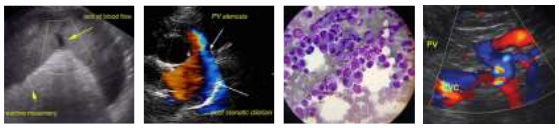


PATIENT

Mitzi Crites

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

10 years

WEIGHT

7.1 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

VCA Delta Oaks AH

REFERRING VET

Dr. Schulke

INVOICE

12280

DATE

9/22/21

PRESENTING CLINICAL SIGNS

- severe rapid weight loss -anorexia and lethargy - exam >>>cachexia and muscle wasting; oral exam is OK - concern is anorexia with hyperthyroidism, which is unusual, and concern for other comorbidity
Abnormal PE/Chem/CBC/UA Results: Will email labs. Only significant finding was hyperthyroidism (T4 >17)

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 was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were 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 loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint to focal areas of medullary mineral were present. No evidence of pelvic dilation was present. The left kidney measured 3.6 cm in length. The right kidney measured 3.9 cm in length.

Adrenal Glands

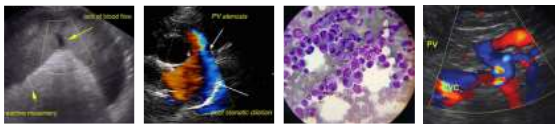
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.46 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.54 cm width.

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.

Liver/ Gallbladder

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. The hepatic and portal vasculature were normal in appearance without signs of congestion. A solitary cystic, non-expansive nodule was noted in the mid to right liver adjacent to the gallbladder, measuring 1.8 cm in diameter. The gallbladder and visualized common bile duct were normal.



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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Minor luminal gas and minor retained chyme was present. The gastric body wall width measured 0.28 cm.

The small intestine exhibited primarily intact wall layering with subjective propensity for mildly prominent segmental muscularis layer. A segment of mid-abdominal small intestine exhibited mild to moderate mural hypertrophy, decreased mural echogenicity, and loss of distinct wall layering. A focal mural cystic component was also present. The thickened segment of small Intestine measured approximately 4.0 cm in diameter with wall width up to 0.5 cm. The cystic component measured approximately 1.0 cm in diameter. By comparison, normal-appearing jejunum wall measured up to 0.34 cm in width.

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

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

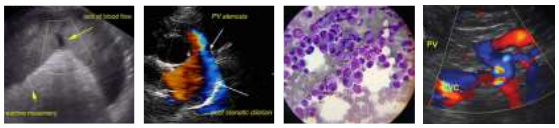
Free Abdomen

Nonspecific subjectively encapsulated cystic mass lesion noted in the right cranial abdomen in the area of the pancreas base and caudate liver lobe was present. This cystic-appearing mass lesion measured approximately 2.7 cm x 2.5 cm. Generalized mild reactive mesentery, most notable around the thickened segment of small intestine, as well as in the right cranial abdomen, was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Segmental small intestinal mural mass with associated focal cystic component, possible generalized enteropathy - segmental to generalized inflammatory vs. neoplastic Inflammatory enteropathy with potential for mural abscess or necrosis, less likely granulomatous (Dry FIP)
- Nonspecific cystic- appearing mass lesion in right cranial abdomen in area of the pancreas base and caudate liver lobe - consolidated abscess, necrotic granuloma, neoplasia, or other possible with potential for pancreatic or hepatic origin, less likely lymphatic or nonobvious gastrointestinal origin
- Chronic active pancreatitis
- Focal definitive cystic hepatic parenchymal nodule - consistent with probable benign biliary cystadenoma



