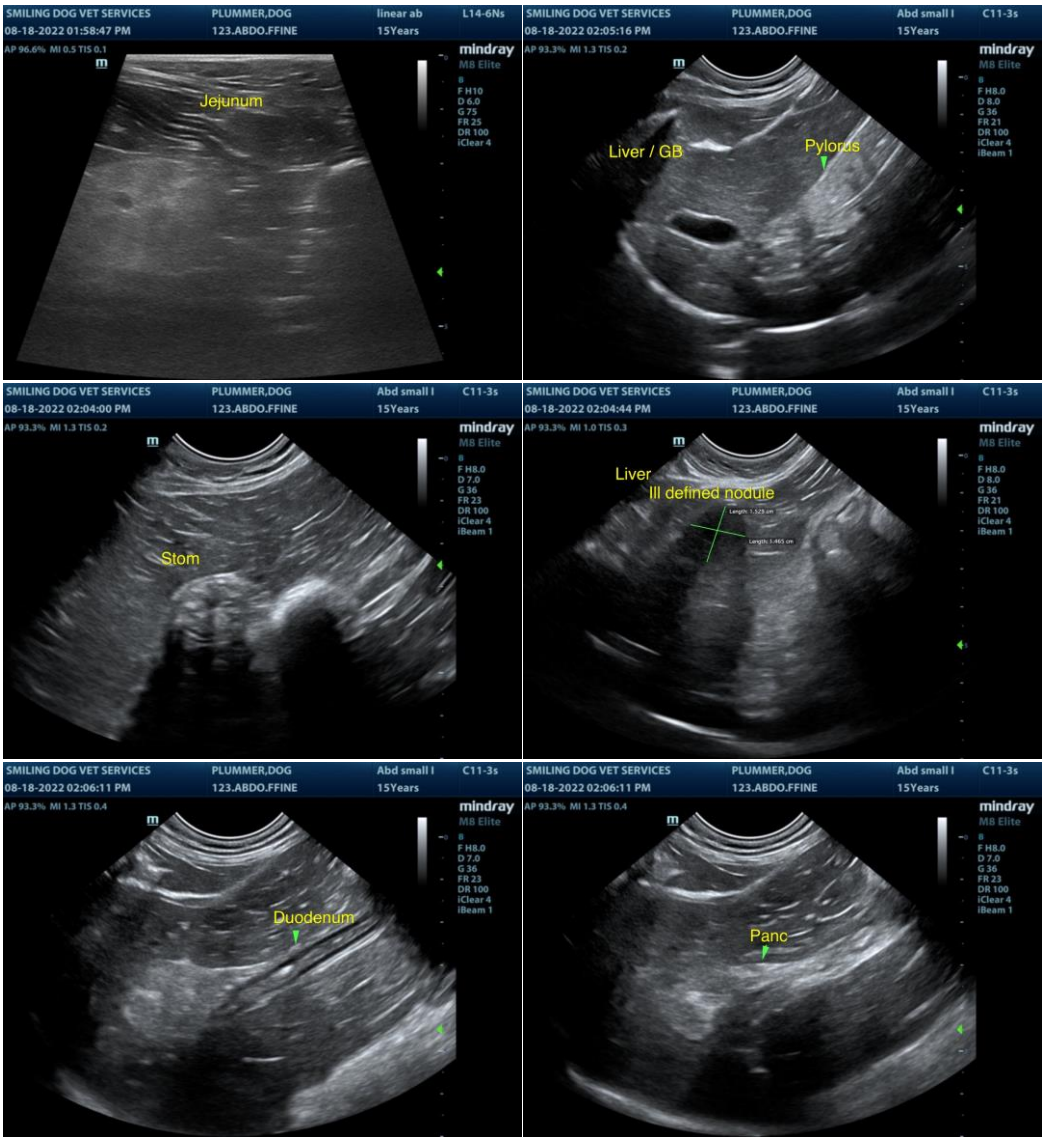

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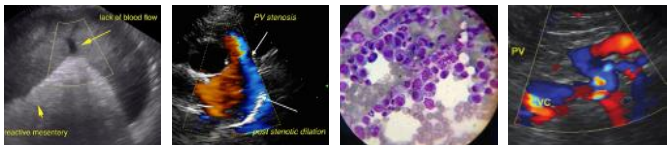