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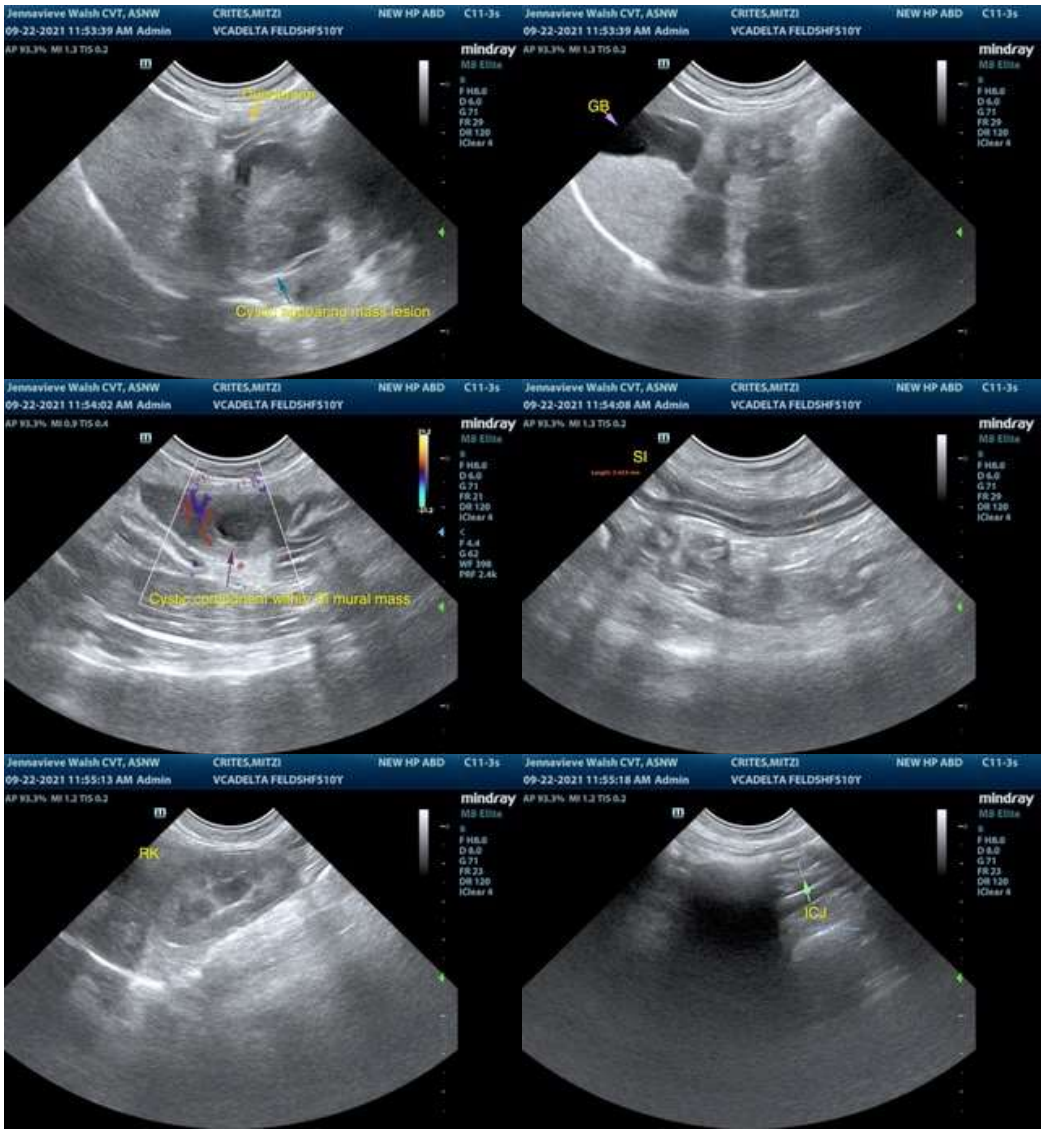
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, ultrasound-guided FNA of the cystic-appearing mass in the area of the pancreas base and caudate liver for cytology +/- C/S could be considered. If possible, further assessment with CT, as well as potential surgical planning with potential for biopsies or resection of the unspecified cystic-appearing mass, as well as resection anastomosis of the small intestinal mural mass and intestinal biopsies may be considered pending control of hyperthyroidism. Surgical consultation could be considered. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Three view chest radiographs are recommended to rule out occult thoracic pathology.



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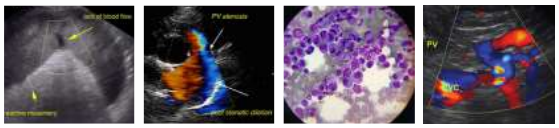

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AnimalSoundsNW.com 541-357-9423

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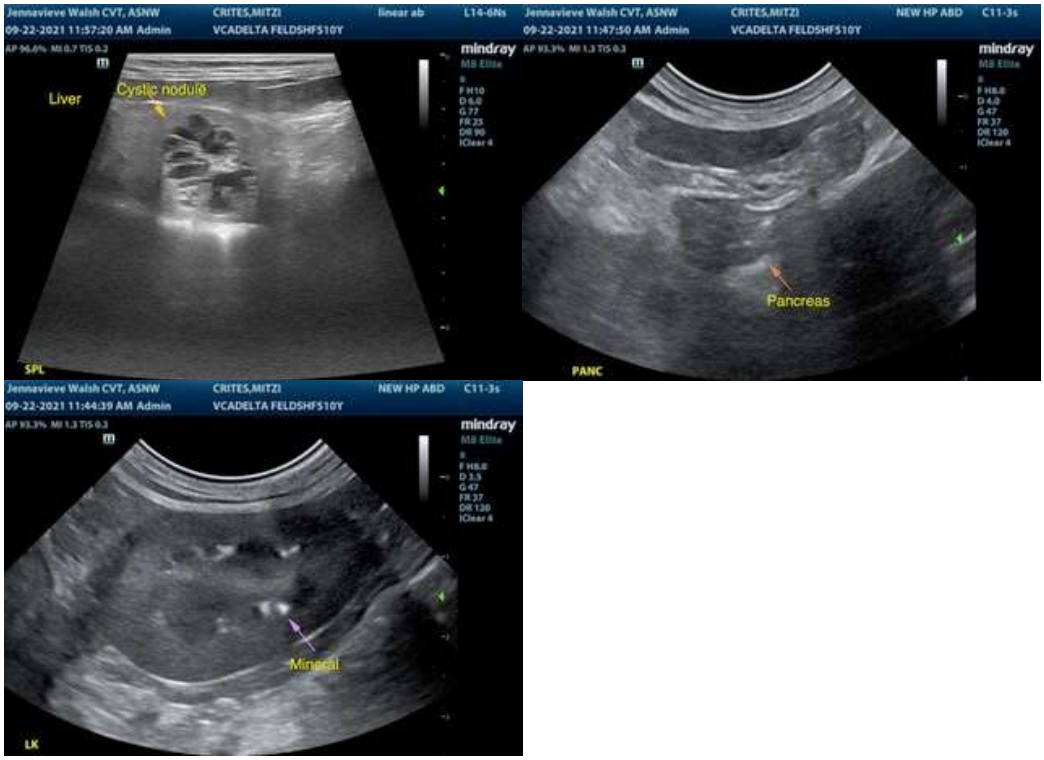

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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