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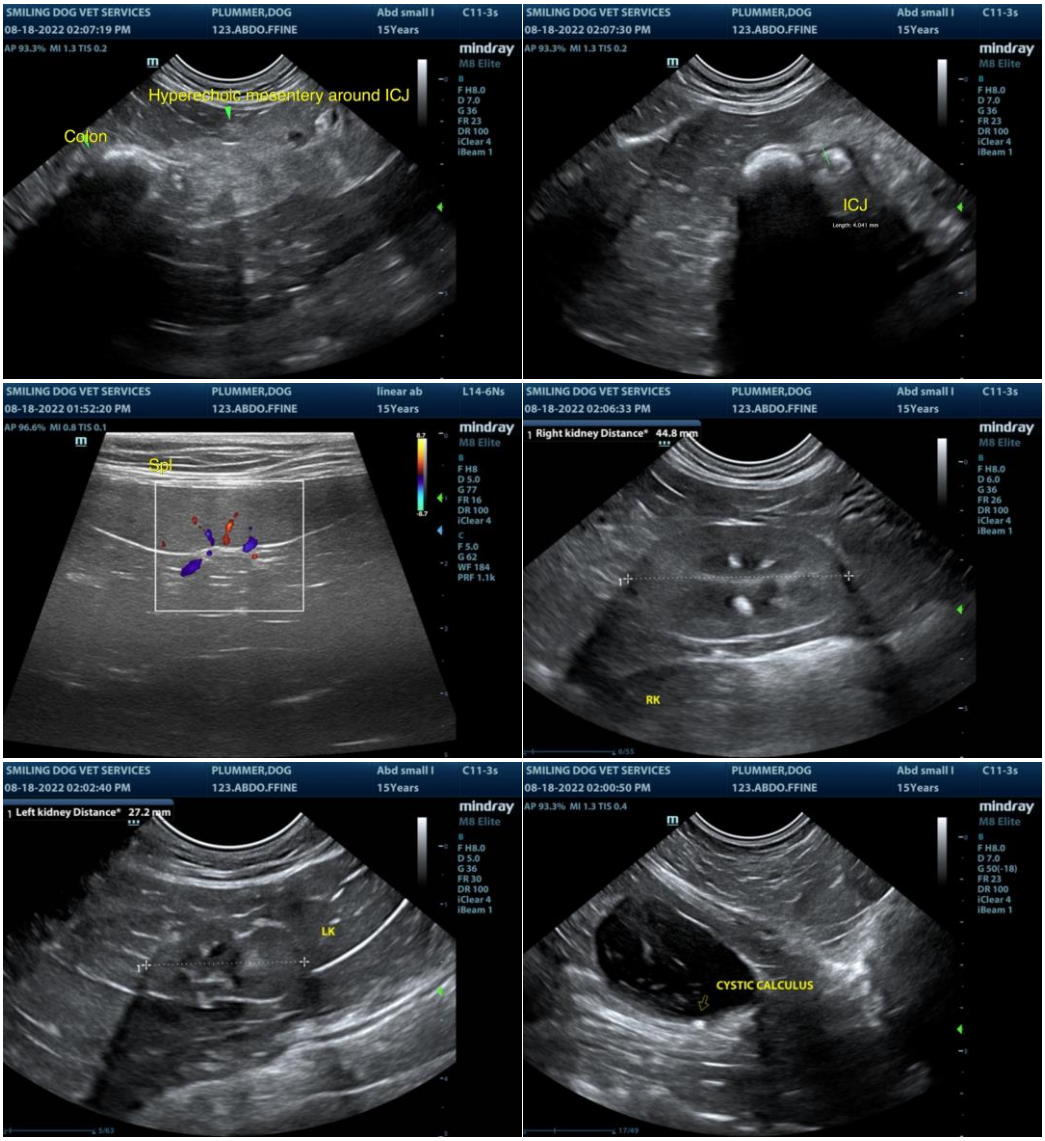

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com